

The Great “Crazy” Cover-up and Its Human Costs

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Psychiatric diagnosis is fiction sold to the public as fact.

--Gary Greenberg (2013, p.333)

[Psychiatry] has something rotten at its foundation: its have-it-both-ways, real-until-it-isn't diagnostic manual.

--Gary Greenberg (2013, p.351)

Is anything less regulated than the financial giants that have so damaged the United States economy? The enterprise of psychiatric diagnosis. Does that matter? Aren't those who seek help in the mental health system safe in the hands of people who have committed their lives to being helping professionals? The tragic answer is "no."

In the land of total lack of regulation, bizarre things transpire. History is rewritten. Cover-ups of facts that destroy people's lives are the rule. There are no black-box warnings. In the brouhaha leading up to the 2013 publication of the *Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5)*, no one mentioned the complete lack of regulation in the creation of this manual. Furthermore, the cockfight among the most powerful men in the realm of psychiatric diagnosis, with two previous *DSM* chiefs trashing the newest ones, pulled the focus from what matters most, that people's lives are being destroyed, and no one with power is taking steps to redress past harm or prevent future harm. Even some of

the previously most trenchant critics of psychiatric diagnosis have seemed blinded to crucial aspects of the history by the recent drama.¹ With crucial portions of the history of psychiatric diagnosis dramatically rewritten, falsehoods have been widely accepted by the public and professionals as truth.

People whose version of history is considered true wield enormous power. The great journalist I.F. Stone (1907-1989) rigorously checked people's claims and statements against what they had said previously and against the facts. Those who maintained power by rewriting history had much to fear from Stone. His approach is too much missing² from the *DSM-5* debate (APA, 2013), its absence especially alarming because the previous edition, *DSM-IV*, did much to lead over nearly two decades to the psychopathologizing of millions more people than ever before in history, and the consequences for many have been tragic (Caplan, 2012a, 2012b).

This chapter is less about the specific people who do the rewriting than about the forces they embody and the power they have to invent History, which then becomes the basis for wrong assumptions, misplaced outrage, lack of outrage where it would be justified, and failure to take action in order to prevent harm.

It is a major and dangerous myth to assume that psychiatric diagnosis is scientific, that it is always or usually helpful and at least never harmful, and that the traditional approaches of psychotherapy and drugs are the most effective and safe ways to reduce suffering. That combination of beliefs is used to justify depriving psychiatrically labeled

¹ It would likely have been called *hysteria* if the top people had been women.

² [Thomas E. Patterson](#), Bradlee Professor of Government and the Press at Harvard Kennedy School (HKS), recently called for "knowledge-based journalism." What a sad commentary that "journalism" is not assumed to have to be knowledge-based (Pazzanese, 2013).

people of their human rights on the grounds that it is good for them or society or both (Caplan, 2013b).

In 1988 I accepted the invitation of Allen Frances, *DSM-IV* Task Force head, to serve on two of his committees. As a longtime *DSM* advocate, I had believed it was scientific. Serving on the committees, I was stunned to watch as high-quality science that failed to support the goals of those in power in the *DSM-IV* hierarchy was ignored, distorted, even lied about (Caplan, 1995), with junk science presented as of good quality when it supported their goals. After two years of attempting unsuccessfully to persuade the committees and Frances to base decisions on the good science, be forthright about their work, and pay attention to the harm to people from psychiatric labels, I resigned from the committees. Since then, I watched as the misrepresentation of the *DSM-IV* as scientific and the failure to redress and prevent harm continued. Increasingly and across the world, not only the *DSM* and American Psychiatric Association leadership but also many other professionals, media people, and laypeople spoke as though these diagnoses were scientifically grounded, the risks getting scant attention. From the late 1980s to the present, I initiated protests and public education about psychiatric diagnosis, so journalists often interviewed me, and when I compared what I had told them with what ended up in print or on the air, I was dumbfounded. I took care in the interviews to provide proof of my claims, but in dozens of interviews, only the rarest of journalists accurately reported the story. Nearly all ignored the fact that the diagnosis advocates' claims were largely unfounded while mine were supported by evidence. Instead, terminology in the stories followed the pattern of "Caplan *claimed* X, but the *DSM*

people *explained* that she was wrong” (details of this pattern are given in Caplan, 1995). Either they had not asked the advocates for documentation about the scientific basis (or lack of) behind their labels and evidence of harm they caused, or, knowing there was no documentation to support the advocates’ claims, neglected to report this fact.

The following is a recent example of how history gets distorted. It is by no means the worst one, but I report it because I was directly involved in it and thus can describe with confidence what transpired. In 2013, shortly before *DSM-5*’s scheduled publication, Elizabeth Saenger asked to interview me for the publication *RecoverE* for the Coalition of Behavioral Health Agencies, Inc., “to showcase problems with the *DSM-5*...where doing so could make a difference” (Saenger, 2013). We did the interview, and she sent me her write-up as it went to press. Immediately, I wrote to confirm that most was fine but that it contained a few serious errors and that a companion article by the *DSM-IV* head (Allen Frances) included a “completely false and totally misleading statement.” I left details about the errors on her voicemail. She replied that I should rewrite the story but at half its original length, much shorter than the companion pieces by the heads of *DSM-IV* and *DSM-5*, and by the director of the National Institute of Mental Health. I wrote to her and her supervisor that “I have been trying to get these changes and warnings made on the assumption, which I am sure is warranted, that you do not wish to participate in perpetuating falsehoods that destroy people’s lives.” In the end, they eliminated my interview altogether, and published the pieces by the three top dueling banjos who had huge stakes in promoting the traditional mental health system as “Three Perspectives on

the DSM-5 from Superstars in Psychiatry” (http://www.coalitionny.org/the_center/recovere-works/RECOVERe-worksMay2013.html)

The Functions of the Rewritten History

This rewriting of history is serious business. It:

Draws attention from the facts. If you believe psychiatric diagnosis is scientific, then when a professional tells you that you “are” Bipolar, you are unlikely to ask “Is there solid proof that ‘Bipolar Disorder’ is a real and reliably identifiable entity?” “Is there evidence that giving this label will alleviate suffering or that getting the label carries risks of harm?”. Not knowing that they need to ask such questions has meant that the lives of an untold number of people have been damaged due to a cascade of consequences from labeling. And journalists have gone far to perpetuate the cover-up of the poor science underlying diagnosis (e.g., Jabr, 2012, claimed in *Scientific American* – without evidence -- that the *DSM-5* would improve the basis for choosing treatments).

Draws energy and resources away from stopping, redressing, and preventing harm. *DSM-IV* earned the APA more than \$100 million, and there is no sign that one penny was spent to gather (never mind solicit) information about the harm from diagnosis, to redress past harm, or to prevent future harm through such actions as implementing professional and public education about the truth regarding these categories (Caplan, 2013a).

Draws everyone’s attention from the most important people, those who have suffered from being psychiatrically labeled. The public debate was largely about what the men who headed *III*, *III-R*, *IV* and *5* were saying to each other.

Maintains the status quo. The nature of the debate about *DSM-5* includes the false assertions of the *DSM-IV* editor, Allen Frances, that his own edition was scrupulously scientific and caused only a tiny number of problems. He also confined his attacks to a dozen or so of the many hundreds of *DSM-5*'s categories. The need for the manual to exist at all was rarely challenged, and the challenges got little or no media attention. Only a miniscule fraction of the devastating harm caused by previous editions was mentioned, and ways to redress and reduce the harm were almost totally ignored.

Causes history to repeat itself. Journalists ask the head of each new edition why *their* edition was needed, and each head answers, "The previous one wasn't scientific" (Caplan, 1995). They fail to respond with, "How can you say that, when that is what your predecessor also claimed?" Each leader has claimed that their edition is *truly* scientific but has actually made the same kinds of errors as before (i.e., ignoring, distorting, and lying about what the science shows; failing to follow respected scientific methodology; failing to document and make public that applying these labels does not tend to reduce suffering; and failing to document and make public the huge risks of harm: Caplan, 1995). To understand the rewriting of history about *DSM-IV* is to see more clearly how the same problems and dangers happen in *DSM-5*. Most of these are inevitable as long as the current obsession with psychiatrically diagnosing people continues.

The Nature of the Rewriting

This contains not comprehensive coverage of what has been rewritten but rather key points of the generally false portrayal of earlier editions as scientific, helpful, and not harmful (or far less harmful than is the case). The portrayal was driven primarily by the *DSM-IV* head but minimally challenged even by the *DSM-5* heads, other professionals, media people, and the public.

False Portrayal as Scientific. Work on *DSM-IV* began in 1988, it was published in 1994, and from 1988 onward, Allen Frances knew that this enterprise could not honestly be described as scientifically based (Caplan, 1995; Davies, 2013; Greenberg, 2013; Kirk, Gomory, & Cohen, 2013). Yet in 2009, when he began his diatribes against the in-progress *DSM-5*, he claimed that, in contrast to *DSM-5*'s "remarkably weak methodology," work on *DSM-IV* had followed a scrupulously scientific method (Frances, 2009, 2013). To describe his own work, he used terms like "obsessively meticulous," "strict criteria," "extensive literature reviews,"³ "painstaking data analysis," "precise terms," "rigorous field trials," "objectivity," "methodological rigor," and "we couldn't afford mistakes" (Frances, 2013, xiii, xiv, 23, 67, 70, 72, 74; Frances, 2012a). Even after *DSM-5* was published, he unjustifiably claimed reliability for his edition (Frances, 2013). Curiously, he said that "*DSM-IV* was faithful to *DSM-III-R*" (Frances, 2013, 72), but he told me when inviting me to join his *DSM-IV* committees that *unlike DSM-III-R*, his decisions would be scientifically-based (Caplan, 1995). Strangely, he also told Davies that "the most important value" when creating *IV* was to "stabilise the existing arbitrary

³ The literature reviews they published in what they called *DSM Sourcebooks* were poorly done, but the massive sizes of the sourcebooks impressed some people who had not considered the quality of the work within.

decisions [*DSM-III-R*'s hundreds of categories] [rather] than to create a whole assortment of new ones" (Davies, 2013, 51). Were the only two options to stabilize the system or create many new categories?

Frances attacked the *DSM-5* editors for failing to produce a scientifically sound document (2012c). He said they focused too much on reliability and not on validity (Frances, 2013) but neglected to mention that, given the poor reliability of the manual, there is no validity, that the reliability of categories in editions before his was poor (Kirk and Kutchins, 1992; Greenberg, 2013), and that for *DSM-IV*, he did not even do reliability studies, despite the fact that *DSM-IV* contained 77 more categories than *DSM-III-R* (Caplan, 1995). He faulted *DSM-5* work groups for ignoring many research papers (Kirk et al., 2013), but for *DSM-IV* he and his colleagues ignored, distorted, and even lied about research when it did not fit with their goals (Caplan, 1995).

False Portrayal about Who Expanded Abnormality. More rewriting of history involves portrayal of *DSM-5* as an unprecedented move toward classifying all behavior as abnormal (Frances, 2013). However, that edition actually slows down the rate of increase. The number of categories skyrocketed from 297 in *DSM-III-R* to 374 in *DSM-IV* (Caplan, 1995), for a rate of 11 more categories per each of the seven years between those two editions. *DSM-5* contains 481 categories, which works out to the lower rate of 5.6 categories added per each year between *DSM-IV* and *DSM-5*. As Davies writes, due to

Frances's work on *IV* "the dramatic medicalization of normal human reactions... was allowed to proceed unchecked" (2013, 52).

Despite having headed the edition that led to the pathologizing – and thus quite likely the harming – of probably millions more people than anyone in history, Frances titled his 2013 book *Saving Normal* and casts himself as having led the fight to save normal from the time he began work on *DSM-IV* (Frances, 2013, xiii). He told Greenberg that in *DSM-IV* they added "a few" categories (not 77) and made only one mistake, and that their work led to three epidemics – diagnoses of Asperger's, Attention Deficit Hyperactivity Disorder, and Bipolar Disorder – that they could not possibly have foreseen (Frances, 74; Greenberg, 2013, 48, 98, 156). Only three? This would surprise untold numbers of people who have been harmed by the hundreds of diagnoses in *DSM-IV* (see some examples at psychdiagnosis.weebly.com). An article in the influential *Scientific American* (Jabr, 2012) included the false statement that *DSM-IV* was "largely similar to its predecessor," helping reify the claim that few additions were made.

Davies asked Frances why he failed to omit from *DSM-IV* the huge numbers of *DSM-III-R* disorders that Frances described as eccentric and having "remarkably weak scientific support" (Davies, 2013, 51). As Davies pointed out, the absence of good scientific support should have led to their removal.

Revealingly, Frances has said that although "we cannot develop a useful definition for the general concept 'mental disorder'... we can quite easily define each one of the specific mental disorders" (Frances, 2013, 23). By that logic, as long as one can define *fear*,

horse, table, and freedom, although there is no way to determine whether or not they are all mental disorders, it is fine to group them all under that rubric. This approach leaves wide open the door to what Gomory, Wong, Cohen and Lacasse (2011) have described, which is that “mental illness” is applied to the many kinds of behavior that have become the targets of a “biomedical industrial complex.”

False Portrayal as Helpful and Not Harmful. _ In his *Scientific American* article, Jabr quoted without question a psychiatrist who claimed that psychiatric diagnosis has increased in reliability (2012), but this is untrue. It had long been known that two therapists using the *DSM* were not likely to agree on what diagnosis to give a patient (Kirk and Kutchins, 1992; Caplan, 1995). If two therapists diagnose a patient differently, which label should be used to decide how to treat the person and thus, ideally, reduce their suffering? Also, patients’ labels are often changed many times. Yet not only Frances but also many the APA presidents over the decades have publicly boasted about the good reliability and helpfulness of their profit-making manual.⁴

After I revealed what I had learned about the unscientific production of *DSM-IV* and that its leaders denied that it caused harm despite knowing it did (Caplan, 1995), I began hearing from people who had experienced damage that cascades from that first step of being diagnosed. *Therapists almost never disclose to their patients the three key points* — that psychiatric diagnosis is not scientific, is unlikely to reduce their suffering, and carries

⁴ Unpublished 2012 complaint by Paula Joan Caplan to American Psychiatric Association’s Ethics Committee, which includes detailed examination of the official convention lectures of every APA president and president-elect from 1988 to the time the complaint was written. Available on request.

major risks of many kinds of harm, *so almost no patient ever gives informed consent to receiving a label*. There is the pervasive fiction that however the therapist diagnoses you, the treatment follows from the label and will likely reduce your suffering and not harm you. Forms of harm include but are not limited to plummeting self-confidence and skyrocketing self-doubt; loss of hope, employment, health insurance, credibility in legal proceedings and other settings, custody of one's children, security clearance, and the right to make decisions about one's medical and legal affairs; having one's real physical illnesses or injuries explained away as figments of one's imagination; and serious physical damage and even death from the negative effects of psychotropic drugs (Caplan, 2012a, 2012b; Whitaker, 2010). A series of 10-minute videos of stories of harm that I coordinated are on Youtube under the collective title, "Watch the Stories of Harm the APA Refused to Hear," and dozens more written stories are available at psychdiagnosis.weebly.com

DSM-IV appeared in 1994 and its minimally altered sequel *DSM-IV-TR* in 2000, but not until 2009 did Frances publicly express concerns about diagnosis causing harm, having asserted until then that the manual was helpful (2013). His mention of harm began in relentless and virulent attacks on *DSM-5* (e.g., 2012c, calling out the 5 leaders for failing to create a safe manual), as recently as 2013 expressing alarm that expansion of the net of mental disorders would expose people to "unnecessary medicine with possibly dangerous side effects," and drug companies would be "licking their chops" to exploit "inviting new

targets for their well-practiced disease mongering” (2013, xiv; see also Davies, 52). (Greenberg [2013, 99], with understatement, describes Frances’s failure “to use his clout” to speak out about massive increases in use of and harm from psychiatric drugs.) Recall that he oversaw the greatest expansion of the manual. It strains credibility that for the first 15 years after *DSM-IV* appeared, he had no idea that the public needed to be warned of harm from labels, and I am surely not the only one who had informed him about instances of harm (Caplan, 1995). It is poignant to think how much suffering he and every post-*DSM-IV* APA president and trustee could have prevented, had they come clean with other professionals and the public, saying, “These labels are not based in science, and using them can be damaging.” But Frances claims he was floored by the three diagnostic epidemics he admits grew from *DSM-IV*, and although he calls his book part *mea culpa* (xviii), it is actually a monumental *mea excusa*, since he lays the blame for harm on a raft of others who “misused” it (xiv) – Pharma, other psychiatrists and therapists and non-psychiatrist physicians, patients themselves, researchers, consumer groups, the internet, and the media (29). His list of kinds of harm is scanty (195) and gives no indication that anyone before him had called attention to the risks. Furthermore, because of the unregulated status of psychiatric diagnosis, it is impossible to know how many other epidemics of labeling there have been besides the three Frances names (Autism, ADHD, and Bipolar Disorder in children).

A kind of harm unmentioned in debates about the manual is that *DSM* labels are the very foundation for “practice guidelines” on the APA website, where *DSM* categories are the foundation for treatment recommendations. Thus, therapists are told how to treat people based on unscientifically constructed categories,⁵ creating insurmountable problems for research on treatment effectiveness, and the guidelines are packed with recommendations for drug treatment (specifically noting that off-label prescribing is “permitted and common”⁶) and even electroshock. The authors of the guidelines have astounding numbers of drug company connections.⁷

Frances and the APA leaders might at any time before the 2009 attacks on *DSM-5* have taken steps to prevent harm. I would have welcomed their joining my 2005 petition calling for Congressional hearings⁸ about psychiatric diagnosis (begun at psychdiagnosis.net, now in expanded form at <https://www.change.org/petitions/everyone-who-cares-about-the-harm-done-by-psychiatric-diagnosis-endorse-the-call-for-congressional-hearings-about-psychiatric-diagnosis>), but he did not propose Congressional action until 2012 (Frances, 2012b). I issued a public invitation for Frances to endorse the requests for the APA to create a system for recording (they ought to solicit)

⁵ I have often said that the categories are like star constellations, in that specific kinds of suffering are real, as is each star, but the categories of “symptom clusters” are no more real than the constellations created by the drawing of lines to connect certain stars rather than others.

⁶ <http://www.psych.org/practice/clinical-practice-guidelines>

⁷ Ibid.

⁸ Greenberg (2013) mistakenly reports that my call for hearings came shortly before *DSM-5* was published rather than in 2005.

reports of harm from diagnosis and for using some of their \$100 million in profits from *DSM-IV* for redress, to try to make whole some of those whose lives have been destroyed because they were labeled (Caplan, 2013a). He did not respond to the invitation. About a month after I suggested blackbox warnings on all copies of the *DSM* and anything related to it (Caplan, 2012b), Frances suggested black-box warnings solely for the few diagnoses in *DSM-5* that he criticized (Frances, 2012d).

While on Frances' committees in the late 1980s, I expressed concerns about the vast pathologizing of women as having "Premenstrual Dysphoric Disorder." The European Union's equivalent of the FDA has declared that the research shows it is not a real entity. I had told Frances that in light of our shared aim of alleviating suffering, and since I knew many women had suffered because of getting this label, I would feel better if I knew at least that more women were being helped than harmed. He replied that there was no way of knowing that (Caplan, 1995). But gathering such information is precisely what science is for.

The uninformed and/or motivated rewriting of history has usually taken the form, in recent books about *DSM-5*, of omitting the history of significant attempts by those outside the APA to prevent and redress harm. But even authors of most of the recent books who do not omit that history make the mistake of identifying as the first anti-*DSM* petition the one created in 2012, where *DSM-5*'s editors were asked to submit their proposals to external review. No mention is made of the first petition, which in the mid-1980s I initiated and which included signatures from individuals and major

organizations representing more than six million people and which had little effect on the actions of Robert Spitzer and the other editors who prepared *DSM-III-R* (Caplan, 1995). I watched excitement grow as the 2012 petition was signed by 12,000 or so people and many organizations; but I felt sad about all the energy going into that new petition and about the hope that it would bring a truly external review by research methodology experts who had no stake in what would go into the manual, because over decades I had seen that *DSM* leaders always claim to have brought in huge numbers of outside consultants, as they ignore input that fails to suit them. As expected, the *DSM-5* editors ultimately replied to the 2012 petitioners that they have external reviewers.

Disappearance from history of the earlier petition was damaging, because energy put into the recent one could more productively have gone into taking action more likely to be productive, since it has long been clear that change from within APA would not happen, and false hopes would not have been aroused.

I organized the filing of nine complaints with the APA's Ethics Committee (Caplan, 2012a, 2012b). The complaints were from people harmed by diagnosis, and the respondents they named were the heads of the *DSM-IV* and every one of its Presidents and Trustees from 1988 — when preparation of *DSM-IV* began — to the present. With one exception, every president had either publicly said nothing about psychiatric diagnosis or had baldly lied about its reliability and/or validity⁹. Had any of them publicized the truth, therapists would have acted differently, patients would have been

⁹ This is documented in the complaints, and a copy of my own is available on request.

better-informed, and the public would have had fair warning about at least some dangers of being diagnosed. The APA dismissed the complaints on spurious grounds, with no attention to their merits, and refused to disclose the names of the members of the Ethics Committee who made those decisions (Caplan, 2012b).

We have now filed complaints with the Office of Civil Rights of the Department of Health and Human Services, the agency where some regulation of diagnosis ought to be done. We argued that civil rights violations occurred pursuant to the Americans with Disabilities Act, according to which it is discriminatory to treat someone as disabled when they are not. The complainants had been variously grief-stricken, frightened, and despondent due to losses and attacks that would understandably cause severe upset which should not be called mental illness, but they had been psychiatrically labeled, thus treated as disabled although they were not, and they had suffered losses and damage as a result. Their losses and damage ranged widely, from plummeting self-confidence to loss of employment and scholarship money to interruption of their education to loss of custody of a child to harm due to psychiatric drugs, the latter including the death of a complainant's loved one from the drugs' effects. The OCR of HHS summarily dismissed them all, we asked for reconsideration, and that is in process.

We have also filed complaints with the Federal Trade Commission, because the *DSM* is a product sold across state lines, falsely advertised, and causing harm. We await the outcome of these complaints.

False Claims to be Transparent: Lies, Deception, and Both Sides of the Mouth

DSM-III-R editor Spitzer (2009) criticized the *DSM-5* editors for following insufficiently transparent procedures, a claim Frances then made repeatedly, contrasting the *DSM-5* procedures with the transparent ones he claimed to have used for the *DSM-IV* (Frances, 2013, xvii, 70; Frances, 2012b). The editors of *DSM-5* proclaimed their work transparent to an unprecedented degree, because they publicly posted drafts online, where anyone could comment, and they said they read every comment. What they did not say, and what such journalists as the writer of a *Scientific American* article (Jabr, 2012) who described the commenting process failed to address, was that they were no more required than the editors of previous editions to make changes based on legitimate critiques.

One striking example of false portrayal about transparency (there are many) concerns *DSM-III-R*, *-IV*, and *-5* and illustrates the pervasive and longstanding pattern of deception in the manual's history.¹⁰ In the mid-1980s, Spitzer proposed adding "Premenstrual Dysphoric Disorder" (PMDD) to *DSM-III-R*, but after massive opposition expressed in that first petition (Caplan, 1995), he announced that he would create an appendix – the *DSM-III-R* Appendix A -- for categories requiring further study, to contrast with the allegedly scientifically-supported categories in the main text. His public pronouncements failed to reveal that it would also be listed in the main text (under Mood Disorders Not Otherwise Specified), and there was no warning in the appendix against applying the

¹⁰ Unpublished 2012 complaint by Paula Joan Caplan, op cit.

label to patients. For *DSM-IV*, Frances had named me a consultant to the PMDD work group, so I saw the review of research that was written by the regular PMDD committee members (all or most of whom received Pharma funding for research on drugs they wanted to market for PMDD: See Caplan, 1995, and Cosgrove et al., 2006, for some of these details). Their review included hundreds of studies, most of which they concluded were unrelated to the question of whether there was a premenstrual mental illness (in contrast to, say, bloating or breast tenderness). They accurately described the few relevant studies as preliminary and filled with methodological errors (Caplan, 1995). One might have expected the committee to recommend removal of PMDD from the manual, especially given that Frances claimed that for *DSM-IV* prolonged disagreements about data for a category “meant that the scientific literature was too sparse or ambiguous to support change” (2013, 71). But the committee told Frances they could not reach consensus about what to do, and he appointed two other people to make the decision. When I asked who those two people were, he refused to tell me, saying if he did, they would be “deluged with questions” (Caplan, 1995). Many journalists apparently asked who they were, and when he finally announced their names, it was evident that neither had expertise about premenstrual matters: one was Nancy Andreasen, a longtime *DSM* insider and colleague of Spitzer (Spitzer had created the category), and the other, A. John Rush, conducted Pharma-funded research about depression. When *DSM-IV* was published, Spitzer announced on “The Today Show” that PMDD would only continue to be in the provisional appendix, but in fact it was also in the main text, switched to the Depression section (Depressive Disorder Not Otherwise Specified). Kirk et al. say

Frances worried about “embarrassing post-publication surprises” (2013, 188) in *DSM-5*, as if there had been none in previous editions, but as illustrated, he and Spitzer had their shares. Continuing the tradition of deception, in perhaps the first major advertisement for *DSM-5*, one of the specific selling points was that PMDD was going into the manual for the first time. The lies are multi-generational.

Frances claims that financial interest compromised no decisions for *DSM-IV*, yet the choice to list PMDD under depression reeks of financial interest. A primary PMDD work group member for *DSM-IV* accompanied an Eli Lilly representative to a meeting with the Food and Drug Administration to convince them to approve Prozac to treat PMDD (which had never been shown to be a valid entity: Caplan, 2005), garnering Lilly enormous profits. Cosgrove, Krimsky, and their colleagues tallied the huge numbers of *DSM-IV* task force members with financial ties to drug companies (2006).

Another example of deceitfulness was that the *DSM-IV* task force announced that Self-defeating Personality Disorder would not go in their edition because the science did not warrant its inclusion (Caplan, 1995). Years later, a colleague doing research in the *DSM* archives came across an internal memo from an executive of an APA district branch revealing that the decision had been political.¹¹

Kirk et al. (2013) correctly report that in work on *DSM-5*, to avoid conflicts of interest, all task force members had to disclose financial ties to Pharma, and that no such

¹¹ The memo is in my *DSM* archives, which are located at Radcliffe’s Schlesinger Institute, Harvard University.

disclosure was required for previous editions. But that does not mean there were no such conflicts in previous editions or that the disclosures required for *DSM-5* were effective. I have some direct experience with this for *DSM-5*. Asked to write a magazine article about what was in store for PMDD in the fifth edition (Caplan, 2008), I emailed Dr. Jan Fawcett, head of the mood disorders work group, saying I was a psychologist writing a magazine article about PMDD. In our phone interview, he mentioned the much-publicized announcement that anyone on a *DSM-5* committee would be required to divest themselves of drug company money. But he spontaneously revealed that that divestment was only required while they were on the committee, and they could even receive up to \$10,000 a year from Pharma during those years. He disclosed other worrying information as well. I turned in my article, and a magazine staffer called to say that in her fact-checking conversation with Fawcett, he claimed that I had failed to disclose to him that I was writing an article for a magazine, and he had thought he had been having a casual talk with a colleague. I resent him my first email message.

Frankly unethical is that, despite attacking others for lack of transparency, Frances takes it upon himself to decide which truths to conceal from the public, allegedly for their own good, because Frances and his colleagues know best: “sometimes we need a noble lie” (Greenberg, 2013, 156). He told Greenberg that he did not want to reveal all of the “Wizard of Oz stuff” (156), a striking statement, given that in 1991 I referred to him as the *DSM* Wizard because of the history of deception (Caplan, 1991).

The most notorious example of blatant falsehood related to the *DSM* is Greenberg's publication of Frances's statement that psychiatric diagnosis "is bullshit" (2013, 278),¹² which starkly conflicted with his multitude of assertions that his work on diagnosis had been scientific. Frances responded by accusing Greenberg of being "Paula Caplan in drag" (278), and my amusement on learning of that preceded the realization that he was equating Greenberg with me as tellers of the truth about him.

The Bereavement Hoax

According to the Centers for Disease Control, nearly 2 1/2 million Americans died during the most recent year for which statistics are available. Using a conservative estimate that four people are seriously affected by each death, at least 10 million Americans are bereaved each year. Add the figures for the dozens of countries where the *DSM* is sold, and it is not surprising that the proposal to call bereavement a mental illness provoked perhaps the greatest outcry of any *DSM-5* proposal.¹³ Frances (2010) warned that once the new edition appeared, the bereaved would be called disordered, saying with ingenious

¹² There are many other examples, albeit less dramatic ones, of statements conflicting directly with his claims about the scientific process he followed, including but not limited to Frances, 2013, 21, 73.

¹³ By March, 2013, the public was up in arms: A google search turned up more than 10,000 items about this subject.

wording that the “bereavement exclusion” would be “eliminated” from the new manual, *as though the bereaved had been safe during the reign since 1994 of DSM-IV*. This elicited the fury of many bereaved people, including some from the website of parental grief expert Joanne Cacciatore (<http://missfoundation.org/>). Frances’s implicit message was that in *DSM-IV*, therapists were instructed *not* to diagnose grief as mental illness.

I.F. Stone would have done what apparently no journalist, academic, therapist, or bereaved person did: he would have checked the verity of the claim about *DSM-IV*. He would have found this: Anyone reading the entire listing for Major Depressive Episode (MDE) – something almost no one ever does – would be hard-pressed even to find mention of bereavement, for one must plow through four pages of dense text to find the first time that bereavement is mentioned. It begins with the statement that MDE should not be diagnosed if someone has been bereaved within the past two months. That is alarming, because bereavement does not end or, often, even diminish much after sixty days, nor should we expect it to. But it gets worse: The statement about the two-month leeway does not end the sentence; it is followed by a comma and the following words: *“unless they are associated with marked functional impairment or include morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation”* (p.352 of *DSM-IV-TR*, italics added). Note especially the word “or” throughout the foregoing. *One need meet only a single criterion in that list to qualify for MDE even as soon as the first day of bereavement*. Who in their right mind would call that a bereavement exclusion? Furthermore, in the MDE listing in *DSM-IV* the

differential diagnosis section includes no mention at all of bereavement and certainly no bereavement exclusion. As Horwitz and Wakefield wrote in their book, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow Into Depressive Disorder*; “a strange case of two ‘wrongs’ seemingly making a ‘right’: The *DSM* provides flawed criteria that do not adequately distinguish disorder from nondisorder; the clinician, *who cannot be faulted for applying officially sanctioned DSM criteria* [my italics], knowingly or unknowingly misclassifies some normal individuals as disordered” (Horwitz & Wakefield, 2007, p. 214).¹⁴ I disagree that the clinician cannot be faulted for the reason they state, because every clinician should be required *not* to accept uncritically whatever a lobby group produces. It would surely be unacceptable for an oncologist, for instance, to diagnose someone with “Cancer Q,” an allegedly newly discovered cancer announced by a lobby group or drug company, unless that oncologist has *read and thought critically about the research put forward to support the claim that a new cancer – and/or treatment for it – has been discovered.*

Some of Cacciatore’s followers told me, and I have heard from individuals beginning in 1994, that *DSM-IV* has been used to classify bereavement immediately as mental disorder (MDE). Probably everyone reading this knows someone whose normal grief was diagnosed as MDE and who was likely medicated as a result. Lacasse and Cacciatore (2013) documented the psychiatric drugging of bereaved parents during the time of *DSM-*

¹⁴ In spite of this perceptive description, Wakefield more recently co-authored a paper with one of the *DSM-IV* editors, in which they mistakenly described *DSM-IV* as having had a bereavement exclusion, part of their argument about what they presented as the *DSM-5* editors’ alleged elimination of the exclusion that they claimed was present in *IV* (Wakefield & First, 2012).

IV, even on the first day of their child's death, a clear sign of the longstanding medicalizing of grief.

Here's another fact: The *DSM-5* allows a bereaved person two weeks before they qualify for MDE, an appallingly brief time but two weeks longer than *DSM-IV* allowed. The new version is also better (everything is relative), because to qualify for MDE if you are bereaved, you have to have at least five of the symptoms they list rather than just the one required in *DSM-IV*.

I told BBC radio producer Gemma Newby about the Bereavement Hoax, citing page numbers and all, shortly before the new edition appeared. However, when her segment aired – and it remained on the BBC website only a few days afterward¹⁵ -- it was based on the false notion that there had been a bereavement exclusion in *DSM-IV*, and it valorized Frances for warning of the allegedly far worse listing to come. As Davies (2013) and others note, *Lancet* and the *New England Journal of Medicine* published railleries against what they called elimination of the bereavement (so much for fact-checking by editors of respected medical journals), and the hoax is perpetuated in recent books about psychiatric diagnosis whose authors otherwise include a great deal of excellent material about other categories and the whole process (Davies, 2013; Greenberg, 2013; Kirk et al., 2013).

¹⁵ <http://www.bbc.co.uk/programmes/b01r11q8> was the URL while the broadcast remained posted

Similar misrepresentations of other labels from *IV* were rampant, but space limitations necessitate limiting the discussion here to this one.

Use of Language to Rewrite History

As I learned when assessing media reports of *DSM-IV* debates (Caplan, 1995), and as noted above, journalistic as well as professional and academic writers use linguistic signposts to validate or disparage the credibility of their sources. For example, critics of diagnosis may be branded as “anti-psychiatry” (Frances, 2013, 243; Greenberg, 2013, 278¹⁶), just as critics of government policy may be called “anti-American.” By this means, responsible and legitimate questioners of diagnostic validity are cast as opponents of the entire project of psychiatry and its practitioners, hence cranks or reactionaries unworthy of attention.

“Anti-psychiatry,” like “anti-American,” treats every particularized criticism as a universal condemnation in order to discredit the critic. The label falsely suggests that raising legitimate questions is equivalent to delegitimizing the work of all psychiatrists. Furthermore, this characterization signals that the debate is only about psychiatry, when in fact the diagnosis of mental disorders governs the daily work of psychologists, social workers, counselors, marriage and family therapists, and even some clergy. The term

¹⁶ Greenberg (2013, 278) compellingly describes Frances’s technique of branding those who raise legitimate questions and concerns about his work as “anti-psychiatry,” but elsewhere in his book, Greenberg applies the term “anti-psychiatry” to some who in fact take care to say that some individual psychiatrists do fine work.

portrays advocates and critics as primarily opposed to some people rather than concerned about helping those who have been or will be harmed.

Public attention is thereby diverted from the vast and real harms done by diagnostic labeling within these non-psychiatric professions as well as health insurance and government services (Medicare, Medicaid, the armed forces, and the VA cover mental health care only for those having official *DSM* diagnoses).

Language also signals how the reader should evaluate the scientific respectability of leading figures such as Frances. Discussing why Frances was chosen to head *DSM-IV*, one author reported that he was “believed to have the credentials” (rather than that he *had* the credentials: Davies, 2013, 46), while others attributed the selection partly to Frances’ being “an expert on personality disorders” (Kirk et al., 2013, 175). The latter illustrates how easy it is for even trenchant critics of psychiatric diagnosis to write as though (1) there existed clearly identifiable, scientifically-established conditions properly called personality disorders, and (2) that it is possible somehow to be an expert on a subject whose very existence is in question.

Motivation, too, is easily attributed, praised or blamed by simple selection of a term of praise over a more neutral one. Kirk et al. (2013, 185) call Frances’s sudden acknowledgement of the “three false epidemics” to which his edition had given rise – “autistic disorder, ADHD, and bipolar disorder” – “an astounding mea culpa.” Certainly it was astounding that Frances’s first acknowledgement of the harms done by these “false

epidemics” came only at the end of the two-decade reign of his edition. However, the authors neglect to report that Frances blamed the “epidemics” entirely on persons and factors other than himself and his colleagues, who “had not foreseen” these consequences.

Greenberg (2013) is in fact wonderfully candid at many points in describing his own views and motives over the course of his years of writing about diagnosis and his longstanding, complicated relationship with Frances. Yet after a fascinating account of Frances time after time saying one thing publicly and the opposite in private, he twice describes Frances as “honest.” And despite Greenberg’s having confided Frances’s “bullshit” statement to the world at large, and having heard him make many similar, though more decorously-worded, statements about diagnosis over the years, at some points he portrays Frances as caring about scientific standards, quoting him as having, in essence, recovered from what Frances himself described as his earlier arrogance (47).

One author describes Frances’s concerns about a particular diagnosis as based on scientific standards (“Frances thought it was poorly conceived and had little empirical support”) and contrasts it with the basis for the concerns of a critic (PJC) who had drawn Frances’s attention to problems with that diagnosis, alleging that the latter’s concern was solely that the diagnosis was “just plain sexist” (2013, 237). That seriously minimizes the scope of the latter’s concerns, which were about the lack of empirical support and the potential for causing harm. Because many people believe (mistakenly) that sexism has

ceased to exist, to cite this as the only ground of a person's concern is to dismiss that person as frivolous and lacking credibility.

A few more examples of the effects of word choice in the rewriting of this history are instructive. Writing about similar sequences of events, one writer (Davies, 2013) describes a questioner/advocate as speaking "energetically" (26), having "convincingly argued" (27) and "extensively assessed the evidence" (25), and goes on to describe the details of that person's scientific critique. Another writer (Greenberg, 2013) describes the same person as simply having "tormented" Frances, neglecting to mention her detailed scientific critique and proofs of harm, meanwhile accusing that person of having submitted her own proposal for a new diagnosis as a result of being "inflamed" rather informed (237). The repeated use of words ascribing overemotionality to female professionals is an old but persistent practice that neatly shifts attention from the substance of her work to its supposed psychosexual origins.

Conclusion

If you have enough power, you can rewrite history, and if you are lucky, no one will correct the record. The *DSM-IV* leaders who led the charge against *DSM-5* have been hailed as white knights. "How brave of them to warn us of the upcoming dangers!" people have said, although all of the knights' criticisms of *DSM-5* had been made for decades about their own editions and been ignored or even denied at the time. As I have written:

Those responsible for causing harm to others ought to be held accountable, and it is alarming when such people take it upon themselves to rewrite history to cover up their role in causing harm. I am as quick to repudiate much of what the DSM-5 heads have done as what editors of previous editions have done; but the virulent attacks by Spitzer and especially Frances on the DSM-5 heads has been wildly successful in taking the attention of the public and professionals away from the harm they themselves caused. Spitzer and even more, Frances, oversaw the ballooning of numbers of diagnoses in DSM-III, III-R, IV, and IV-TR and thus of people classified as mentally ill on a scale far beyond anything anyone else had ever done. (Caplan, 2013a, 386).

The mountain of writings and broadcasts about the *DSM-5* debate has centered on roughly only a dozen of the hundreds of categories (Caplan, 2013a; Davies, 2013; Frances, 2013; Greenberg, 2013; Kirk et al., 2013). Left unmentioned in Frances's and others' critiques of those categories is the fundamental question of the very need for a manual of psychiatric diagnosis. The current debate largely proceeds as though the basic approach, creation, and marketing-as-scientific of an arbitrary and idiosyncratic classification of the varieties of human suffering had been proven reliable, valid, beneficial, and harmless. In this connection, Greenberg accurately wrote: "Without a single mental disorder that meets the scientific demands of the day, let alone enough of them to make the *DSM* more than an invented world, and with its claim to 'real medicine'

still mostly aspirational, it cannot make good on its assertion that psychological suffering is best understood as mental illness. So it must guard its position jealously. Lacking confidence in itself, psychiatry must work ever harder to command ours. [Allen Frances] and Darrel Regier [head of DSM-5] may be bitter opponents, but they both have the fear that comes with knowing the fragility of the edifice they share” (Greenberg, 2013, 335).

Robert Whitaker calls the manual “the most barren philosophy of life imaginable” (2013, December 5 personal communication), something Kriss (2013) brilliantly demonstrates by “reviewing” the manual as though it were a bad novel.

As post-*DSM-5* debates continue, the focus needs to shift to redressing past harm and preventing future harm. All over North America and, increasingly, throughout the world, people who have sought help in the mental health system because they were suffering ended up with and (though some were helped) have suffered devastating and often lifelong losses and damage because of having been psychiatrically labeled. Frances and Spitzer are unclothed emperors who draw attention away from their own nakedness by crying out about the nakedness of the emperor who has replaced them (Caplan, 2013, 387). And their distorted claims have been reified by professionals, academics, media people, and laypeople who neglect to check out their verity, simply repeating them as gospel and thus become complicit in the harm.

Note:

Those looking for ways to redress and prevent harm might look at <http://psychdiagnosis.weebly.com/working-toward-solutions.html> and at the description of “The Need and 9 Demands” document that we attempted to deliver to the American Psychiatric Association and that they refused to accept (Caplan, 2012b).

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