Dr. Paula Caplan

On the Diagnostic and Statistical Manual of Mental Disorders (DSM), American Psychiatric Association (APA), and Premenstrual Dysphoric Disorder (PMDD)

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Dr. Paula Caplan is a clinical and research psychologist. She received her A.B. with honors from Radcliffe College of Harvard University and received her M.A. and Ph.D. in Psychology from Duke University. Starting June 1, 2008, she is Research Associate at Harvard University's DuBois Institute, working on their Voices of Diversity project. She is former Full Professor of Applied Psychology and Head of the Centre for Women's Studies in Education at the Ontario Institute for Studies in Education, and former Lecturer in Women's Studies and Assistant Professor of Psychiatry at the University of Toronto. She does expert witness work for a variety of court cases, both civil and criminal, including cases in which psychiatric diagnosis is an issue.

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[LGG]: In our 2006 interview, you said that ‘psychological malady was a socially constructed term. Can you explain what you meant by this statement?

[PC]: Yes, just like mental illness and mental disorder, these are not real entities. They’re like intelligence or love; they’re not like a table or a chair. In other words, if you ask ten different people, even ten mental health professionals, how to define ‘mental illness’, how to distinguish it
from normality, from emotional normality, you’re going to get different answers. They’re going to contain terms that are hard to put into operation. Even the authors of various editions of the main psychiatric diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders*, have said quite openly that they haven’t been able to come up with a good definition of ‘mental illness’. So that makes it really clear that if we don’t even have a good definition of the overarching category, we have to think carefully—well, what are we doing when we say that we know that there is a particular subcategory, a particular instance of mental disorder, a particular kind of mental disorder, such as Premenstrual Dysphoric Disorder and many others. How are we going to go about that if we say PMDD is a mental disorder, but we don’t really have a good definition of ‘mental disorder’. That in itself wouldn’t mean there’s no such thing as what they’re calling Premenstrual Dysphoric Disorder, but it means that maybe we don’t want to rush to call it a mental illness.

[EV]: Paula, if there are, even theoretically, social and biological elements in the classification, diagnosis, and treatment of mental disorders, maybe even specifically PMDD, how do you think these elements interacting, or how do you see them interacting?

[PC]: Well that’s a good question. I guess the kind of thing you’re referring to is that because the word ‘premenstrual’ is the title of that particular category, the implication is very clear there: Something physiological is going on here. The problem is that what the research has shown—and believe me, people have done an enormous amount of research trying to find that there is a mental illness that is related to something that’s unique to women, which is their hormonal changes of particular types—they haven’t been able to find that. In fact, there was a brilliant study that was done by Sheryle Gallant and her colleagues, and what they did was they took the list of symptoms that are in the *DSM* for PMDD, and they made a checklist out of them, and they said to their research participants, “We’d like you to just fill out this checklist every day with regard to-do you fit each of these symptoms every day.” And they gave that checklist to three groups of people, and they were women who had been given the label of PMDD, women who said they didn’t have any premenstrual problems, and men. If there is such a thing as a premenstrual mental illness, and if the *DSM* authors have accurately identified its characteristics, then of course those three groups of people would have answered very differently from each other, but they didn’t! So when people have tried to find that women get angrier or more depressed or more anxious right before their period than at any other time, they in general haven’t been able to find that. There are occasional women that fit that description, and sometimes, they’re found to have quite severe hormonal problems, but this is a hormonal problem. This isn’t a mental illness. There is no equivalent in the *DSM* for men.

And I want to point out, and this is still with regard to your question how do the social and biological factors interact, when people have tried to connect women’s severe mood states...
with where they are in their menstrual cycle, what they’ve found is that the severity of the mood or the emotion, like anger, doesn’t go beyond what men experience and report. So that’s why we have to wonder, Why does anyone think there is such a thing as PMDD? Why do they keep putting it in the DSM? They just recently said on the DSM-V website, in their opening paragraph, that they’re going to put this new category of PMDD in the DSM, which is absurd. It’s been in the DSM for the past two editions.

So how do the biological and social factors interact when it comes to PMDD? Well, the answer in a way is very simple. There is no evidence that there is any biological basis for a premenstrual mental disorder. There is no evidence that is from good research that shows that there is such a mental illness as PMDD. In fact, the European Union’s equivalent of the FDA has issued a statement some time ago. What they did was they looked at the same research that the FDA looked at, and, like the FDA, they said that the evidence shows that PMDD is not a real entity. Of course they apparently were not as influenced by drug company pressure and money as the FDA committee was.

What I think happens is that all of us have had experiences with physiological changes, whether it’s bloating, which can be hormonally based, or whether it’s spraining our ankle. When other things are difficult in our lives, that physiological change, that physiologically-based problem, can be kind of like the last straw. It can add to the difficulties. So I’m not saying that women don’t have cramps. I’m not even saying that women’s moods—for some women—I’m not even saying they don’t change during some times during the cycle. I’m just saying, first of all, we must be very careful about when we want to call that a mental illness, and secondly, when there are changes, if they’re not consistently tied to where you are in your menstrual cycle, and if they’re not consistently more problematic than those that men experience, why are we calling this a mental illness and saying there’s a mental illness that only women can have.

[LGG]: So the next question is a big one because obviously you’ve written extensively on this, but if you want to give some summary points for why you think PMDD should be removed from the DSM?

[PC]: Because first of all, the DSM categories are supposedly based on good research, and there is no good research that shows there is such an entity as PMDD. As I just said, even the European Union’s equivalent of the FDA drew the same conclusion. I have looked at all the research that has come out over the years, and there’s still not anything good that suggests that PMDD is a real entity. Secondly, what do we do about those women’s who say, “But I do have trouble before my period. I am a shrew, or I feel so down.” I would say we need to say to those women, instead of “That makes you mentally ill”, we have to say, “Those are very upsetting feelings, but that doesn't make you mentally ill.” What's the point of calling it a mental illness? Do we want to call every mood change a mental illness?
I was actually on—I was an advisor on the committee for PMDD of DSM-IV-TR, so I got all the memos from the head of the committee, and I have a memo from her saying: "We have not been able to find any evidence tying these mood changes to hormonal changes." So what is it doing in there anyway? I think we have to see that it's a very misogynist category. When I lived in Canada, there was a media person who wanted to do a story about PMDD. She was quite troubled about the existence of this category and the harm done to women, which I'll get to a moment. She wanted to do a story about it, and her boss wouldn't let her. And then when it looked like Canada was about to have its first woman Prime Minister, this media person called me back and said that her boss, who was a man, said, "Quick! Do that story about PMDD because maybe now we can make it look like women go crazy once a month, and she won't be Prime Minister." That's just one stunning example of the ways in which that category is used to pathologize women, to pathologize something that is essentially female about us, which is the hormonal cycles that we have and that men don't have, not in the same ways. Although, as Gloria Steinem describes in one of her books many years ago, it has been show that men have cyclical changes in their moods to the point where in Japan, the schedules for which man should work on which days to operate, to run the train system—they plot their cycles, and when they're not doing well, then they don't let them run the trains. But we don't talk about that in this country, and there's nothing like that in the DSM. And that's an instance in which it's been show men's performance really changes cyclically.

So we need to remove PMDD from the DSM because there's no evidence that it's a real entity; it's used selectively to pathologize women; and because if you get just about any label from the DSM, certainly including PMDD, it can lead to all sorts of disastrous consequences in your life. There are cases of people losing their jobs, losing custody of their children, losing the right to make decisions about their medical and legal affairs. If nothing more, just being told that you have a mental illness makes you unsure of yourself, makes you ashamed, makes you feel like there's something wrong with you that needs to be fixed, and, as I said, there is no evidence that there is real pathology here. What we can do--we can help women who say, "But I feel worse before my period." It's been show that what's useful are self-help groups. This is because women who get diagnosed with PMDD, what they have been shown to be characterized by, they are in upsetting life situations. They are being sexually harassed at work; they are over-worked at home. So when they get a chance to talk about these very upsetting situations, that is helpful to them. What happens, given that PMDD is in the DSM and is considered a mental disorder? Well, if you get that diagnosis, you are very likely to be quote-unquote "treated" by being put on psychotropic drugs. Now, these often create more problems than they solve. The drugs that the FDA approve—I mean, this just astonishes me. I think it's shocking. It's so political. The FDA has approved the so-called anti-depressant to treat Premenstrual Dysphoric Disorder. Think about it. If you give just about anybody these drugs, they may temporarily feel better because that's what they're supposed to do—elevate your mood. That doesn't prove what you had was PMDD. It proves only that, given these drugs, your mood might get better.
What is also quite shocking is if you diagnose somebody with PMDD and put them on anti-depressants, and they feel better—if they were feeling badly, but you say, "Well, it's not because you're being harassed at work. It's not because you're being beaten at home or because you have all the responsibility for the child care. It's because you have PMDD, so I'm going to put you on this drug", then if your mood does get better, then, because what you were given was an anti-depressant, and if you're one of those people who get less depressed when you're taking one of these drugs, then, we need to be saying to you not "You have PMDD. It's this hormonal thing." Instead, we need to be saying, "You're feeling really sad. You are feeling hopeless. You are feeling helpless." Some people who are depressed attempt suicide. It's very serious not to call the problem what it really is. The use of PMDD often covers up real problems, other problems that need to be looked at, whether they are internal to the woman or whether they are problems in what her life is like right now. I have letter from women, for example, saying that they were diagnosed with PMDD, and when they went to court in a child custody battle, this was used to prove that they have a mental illness because PMDD is in the DSM. I also have a letter from a woman saying, "I was depressed" --never mind, 'depression' is a term that is thrown around in all kinds of ways, but this woman was feeling very down but certainly not suicidal--and she was put on the so-called anti-depressant medication, and because this precipitates suicide in some people, she tried to kill herself by overdosing on that drug. These are very serious problems.

Those are some of the reasons that PMDD should be taken out of the DSM. And why the DSM-V authors would claim that this a new category that they're thinking of putting in, when it's been in there for two editions, I just have no idea.

[EV]: So, plugging right along, if the APA insists that PMDD or, as an alternative, something like a gender-neutral, hormonally cyclical mental disorder not otherwise specified was real, and they presented some sort of evidence for this, how would you suggest altering its placement or wording within the DSM?

[PC]: Well, I just have no use for the DSM because it has been shown to do so much harm, and the inter-therapist agreement about who should get what diagnosis is terrible. The DSM authors' own research showed that a long time ago, so it has no validity. It doesn't have the most fundamental kind of validity, so I would say, don't use the DSM, and don't put anything in the DSM. But, if you told me, "Yeah, but they're going to do it anyway, and they're going to say it's gender-neutral. Anybody can have a cyclical set of mood changes." Do I think that would still be used against women? Yes, because in misogynist culture, which we do still live in, unfortunately, anything that can be used against women will be used against women. Whereas if you have testosterone abnormalities or anomalies, somebody is more likely to say, "Oh, the poor guy, his testosterone is low. Let's elevate it, so he can be a real man, and a real man is respected"-- Whereas if a woman is said to have a hormonally-based change in her mood or behavior, well,
women's behavior is—this has been shown by a vast amount of research—women's behavior
generally is more likely to be treated as pathological or as a disorder, as a dysfunction, as a
defect than just about any behavior in men is. Women are still selectively more likely to have
their allegedly hormonally-based changes in mood or behavior treated as pathology. The fact that
something, a category is in the DSM doesn't mean it's going to be applied to everybody without
bias. In fact, I co-edited a book called Bias in Psychiatric Diagnosis because every conceivable
kind of bias—racism, sexism, homophobia, classism, ageism—all of these come into the way
diagnoses are used. If it's in the DSM, you can be sure it's going to be used in a misogynist way.

[LGG]: I suppose the follow-up we want to ask then would be, if it were the case that the APA
was not going to abandon the DSM any time in the foreseeable future--

[PC]: It's not going to. I was just told the last edition made $100,000,000 for them, so this is big
business we're talking about. There's a huge profit motive at work here, not to mention the profit
motives of the drug companies, which whole-heartedly support the DSM.

[LGG]: So given the fact that the DSM has a very firm grip as far as the American Psychiatric
Associated is concerned, do you think that there are ways that the DSM could acknowledge
something like PMDD--again, from the standpoint of the APA, if PMDD is simply fact--do you
think there are ways they can word it, so it would be more responsible, so it could incorporate all
these different factors that you've been talking about?

[PC]: Absolutely not. One of the most brilliant students I ever had, a woman named Meadow
Linder, who did her undergraduate work at Brown, did some extremely important work in which
she interviewed some therapists whom—I knew most of these therapists, and they were
wonderful therapists and very humane people—and they were very honest with her when she
asked them, "When you assign a label to a patient, do you make sure to follow what the DSM
says?" And they said, "No. If it seems in the patient's interests, and if it kind of approximately
seems to fit them, then I'll give them that label because they can't afford therapy, and this way
their health insurance will pay for it." We've got shifting sands on top of shifting sands. A) The
DSM, at the lowest level, the DSM is not scientific. B) Use of these labels can often get in the
way of learning what the therapist needs to know about the patient in order to help them. C) It
can cause harm to get any of these labels. D) People don't follow the DSM criteria anyway much
of the time, so it doesn't matter what they write in there. They put in the DSM a long time ago
some statement: "You should make sure, if you're a therapist, to take into consideration cultural
differences in what you're saying. Don't pathologize somebody just because it's a cultural
difference.” People paid attention to that if they would have thought about that before, pretty much. People who still have culture biases and racist biases paid no attention to it.

No one regulates the DSM. That’s a major problem: There’s no regulatory body. The FDA does not regulate it. The American Psychiatric Association that publishes it does not regulate it; it just makes a lot of profit from it, but it continues to publish this terribly unscientific collection of alleged kinds of mental illness. As you probably know, the people who edited the DSM III, III-R, and IV are now speaking out very publicly about how unscientific their editions were—even though that was not what they said at the time—and they’re very concerned about the way the DSM-V is being put together. It’s even more secretive; it’s even less open to debate. You can go to their website and post comments, and they can pay attention to it or ignore it, as they always have. So no, I think there is about nothing that they can put in the DSM that would make any difference.

[EV]: I think one of the concerns, then, that has been voiced by you and a lot of other people has to do with how categories like this and labels such as PMDD make those that are labeled and stigmatized of course vulnerable and cause harm in very particular ways. Particularly after a lot of the concerns that you just mentioned about the lack of oversight and transparency about these processes, do you think there ways that the APA could better influence--

[PC]: I can respond to that. I don’t think people realize how serious the lack of interest by the DSM heads in such things as the effects of sexism, racism, and so on, as they combine with psychiatric diagnosis--And so, among the things they could do--and we asked them if there were some consumer groups, and I was representing one of them, MindFreedom International. We had a conference call with the head and second-in-command of the DSM-V a week ago last Monday, and I’ve written about this on my Psychology Today blog, and we asked them, David Oaks from MindFreedom International asked them, wouldn’t they please put in some kind of warning in the DSM, publish a statement about the ways that people should be careful about how they use these diagnoses and what they’re taken to mean, and that to say that the fact that somebody gets a diagnosis from this book should not be taken to warrant depriving them of their rights. And they said, ”Well, you know, we have something like that in there.” And see, they do, but it doesn’t matter. Tell that to the people who are being submitted to forced drugging, and tell that to the people who have lost custody to their children because they were diagnosed with PMDD or some other kind of Munchausen by Proxy and so on.

When you’ve got a manual—I don’t know how many categories they’re going to have in the DSM-V. There are 374 categories of alleged mental illness in the current edition. When you’ve got a weighty tome, and somewhere in there there’s a little disclaimer about ”Be careful how you use these categories”, it doesn’t matter. And one of the astonishing things that came up in this conference call was--there’s a man named Jim McNulty, whom was introduced as
representing the consumer groups, but he's with the National Alliance for the Mentally Ill, which gets almost all of its money from drug companies, so they've done some good work, but you can't exactly say they're unbiased--but McNulty said, "We have just been amazed to learn how often these categories in the *DSM* are used in forensic situations." And I thought, "You've been amazed? Do you not watch *Law and Order*? Do you not watch Oprah? Do you not read the newspaper?" How dare the heads of any *DSM* say they were amazed to learn how often these labels are used in forensic contexts. So I'm pessimistic about sticking another disclaimer or caution or two in the *DSM*.

[LG]: When it comes to actually having diagnostic tools--So I understand your skepticism in regards to the *DSM* itself, but if we instead look at the interaction between a specific health care practitioner and a patient, do you think there are certain diagnostic tools that that health care practitioner could use that would be preferable in the case of PMDD and other disorders that contribute to the marginalization of a group of people, that could help mitigate some of the harms?

[PC]: No. That's the short answer. I'm not a big believer in diagnostic tools. One of my specialties has always been research methodology, and I'm the co-author of a textbook on research methodology. I can tell you that the best way to help people who are going through emotional suffering is to listen to them carefully, and this is what the research does show. Not to use any fancy diagnostic tools, but to listen to them very carefully, to be compassionate and respectful, to be intelligent, to think critically about what you're hearing, to read—yes, read—the research that's been published about these kinds of problems, but to think about it critically, to talk to other people who have worked with people who have these kinds of problems, to observe your patient and to listen to them when you make a suggestion or make an interpretation or ask a question, and see if that seems to be helpful to them. Listen to what they tell you. Is their life getting better when they're trying what you're suggesting or when you make a certain comment?

Diagnostic tools are not helpful because the categories to which they refer are not scientifically based. I have a new book out about veterans, war veterans, so of course I was writing a lot about the category of Post-Traumatic Stress Disorder. I can't remember the number now right off the top of my head, but it was a phenomenal number--in the thousands--of the different symptom patterns or behavior patterns that you can have and still get diagnosed with the same label, which means that any two people—and that's true of all the *DSM* categories, or most of them—If you say, "There are two people, and we diagnosed them both with PMDD", they could have little or no overlap in their symptoms, and beyond that, there is nothing in the *DSM* where the authors insist that you find out about the person's strengths, about their resources, about whatever. So all of these therapists, even the ones wishing to help, and there are many of them, are pressed for time, so they've been trained "Use the *DSM.*” What they focus on
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is "Which matrix, i.e., which diagnostic set of symptoms, which category, does this person fit most closely?", not, "Who is this person, and what do I need to know about them?" Because if I tell you, "Well, somebody had problems, a woman had problems concentrating, and she got irritable before her period she said more than other times, and she had some food cravings"--Did that tell you how to help her? I mean, isn't there a lot more than you need to know about her? So no, diagnostic tools I cannot endorse.

I should also say if you think about it, just logically, if you got Therapist A and Therapist B, and they're both asked to see the same patient. Because the inter-therapist reliability has been shown to be so low, using the DSM, then Therapist A and Therapist B are likely to give her different labels. So whose treatment plan do we decide to follow? And how are we going to choose, whether it's Dr. A or Dr. B, who we'll listen to? Because we don't even have the absolute foundation that we need of having inter-therapist reliability. If we go on from there, then we say, "OK, even if you use a diagnostic tool, in principle that means they're going to give the same diagnosis, but that's not how it tends to turn out. Given that you'd be using a diagnostic tool to decide which unscientifically-generated diagnostic label to apply, where does that lead us, how does that help us? If getting the diagnosis right--whatever that means in this context--if giving somebody a diagnosis has been proven to improve your chances of helping them, and improve the prognosis, that would be different. I wouldn't be saying a lot of what I'm saying right now. But that is not the case. And it is very hard for people to believe because a lot of people mistakenly believe that therapy is science, and diagnosis is a science. And it’s not. That’s why I say forget diagnostic tools, and just listen, and think, and read, and talk to other people.

[EV]: I had a quick follow-up, and actually this was something that was placed near the end, but I think it nicely flows from the way the conversation’s going. Do you think, then, that developing something like narrative-focused structured interviews or making context part of the diary-keeping diagnostic tools that are currently used would be a step in the right direction? Or do you think it’s not enough?

[PC]: It’s certainly not enough. It would be better than just going through your DSM checklist, and it would take us well beyond that, but it’s not enough for a couple of reasons. One is, I wouldn’t want it to be used to diagnose PMDD. We’re talking about something that has been shown not to exist, and I would want it to be used to help understand the problem the woman is describing. But if you have a category like PMDD, you just want to stick that mold on it, and let’s read their diaries, but then it’s too easy to say, “Oop! Clearly, PMDD.” Instead, let’s look at the, as you say, richly detailed description of what this woman’s experience is, what her life is like, what the problems are, what helps her, what makes it worse, and just throw out PMDD and
use your energy to concentrate on noting what you need to learn about her, and what helps her and what makes her feel worse.

[EV]: OK, I think that was helpful. Laura, do you have any additional follow-up questions about that?

[LGG]: No.

[PC]: I just got a couple more minutes left, and I think we’re a little over time, but let me just say. This is in response to the last question that you sent me. I think a whole lot of things need to be done. There needs to be many changes. One is that training programs for therapists of all kinds need to include the detailed information about the almost totally unscientific nature of diagnosis. Most even undergraduate’s normal psych textbooks are organized around the DSM. It’s treated like the Bible, except it’s supposedly scientific. So therapists, therapists in training, continuing ed programs for licensed therapists, licensing bodies all need to make sure that all therapists are aware that psychiatric diagnosis is a) not scientific, b) not helpful in knowing how to help your patients, and c) is often harmful, can destroy people’s lives. I have a website called Psychdiagnosis.net, on which there are 53 stories of people whose lives were ruined in just an astonishing variety of ways because they got a diagnosis. We also need congressional hearings about psychiatric diagnosis. As I mentioned earlier, most people—in fact, many therapists—think somebody is regulating psychiatric diagnosis, and nobody is in any way. If you were hurt by psychiatric diagnosis—I wrote a book called They Say You’re Crazy back in 1995, and in there I said, “I wish people would file lawsuits against the APA because of their false advertising about the DSM’s scientific nature. I wish that they would file lawsuits against therapists.” If you’re an oncologist, you’re under an obligation to know the nature and the quality of the science behind treatment of cancer, but therapists just kind of use the DSM, and nobody is making sure that they know about the enormous number of problems and flaws or about the huge array of dangers to their patients just from giving them—You can lose your health insurance by being diagnosed with Adjustment Disorder. I mean, it’s appalling, but there are cases like this. I get phone calls from lawyers.

So we need to have congressional hearings to have a national conversation about the problems with psychiatric diagnosis. If people feel they have been helped by it, they can testify as well. And then have a national brainstorming about how to protect people from this harm and how to find a way to make sure that suffering people who want to seek therapists can get insurance coverage without having to jump through the hoop of getting a DSM diagnosis. The American Psychiatric Association should be required to do public education about the lack of
science and the dangers of using the *DSM*. I don’t know why someone hasn’t gotten them for false advertising. It’s pretty scary. But those are some of the things that need to be done.

[LGG]: We really appreciate the time you took to talk to us.

[PC]: Thank you. Thank you for doing this, thank you for inviting me.

[EV]: Thank you very much.
Supplemental Resources


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