Psychology's Feminist Voices Oral History Project

Interview with Paula Caplan

Interviewed by Alexandra Rutherford
Cambridge, MA
November 19th and 25th, 2007

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PC: Paula Caplan, Interview participant

AR: Alexandra Rutherford, Interviewer

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PC – I was born in 1947 in Springfield, Missouri.

AR – Great. Well the first question we usually ask to help get us started is: How did you become a feminist?

PC – I don't remember! It's true. I've tried to think about this, and I know that when I was in graduate school, which was, I started in 1969-70, I know that I wasn't calling myself a feminist then. I don't know if I'd heard of feminism, but what I do remember was that I was in graduate school, at Duke, then, in clinical psychology, and I hated it. I was married to my first husband, and I thought "I want to leave; I hate this place." And yet it was 1969-70, and you weren't supposed to leave where your husband was. And I remember writing a letter, which I still have a copy of, to my parents, trying to explain to them that I wanted to move back to Cambridge, where I had been an undergraduate, until my husband had finished his M.D./PhD program at Duke. Because, I said, I know if I weren't in a place where I'm unhappy, and I'm not happy in the South, and I'm not happy at Duke, then I think it would be better for our marriage. Right, that was how I was having to justify it. I had no idea that other women had ever been through that kind of experience. So I was trying to make the feminist argument in that way.

AR – Right.

PC – Except I had to do it through the route of 'it would be better for the marriage.'

AR – Right.

PC – But I didn't know that other people were feeling the same way and that there was a whole movement going on around that. So sometime in the next couple of years I think was when it really became something I was conscious of and felt a part of.

AR – What did you first become aware of in terms of the women's movement?

PC – That's what I'm trying to remember. I think I must have heard about the march down Fifth Avenue, but I don't even remember what year that was. I think that was 1968, but I know that I

wasn't thinking about feminism then, so I must have heard people talking about it some years later.

AR – Okay

{2:20}

PC - And I think I started to hear about Gloria Steinem, and maybe seeing her interviewed on television and thinking "That makes sense. " And hearing people talk about equal pay and about wife battering. So it's kind of a vague memory. But I know that when I was in my first year of graduate school – and in the spring of that year I got kicked out for allegedly having weak ego boundaries; I had no feminist analysis of that. Years later, when I really was a feminist, and I looked back, then it hit me: "Oh, I was one of only two women in the first year of that clinical program, and there were six men, no women teachers, and I was expressive. And I had been at Harvard, which they found very threatening, I found out." But I thought "Oh okay, so they didn't know what to do with me, because I was a woman they perceived as smart, although I didn't think I was, and I was also open and nice, and I wasn't that detached, a blank screen kind of person that psychologists were supposed to be.

AR – Right, right.

PC – So I know that I had no feminist analysis of what was happening to me in 1970.

AR – Right. Well tell me a little bit about how you actually got attracted to psychology.

PC – Oh, this is funny, well, partly funny, partly kind of poignant. When I was seven, my mother told me that, and I remember this conversation so vividly, she said, 'You know how I clean the house a lot? Well, I have something called a mental illness.'" And she told me that she wanted me to understand this, she wanted me to know that although she spent a lot of time cleaning, nothing was more important to her than my father and my brother and me, and she also told me there were periods of time, and that was one of them, when she wouldn't have anybody else in the house. And she said, 'I want you to feel free to explain to your friends that that's why you don't have them over. I don't want them to think that it's anything about you." Now this was in Springfield Missouri, and in the '50s, when nobody was talking about mental illness; they thought that meant crazy and weird. Nobody was in therapy, and what amazing courage it took for her, and what selflessness, to basically have the whole town know that this was what was happening with her, just in order for me not to have my friends think that I didn't like them, or I was weird, or something.

AR – Right.

PC – So that was part of the groundwork. Then, I didn't connect this to it at all, but when I was 16 I somehow started reading Freud's interpretation of dreams, and I though this is really interesting. It was kind of like poetry, you know, it was like literature, and I found out later that he won the Goethe prize for literature and was very upset, because he wanted to be a scientist, not a writer. But I still didn't think about going into psychology. I came to Radcliffe in 1965

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planning to be a journalist; I had edited my high school newspaper, I had worked on the Springfield, Missouri, city newspaper, on vacations and so on, and I wanted to be journalist. I wanted to write about things so that people could have exposure to things they never would otherwise. That was my mission. So although there was no journalism program at Radcliffe, I thought, "Well I'll major in English," which I thought would be great and turned out not to be, "and I'll write for the Harvard Crimson daily newspaper." That turned out to be impossible as well. First of all, majoring in English, I didn't like to do the kinds of things they wanted us to do: close textual analysis. I wrote my sophomore essay about the relationship between Huck and Jim, and I remember I got a comment from the teacher saying, "Well it's interesting, but of course this isn't English literature, this is psychology." And I thought "What?!" And actually, that woman ended up at the University of Toronto teaching medieval studies, Roberta Frank, yes.

{6:50}

AR – Wild.

PC – So the English department wasn't interested in my work, and I didn't do all that well, and when I walked into the Crimson office, I was so naïve. I walked into the Crimson office and said, "Hi, I'd like to join the staff." And they looked at me like I was crazy, and they said "What experience have you had?" And I said, "Well, I edited my high school newspaper." And they said "What high school did you go to?" And I said, "Greenwood High School in Springfield, Missouri," and I also said "I've also worked for my hometown newspaper, the Springfield, Missouri *News and Leader*." And I remember when I said I edited my high school newspaper the guy said, 'We all did." Anyway, then it turned out you had to compete; you couldn't just join. They took almost no women. I got sexually harassed when I was competing, and we didn't have that term for it, so I just was mortified and didn't know what to do about it. I was told that I couldn't write; that was yelled across the newsroom at me. So I didn't make the staff. I had learned that I couldn't write, so I gave up the idea of being a journalist.

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AR – Wow.

PC – So then I thought, "I'm going to go to law school." I've always been interested in the law, and my uncle was a lawyer, and I thought it was really interesting. And then sometime in my junior year, I remember thinking "I don't want to go to law school. I went to nursery school and kindergarten through 12, and then unlike a lot of people that I thought were really brave, I didn't have the guts to take a year off before or in college," and I thought law school would be three more years. So I put law school out of my mind. Then one day somebody in the dorm at dinner said "What do you want to do?" And I said I don't know. And they said, 'Well I remember your first year you took psychology, and you came back and you were talking about Jerome Kagan and Jerome Bruner and George Miller, and all these people, and you were always so enthusiastic." And I thought "That's true, I really am interested in psychology, I think I'll be a psychologist." Well, and I thought I'd like to help people. Not until four years after I started graduate school, I got my PhD, and I thought "I could have finished law school a year ago!" But it didn't enter my mind during that time. So that's how I ended up in psychology. Isn't that weird?

{9:20}

AR – Wow. Well tell me a bit about your graduate training. I know you mentioned you hated the South.

PC – It was horrible.

AR – So tell me a bit more about that.

PC – Well as I said, there were six men and two women [students in the class], and I was the only white woman, the other one was Black, who were in our first year clinical PhD program at Duke. And it was 1969-70, and we were going to Washington for the marches against the Vietnam War. I was very, very involved in politics then, not as much as I wish I had been, but people in the department knew that a bunch of us were going to Washington. The faculty, the two guys who taught the core courses for us were new PhDs, they told us to call them by their first names, "Call us John and Phil," said John Coie and Phil Costanzo. But I think because they were recent PhDs, and they were very easily threatened, but I didn't get that at the time, they really wanted to make clear who was boss. Well, I was getting all As in the testing course, in the interviewing course, and I remember thinking to myself, "Do I have no backbone? Because whoever says anything in class, I always find myself listening and nodding. I mean, I must have no opinions of my own. What's wrong with me?" And of course later, from a feminist perspective, I thought, "Well, you were trying to find the merit in whatever anybody said, and you were trying to find common ground." But then I just felt like I was stupid and spineless. But I was getting all A's. In November of that first year I went to see my advisor, John Coie, and I said, "John, I feel like I'm getting funny vibes from the faculty." And he said, "That's just first year graduate student paranoia." I thought "OK," so I stopped worrying. Silly me. In the spring of that first year, my grandmother had just died, I was just devastated, and I came back from the funeral, and there was a letter saying I was kicked out of the clinical program; I could stay in the psych department and get a PhD, but I couldn't do the clinical program. So I took the letter, and I went back to John's office and I said, "What is the reason for this? " And he said, 'Well, you have weak ego boundaries." And I said, "What is that supposed to mean?" And he said, 'Well, for example, we had the feeling that if you were seeing a woman who was depressed, you'd probably say 'Oh you poor thing' and leave it at that." And I said "John, I think I'm the only person in our class who's been in therapy, at least that I know of. I would never do anything like that. The closest thing to doing therapy was the interviewing course that you and Phil taught, and you gave me an A, and when I asked you for feedback on how I can improve, you said, 'Oh you can't, those [interviews] were just perfect.' "And I said 'I was really embarrassed, because you were giving other people suggestions,'" and he said, 'Well that's because we sensed you couldn't take criticism." I was just, I was beside myself. And so I went running back to my apartment, and I called Bruce Baker, who had been a teacher of mine at Harvard in a clinical course, and I said, "Bruce did you feel like I couldn't take criticism?" And he said, "No, I felt like you could better than most people. What's going on?" And I told him and he said, "That's crazy." But there was nothing I could do.

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{13:00}

AR – Right.

PC – And I was married, so I was supposed to stay in Durham. So I thought "Well okay, I'll get my PhD in psychology, and then I'll try and do a clinical internship." So I went to see Marty Lakin, who was a professor in the department – and by the way, I went to see just about everyone of the 11 clinical faculty. They were 11 white men, and each one of them said to me, they either said, well, except for John and Phil, they said, "Well, I don't know you" or "I don't know you very well, but I listened to those who know you, and we are 11 sensitive clinicians" - they all kept saying that – "and we unanimously thought you shouldn't be in the clinical program." So one of them was Marty Lakin. I had just taken his course on theories of personality, or therapy, and I had written my paper in his course about, we had read Freud and Jung and Adler, and everybody, and I had thought for my paper topic, "Nobody's writing very much about women. I'm going to take what each of these people says about women and put it together and see what we do know about women." That was what I thought, it wasn't "I'm going to write a critique."

AR – Right.

PC – It was that accepting. But when I started putting these pieces together, I think the strongest thing I said was that something Freud said didn't ring true about mothers and daughters. So I get the paper back, and Marty Lakin has scrawled on the front, with such force that you could see the indentation several pages in, 'How many times in this century is Freud to be attacked for his views on women?" Well a) I didn't think I was attacking, b) I didn't know anybody else had ever raised any of these questions. I just was so puzzled. So I went to go see Marty Lakin after I got kicked out, because he taught a course on group process. And I knew people who had taken it and who said "It's really great. You learn to see yourself as others see you." So I went to see him and said, "I would like to take your course, and it says I need your signature, so in the fall can I take your course?" And he said, 'Why do you want to take this course?" And I said, "Because it's become clear to me through this process of being kicked out that other people see me very differently than I see myself." And he said, 'Well I'm not going to let you take the course because you would destroy the group.'" Well later in my life I did express more outrage and anger and objection and critique and stuff, but at that point in my life, as I said, I thought I was spineless. And I thought, "What is going on here?"

{15:55}

AR – Yeah.

PC – Then I heard about a guy named Paul Kirwin at the VA hospital across the street from Duke, and he was teaching something he called expressiveness training, and I heard he was really good and interesting. Anybody could join the group and learn the techniques, and I thought, "Well, good, I want some clinical training." I went to meet with him, he said sure, but you've got to get permission from Dr. Krugman, who was head of psychology at the Durham VA hospital. So I went to see him and said, "Dr. Kirwin said its okay, but I need your permission, since you're head of the department." Now, I'd never met Dr. Krugman, and you have to understand with what you're about to hear, I never swore. I maybe said "damn" or "hell," but I never said anything worse than that. And I was starting to hear the term "sexist," but I didn't

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like the term “male chauvinist pig,” and I never, never used that in my life. So Krugman says to me, ‘Well, I’m going to sign, I’m going to let you do it, but I know you’ve called me a fucking chauvinist.” I thought, “Oh my God, those words have never crossed my lips!” It was just bizarre.

AR – Wow.

PC – Now, he was later made to leave because it was learned that he had been having sex with his patients. So of course he got a promotion, he got transferred to an administrative job up in New Jersey at a VA hospital. But these were the kinds of idiots that had control over my fate. Well, the other thing I did was I went over to the Duke walk in clinic, and I said I want to see a therapist. So they ushered me in to see this guy, Dr. Pauk, and I said, “I apparently have weak ego boundaries and I would like you to help me strengthen them.” And I really meant that, you know, I wanted to get better.

AR – Yeah.

PC – And he said to me, “Why do you think you have weak ego boundaries?” And I told him the story, and he said, ‘You don’t have weak ego boundaries, but you’re going through an awful time, so we can talk about that.’” So that was just the most crazy making time, and what I ended up doing was enrolling in some classes, so that I finished my course requirements, I wrote a master’s thesis, then I wrote a PhD thesis, and then I wanted to do a clinical internship. Well by then I was divorced from my first husband, I was getting married to a guy who was married before and had two older kids, I wanted to start having kids right away, and I wanted to do a clinical internship. Well, I couldn’t apply to Duke because it was the same folks, so I heard there’s this consortium program through the University of North Carolina at Chapel Hill.

AR – Okay.

{19:00}

PC –I drove over for my interview, and I was dreading the moment when they would say, “Well, why don’t you do your internship over at Duke?” because I knew I was going to have to tell them. We go through the interview, and I really clicked with this guy who was doing the interview, and I thought, This is great. It’s such a shame I’m not going to be able to do anything with them.” And then came the moment I was dreading; he said, “Why aren’t you going to do your internship at Duke?” And this was so weird, it couldn’t have been scripted more perfectly. As I was answering his question by saying I got kicked out of the clinical program for having weak ego boundaries, he was saying – I know this sounds unbelievable – as I was saying that, he was saying, ‘You know, our clinical faculty used to play basketball against theirs, and we had to quit because they were so vicious.” And I said, “Oh really?” and he said “Who was your advisor?” And I said, “John Coie,” and he said, ‘He was the worst.” And I got the internship.

AR – Wow.

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PC – I probably wouldn't have, had that not happened to me. So I did this four-day–a- week internship, driving one direction two days a week, the other direction two days a week, while writing my dissertation and having constant morning sickness, because we got married, I got pregnant very quickly, and I had morning sickness all day for nine months, and was doing all of this stuff and taking care of the two stepchildren most of the time. I ended up finishing my PhD, finishing my internship, and then we moved to Toronto right after that.

AR – Well, before we leave this period, tell me a little bit about what your dissertation was on and also what your experience was at your internship.

PC – Oh, okay. Well, my Master's thesis had been about sex differences in children's response to failure. So I used the famous Kenneth Clark thing about dolls, but what I did was that I had these wooden sort of humpty dumpty looking characters, and three were girls and three were boys, and with one of them the face was drawn on in red magic marker and one in blue and one in black, but I wasn't looking at race. And I was asking kids questions about children's responses to failure, to school failure. Then for my doctoral dissertation, I was looking at something related to that, which was looking at aggressive versus prosocial behaviour after a failure experience, and I was looking at sex differences in that.

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AR – Okay.

{21:56}

PC – And so what I did was I would call in each kid one at a time, and I would say "I'm going to give you a test," and then I would give them this paper and pencil, and then I would tell – this makes me feel so bad thinking about it now – randomly told half the kids they did very well, better than most kids, and told the other half "Most kids do better than you did." And of course I debriefed them later on, that I was just joking, you were great. So half the kids were success and half were failure kids, and then I said for half of each group, I said, 'Now other kids will be coming in here later, and here's some candy,: and I gave them six M&Ms, or six Smarties, and I said, "I don't have enough candy for everybody. So if you want, you can leave some or all of your candy for the kids coming later." And then I had two conditions, either observed or unobserved. So for the observed, I said "If you want to leave any, you can put them right here in this glass jar right here, right in front of me." And for the unobserved, I said, "If you want to leave some or all of them, then after you leave the classroom and close the door behind you, you can put them in that box outside the door." And of course I knew how many were in there. So that was what I was looking at, and whether there was a sex difference in being more or less prosocial after a failure experience.

AR – Oh wow. So at that point what was the literature like on sex differences?

PC – Well, I was doing something very conventional. Mostly people were trying to find sex differences in everything. And I remember writing my explanation of my findings by referring to sex differences in socialization, and so mine was a little more progressive in that sense.

AR – And what about your clinical internship

PC – Well my internship, I spent two days a week at Butner Hospital, and those two days a week, I was on an adolescent in-patient unit, and I would see a few kids for psychotherapy, and I would do some testing. I had a problem in that setting, because I was only supposed to see a certain number of patients and do a certain amount of testing and write stuff up, and have an hour or two of supervision a week, and that left me with all this other time, and I wanted to be learning more stuff. Oh, and there was a staff meeting once a week. And other interns, I was asking for more work to do, and other interns got upset with me, because they said, "Now that's going to get us in trouble, because if it's obvious that you can get the work done in this amount of time, it's making us look bad." So I just remember feeling ridiculous in that situation.

AR – Yeah

{25:10}

PC – And I remember sensing that one of my two supervisors didn't like women, really didn't respect women, and not women that he thought were intelligent and all that stuff. Oh, and this reminds me of one other thing. I should mention that when I was in the graduate program and when I got kicked out of clinical, I went to see Phil Costanzo, who was the other main teacher that I had had, and I had asked him if in that second semester I could do an independent study about autism. And the way we did it was that he told me to get a reading list, and I did and gave it to him, and then he said "What do you want to read?" and I told him, and then he said, "Come and tell me about it," and I would. He never taught me anything. Then he said, "What do you want to write your paper about?" So I was writing my paper when I got word that my grandmother back in Springfield, Missouri, had died, and I was just devastated. And I was just typing, it so I thought, "Well let me finish typing it, it's not due yet, but I don't know when I'll be back." I typed it, left it in Phil's mailbox with a note saying, 'It's Sunday. I'm having to leave town because my grandmother died." So a couple of weeks later, when I come back, and I'm out of the program, and I go to see Phil, he says to me, "We knew," and I go to see him, because I want to find out, from your point of view, why I was kicked out, and he says, 'We knew that you thought you were better than we were because you had been at Harvard.'

AR – Wow.

PC – I thought I was dumber than everybody else, even though I had been at Harvard.

AR – Wow, incredible amounts of projection coming in.

PC – Oh it was awful. And he said, 'We knew that you had already done an independent study on autism at Harvard, and you were just doing this because you had already done the work." Well that was completely untrue, but I really was very aware of this assumption that I must think I'm better than other people because I went to Harvard. So at the clinical internship, I was getting those similar kinds of vibes: "We don't like smart women here," that sort of thing.

AR – Right.

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PC – And I still wasn't feeling very smart. The other two days a week of my internship, I went over to Chapel Hill, which was wonderful. It was like another world. I was in the main hospital there on the campus, and I worked with some wonderful people. Now keep in mind, this is 1972-73, I guess. I was working in the walk in clinic, and a young man came in and he told me he that was homosexual, and he was in a relationship, and he was having some problems in his relationship. And so I remember working with him about the problems in his relationship, and I had a supervisor who did not try to get me to pathologize him. I mean it was really great, and that was amazing for that era.

AR – Yeah, truly.

{28:25}

PC – So that was a really good experience. I learned a lot about testing. One experience I had, just to give you a sense of how tense my life was, because remember, I was taking care of the two stepchildren, I had more time taking care of them than their father did or their biological mother, while I was doing this four-day-a-week internship, and writing and then defending my dissertation, and being pregnant and having an awful pregnancy. So I was taking a course at Chapel Hill on the MMPI, and this guy who was the expert, we would sit in his office, and there were about six of us in a row, and he would go through the 2-point codes. And he would say somebody's whose score is a 1-2 would have these characteristics, and a 1-3, and so on. And he had told us to take the MMPI, but don't tell anybody what your code was. Well, mine was way down the list, it was a 6-9, and I thought, "Oh well I wonder what mine is going to be." And I mean I was just tense all the time; there was going to be a custody dispute about the step-children—

AR – Oh gosh.

PC – With a mother who clearly didn't want to be the primary parent but couldn't say that because of when that was. Oh it was just horrible, it was a nightmare. So I was just in a state of incredible tension all the time, and my husband was gone all the time, travelling, giving lectures, and so it was a terrible time. So we did the 6-8s, and I'm looking down at my notebook, and Chuck, the teacher, I didn't know he was doing this, he picked up one of those huge hardcover MMPI interpretation books, and I'm looking at my notes, and he picked it up, and he pulled his hand out from under it, and it fell on the desk with a crash, and I went [Gasps with fright], and I almost went through the ceiling. And he said, "6-9s would go through the ceiling." And I thought, "Oh, God, now everybody knows what?" and then he described 6-9s. Well, it was the most horrible two-point code you could possibly have had, and I was just devastated. I mean, you're full of all this anger and tension, which was exactly how I felt, I was just tense and scared all the time. Years later, a few years later, I took it again, and I thought, "Answer honestly," and it [the score] was nothing like that anymore.

AR – Oh interesting.

PC – And so that was a very good lesson. I thought, "Well, some scales on the MMPI really do have more to do with your state at the time."

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AR – Okay. Well let me start sort of a different line of questioning, deviate a little bit from a more biographical approach. And that is, one, the areas, and you've written about a lot of different things, but one of the areas where you've really made a huge impact is in the area of critiquing psychiatric diagnosis. Can you tell me how that line of work evolved?

{31:35}

PC – Well when I was in Toronto, and my first two friends there were Kathryn Morgan and Ronnie deSousa, both brilliant philosophers at U of T. Over dinner one night, Ronnie was saying to us that he was going to be teaching a course on the philosophy of psychoanalysis. And I thought, "Boy, you know, I've never had a philosophy course," and I suddenly thought, "It almost seems unethical to me not to have any thoughts about the philosophy of, I'm not a psychoanalyst, but of therapy." And for the first time in my life I wasn't enrolled in a program, I didn't *have* to do something, and I said, "Can I come and sit in on your class?" So I went and sat in on his class, and I was re-reading Freud, and when we read the parts about mother-daughter relationships, I thought, as I had written in Marty Lakjn's course, "That doesn't ring true; the daughter resents her mother for not giving her a penis?!" And so that led me to write the first book I wrote on my own, which was first called *Barriers Between Women*, and then *Between Women: Lowering the Barriers*, and there was a whole chapter in there about mothers and daughters. And by the way, that was very feminist. It was a very clearly, consciously, feminist thing to do.

AR – So at that point you really were thinking more consciously and intentionally about being feminist.

PC – Yes, right, because the whole reason I wanted to write this book was I thought, "We want to build a women's movement, and women do seem to be able to get along with each other better than men do, or than women and men do in a lot of ways, but if we want to build a movement, it would be really helpful for us to be aware of what things tend to be barriers between us, and societal factors." So that's what that book was about. And then also as a result of re-reading Freud and reading about "women are naturally masochistic," I thought, "What?!" And I wrote an article called "The myth of women's masochism"; it was published in *American Psychologist*, and then somebody asked me if I would write a book about that. So I wrote this book *The Myth of Women's Masochism*. It was in press, and every time I write a book, like most people, I think, "Why did I do that? Everybody already knows this, or maybe it's all wrong; I'm so stupid." I got a phone call, it was just about to be published, and I got a phone call from Jean Baker Miller, saying, "Did you hear what the American Psychiatric Association is planning to do? They're preparing for *DSM III-R,* and they have proposed these categories that we feel are very dangerous to women." And one of them was Masochistic Personality Disorder. And I thought, "I thought that was on the way out, I guess I'm glad I wrote the book." So she invited me to come to a meeting that was going to be of some women within that APA, she**,** Teresa Bernardez, and Judith Herman, and they had gotten together with Lenore Walker and a couple of other people, and they wanted to know if I would come, because they were making such a fuss about these categories that the *DSM* committee people had appointed something they called the Ad Hoc Committee on the Controversial Diagnoses to go meet with the women. Well, it turned out

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just by chance that I was going to be in Washington that day on a book tour for *The Myth of Women's Masochism*. The previous day, I was starting my book tour by being on Phil Donahue's show. So I do the Donahue show, in which I was saying the main message of the book is nobody enjoys suffering. Masochism is a dumb idea, because it's defined as pleasure in pain. That's like saying the good in evil; it means nothing. And so I was talking about "What are people talking about when they say something is masochistic? Well it's well socialized traditional feminine behaviour, and so that's not good, we shouldn't be calling it masochism." So that's what the book was about. So I'm going to this meeting in APA headquarters, and this was my frame of mind as I headed for that meeting: I knew some of the names of the people who were on that ad hoc committee to deal with the women, and these were people whose work I had read in graduate school. These were experts. And I thought, I was raised in a family in which we were really encouraged to ask questions, never be afraid to be wrong, so I thought, "Okay, I'll make my little two-minute speech that I prepared, and then the experts will tell me what I'm failing to understand, or material I wasn't familiar with, and I'll learn something; that'll be good."

{36:36}

AR – Yup.

PC – So I get up there, and I make my little speech about nobody enjoys suffering, and you're pathologizing traditional socialized feminine behaviour, and especially, this is the way that victims of violence will act. Silence. The first comment was Robert Spitzer, head of the *DSM III-R*, says to me, 'I saw you on Donahue!" I was speechless. What am I supposed to say? I was so embarrassed for him, and I didn't want to make him look more foolish, so I just said, "Oh." And he said, 'I agreed with almost everything you said." And I said, "Oh, well, then, I'm not sure why you would want to be putting this category in the *DSM*." And he said, "Because we see people like this all the time." And I said, "Well, I think that what you're seeing are people with not much self- confidence, or who are just well-socialized women, or who are victims of violence." Anyway, it was just the most bizarre exchange

AR – Yeah, bizarre.

PC – And Lenore spoke, Judy spoke, Jean spoke, Teresa spoke, they were amazing, and then the Ad Hoc Committee says, the head of it says, 'Well shall we adjourn" – and he's saying it to his committee, in front us – "shall we adjourn to, dare I say it, the Freud Room?" So they all go off to the Freud room to decide what to do, and they come back, and lo and behold, yes, they're still going to keep pushing for this to go on, but they're going to rename it Self-defeating Personality Disorder. So that was how I got involved in that. When I sat there and saw these so-called experts saying idiotic things, and irresponsible things, I was horrified, because I was teaching the *DSM* as an advocate to my graduate students. I love logic, I used to be a debater, and I would say, "Look, they have these wonderful decision trees, and it's all based on science. Somebody read all the research and then pulled it all together for us." I was shocked, and that was how I got involved in the whole *DSM* process.

{38:49}

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AR – Okay.

PC – And then I went to a meeting of the Association of Women in Psychology, in California, and at that meeting we were talking about what the *DSM* folks were doing. And that was when they had just proposed Premenstrual Dysphoric Disorder as well. So I thought, “You know everybody was saying we ought to do something,” and I thought, “You know what, everybody is so busy these days, if we say well let’s go away and figure out what to do,” it was just such a great opportunity with all those good feminists there.

AR – Yeah.

PC – And so I just handwrote a little petition, and we circulated it, and then I started sending the petition out to as many places as I could think of, and people were signing, organizations were sending letters. In Canada, it wasn’t LEAF, it was the equivalent of NOW, I can’t believe I don’t remember it, I don’t think it exists anymore, but it was an umbrella organization for a huge variety of women’s organizations in Canada. We got a letter from them, we got a letter of support from NOW, I mean, we ended up with letters and petition signatures representing over six million people. And we would send these in, I would send in copies to Dr. Spitzer, and so we kept this thing going. We tried to get media attention to the problems. And it was very interesting, because laypeople would hear this, and I didn’t even have to explain very much; they got it right away. They would say, “You have got to be kidding.” So it was pretty easy to get a lot of media attention to this.

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AR – Right.

PC – Well, then they decided, “We’re going to put it into *DSM III-R* anyway,” and Spitzer’s “compromise” was, “We’re going to create a new appendix called the appendix for categories requiring further study.” And they put those categories in there, but what they didn’t tell us, in fact, they lied, Spitzer on national television said they’re only in this provisional appendix. Well, PMDD was also referred to in the main text as an example of a mood disorder. And it didn’t say in the appendix, “Don’t use these labels for real people, because we don’t even have scientific evidence that they represent real entities.” And they had the numbers that went with the categories and the criteria you have to meet, and so on, and so people were using it.

AR – Yeah.

{41:30}

PC – Clinically and in research. So when the *DSM III-R* came out, I called Allen Francis, who was going to be head of *DSM-IV*, and I said, “I know you’ve got these provisional categories, I know you’re going to be looking at new research as it comes out, so are my graduate students and I, and I wanted to suggest that we send you our reviews of the literature and maybe we cannot keep reinventing the wheel and duplicating each others’ work.” He said, “I have a better idea. Why don’t you be a consultant or advisor to those two committees for us?” And I said, “Well, I think I should tell you what my position is about these,” and he said, “Oh, I know who

you are, I know your position, but" — and this is so fascinating to me — he said, "This time we're going to make the decisions based on what the science shows. And this time, we want to have an open and honest debate from all perspectives." And I thought, "That sounds great."

AR – Yeah.

PC – You know, I grew up in Springfield, Missouri, "authorities are our friends," and I wanted to believe him. You know, I thought, "Good. He sees the problems, he wants to fix them. I would like to be part of that." So I said, "I'll be glad to do that. Now I think I should say, though, if I'm not comfortable with what's going on, I will resign and I will feel free to speak publicly about it." And he said, "Well, I'm sure you will." And that's what happened.

AR – Okay. So what did you see that made you want to resign?

PC – Well, what did they do with the scientific research? When it's bad scientific research, they will distort it or lie about it in order to make it look like it supports whatever they want to do. When it's good scientific research, I've never seen any good scientific research that supports what they wanted to do with those categories, and so they would ignore it. There was one brilliant study, especially of PMDD, that came as close as you can to proving that there is no such thing; it was just beautifully done. I mean, it showed that men have shown the same symptom patterns as women, as women with and without premenstrual problems. Now, that should have done it for them, they should have said, "Okay, we cannot in good conscience keep this in the book." Well they did; it's in *DSM-IV,* and not only that, it's listed under depressive disorders in the main text as well. So I saw that there isn't good science in there, that they will go to any lengths to use and misuse science just to do what they want to do, and that the decisions are made so largely either arbitrarily or based on politics and power and territory. I was really horrified by that.

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AR – Wow.

PC – And it's still going on. I mean, they're getting ready for *DSM-V,* and it is still happening.

{44:25}

AR – Right. Well, can you speak now, since we're on the PMDD topic, about the repercussions of that in terms of treatment? So how PMDD now gets treated.

PC – Yes, well PMDD, when they proposed PMDD, the *DSM* people were very careful to say, "We're not talking about PMS, we're not talking about bloating and chocolate cravings and breast tenderness; we're talking about a serious mental illness that affects a tiny number of women." Those were their words. Well then, when I started looking at what they wrote, if you did the math, when they would say well x percent of women, if you did the math – and I said this, we did a Donahue show about this. Judy Gold from Halifax was head of the PMDD committee, and she and I were on Donahue, and I said, "Look, by their own figures in their own newsletter," and I held it up, I said, "We're talking about at least half a million North American women getting this diagnosis." And what happened was that of course the drug companies were just

thrilled to have this category in there, ready to pounce. So all these drug companies that had SSRI's whose patents were about to expire, the first one was Eli Lilly (45:42) with Prozac, if they could get the Food and Drug Administration in the States to approve Prozac for use in treating PMDD, then they get an extension on the patent and that's worth millions or maybe even billions of dollars. So they went to the FDA, they so horrifically distorted what the research shows, and they got one of the members of the *DSM*'s PMDD committee to go with them to meet with the FDA, and they said Prozac helps women with PMDD and doesn't hurt them. Both of those things are wrong. Now I spoke with the woman who was in charge of the women's program within the FDA after this, it was Susan Wood, who later quit over the morning-after pill, and she was good, but I said to her, "If a drug company had said this drug helps with cancer Q, you would have said, what is cancer Q? We've never heard of it. Where is the evidence that there is this kind of cancer that we've never heard of? But why don't you do that with PMDD?" And she said, 'We have to rely on the professional associations to tell us what the diagnostic categories are." And I said, "The APA is not a professional association, it's a lobby group." It didn't matter.

[Recording is stopped b/c of interruption]

AR – We were talking about the repercussions then in terms of treatment, and the reactions of the drug companies, and having talked with Susan Wood about it, and questioning the clinical entity, and that kind of thing.

PC – Right. And so I think it's really irresponsible of the FDA just to take the APA's word for, oh there's all of a sudden another psychiatric disorder that nobody was talking about before. And the drug companies have made huge profits from this, from the marketing of this entity that as far as we know doesn't exist. And what's ended up happening is that on the drug company's website, they look like they're just, "Hi, we're here to help women!" websites, that's how you find them. But what they'll say is, they'll have a list of symptoms, and what they've very cleverly done is included in this "mental disorder" descriptions of PMS: bloating, breast tenderness, food cravings, all the things they said we weren't talking about.

{48:24}

AR – Right.

PC – And in fact you only have to have one mood symptom to qualify [for PMDD]. The others are all of these [PMS] symptoms. What is that doing in a manual of psychiatric disorder? And so on these websites and in the advertisements on TV and in the magazines, it lists all of these symptoms, and it says, "Do you ever have these? You may think you have PMS, but you really have PMDD." So there are two major problems with these ads. One is that they're doing the exact opposite from what they said. They're not saying, "Oh it's not PMS, this is something much more serious and much more limited." They are trying to make every woman who thinks she has PMS think she actually has a serious mental illness and needs their drug. And the other thing is that there are a certain number – if you walk out on the sidewalk, and you grab the first hundred people walking by, and you put them all on Prozac, a certain number of them are going to say they feel better, because it's an anti-depressant, and a lot of people are feeling sad or alone

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or alienated these days, and so they're going to feel better. Since they are marketing Prozac partly as Sarafem for PMDD, and it's identical to Prozac, they say it's similar to or something like that. [But] it's the exact same ingredients, the inert ones as well as the active ones; it's just that it's in pink and purple instead of green and white, and it's called Sarafem. Now I'm telling you, if somebody comes to see you as a therapist, and you say "You have PMDD, take this SSRI," then if you feel better, then I think they're guilty of malpractice, because they should be saying to you, "If you feel better, you probably have depression or some sadness or you're very lonely. These are things that need to be dealt with up front, and if it's real serious depression, then we need to know about that and we need to watch for danger signals, and so on." But that's not what's happening.

AR – Right.

PC – Women are thinking, "Oh I have PMDD." And in the commercials they show a woman looking angry. Oh heaven forbid, even now, heaven forbid. So there are women who just feel angry sometimes, usually for a good reason, but you're not supposed to be angry if you're a good woman. So they see these ads, and they think "That's what's wrong with me." So first of all, what they're thinking is "Something is wrong with me. That's what it is. I need Sarafem, or Zoloft, or whatever brand it is." And so they are rushing to doctors to ask for these prescriptions, so they'll be nicer women. It's really scary. And one other thing: An attorney said to me, "Are you telling me that there is no proof that PMDD is a real entity?" And I said, "That's right, and in fact the European Union's equivalent of the FDA said you cannot prescribe Prozac for women for PMDD, because the research shows that it's not a real entity. They saw the same research the FDA should have looked at."

AR – Wow.

{51:35}

PC – Probably did look at and drew a totally opposite conclusion. And so anyway, this lawyer said to me, "Well if there's no proof that it's a real entity, then anybody who uses that diagnosis and bases any treatment decision on it, even if it's 'no treatment,' is essentially subjecting the patient to experimental treatment without their knowledge or consent." This should be a major scandal, I've been talking about this for 15 or 20 years, and nobody will listen, nobody will take that seriously.

AR – Do you have any, I mean we could go on about this, but can you tell us what you think are the forces that militate against that kind of change happening?

PC – Well yes, in the *Bias in Psychiatric Diagnosis* book, Jeffrey Poland and I tried to write a chapter about that, about what keeps this going, and it was very hard to write the chapter, because there are a number of major forces that all intersect and interact with each other, and each one is very powerful, but it's a combination of a number of factors. In the United States, it's the insurance companies, even in Canada for secondary insurance; they say "If we don't have the *DSM,* what do we have?" and they get scared. And they know that it's a mess scientifically, but they want to have something they can go by. I actually have a solution for that, which is

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what we are in fact doing, and have been doing for decades now, is we're saying, "If you have the right kind of degree, and if you say the patient has x and needs this, then we'll say, okay, if that fits our guidelines."

AR – Right, right.

PC – Even if we know there's no scientific basis. So why not just be upfront and instead of saying "Go by the *DSM*," say "If you have the right degree, and you think this person will benefit from a certain kind of thing, then we'll go along with it, because that's what we're really doing anyway." Okay so the insurance companies, the government, because in the States Medicare and Medicaid, they're rooted in the *DSM* for psychiatric treatment, for mental health treatment. The American Psychiatric Association, and of course the *DSM*, the drug companies, very powerful, very powerful at wanting to maintain this whole system. So those are some of the factors. And then for the individual, the fact that the average North American worker is working vastly higher number of hours per year, so everybody's busy, so they want quick solutions. The fact is that we live in a very psychiatrized and psychologized society. So instead of thinking "This person's lonely, or this person doesn't get any vacation time," or whatever, we think "diagnosis, drugs."

AR – Right.

{54:48}

PC – Maybe a little psychotherapy. We don't think about meditation, exercise, nutrition, friends. Whatever happened to friends being helpful and protective? I hear friends all the time say, "Well her boyfriend broke up with her, but I didn't talk to her about it, because I'm not a therapist." So we're professionalizing. Or somebody died, somebody lost somebody through death, and they're feeling horrible, send them to a therapist. Well no, that's what your community is supposed to do for you. I'm not saying there's not a place for therapy, and I'm not even saying that there's never a time to use a psychotropic drug, but these are the two default kinds of approaches, and there's a whole huge range. I wrote the chapter on emotions for the current *Our Bodies, Ourselves*, and we were talking about this huge range of other things that people don't think of. And individuals assume that what the experts are telling them is the truth and is scientifically grounded, and so they think they need a diagnosis and a pill, and maybe some psychotherapy. And they think, "I feel better when I swim three times a week, but surely that can't be what I need."

AR – Right. Well in fact you have written at some point, I think it was in the *Bias in Psychiatric Diagnosis* book, I mean you have written "In principle, psychiatric diagnosis can be helpful also, in the same way that accurate physical diagnoses can be." So you're not in fact saying that at every turn, psychiatric diagnosis is unhelpful, but it sounds like you've really come to question the whole process on which those judgments are made and pointing out and highlighting the harm those labels do, in terms of the way people think about themselves and so on.

PC – Oh, they do tremendous harm, and I've written about this in a lot of different places, but there's one other thing. I want to make it clear that when I say in principle psychiatric diagnosis

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could be helpful, I don't think in practice it is, virtually ever. And let me tell you why I would say such an extreme thing. There are two feminists in Saskatoon, Nikki Gerrard and Nayyar Javed, and if you haven't talked to them, you should. They're brilliant. They work at the Saskatoon Mental Health Clinic, and they used to put up signs in the clinic, people would put up signs, and they would say "We're going to run a group for people with eating disorders, or a group for anxiety disorders." And one day they said, "Wait a minute, why are we doing this?" So they changed one word. So now the signs say "for people with eating problems, anxiety problems"; it's a huge difference in the way people think and feel about themselves. Even the *DSM* authors will tell you that trying to figure out where you draw the line between "this is a disorder and this isn't," can't do it. There's a brilliant psychologist in Rhode Island named Paul Block, and we have the following conversation: he says, "I think diagnosis is useful," and I say, "No, it's not." And he says, "Yes, let me give you an example." He says, "A teenager came to see me the other day and was telling me all these awful upsetting things that are happening to her and what she's feeling about it, and at the end of the session I said to her, 'What you have is Generalized Anxiety Disorder,' and she said, 'Oh what a relief! So, it's real, and you've obviously seen this before, you know what it is, so presumably you know how to help me?'" And he said, "Yes." And I say, "Paul, there's only one word of what you said to her that I would want to change. Instead of saying 'You have Generalized Anxiety Disorder,' why didn't you just say, 'You have generalized anxiety?' What difference would it have made? And then the benefit of doing it that way is that you're not pathologizing her."

AR – Right.

PC - She's already got enough problems; now you've also told her that she has a psychiatric illness and that doesn't help you at all. And Jeffrey Poland, in the *Bias in Psychiatric Diagnosis* book, wrote a brilliant chapter; it's focused on schizophrenia, but it applies to everything, and what he's talking about is that as a result of the whole system now, what people do, when you go to see them when you're suffering, is the therapist will sit there and try to figure out which template in the *DSM* you match. Now once they've matched you, with HMOs and such, they don't have time, or they're not interested, or they haven't been trained, to do anything else. They say, "That's your match, that's your category." And aside from the fact that that tells you almost nothing about what's going to be helpful to the person — because what's helpful to most people, regardless of what label they get, is just the obvious: listening carefully and respectfully, reading the literature with a critical eye, having experience, being willing to consider various perspectives, looking for the persons strengths, which the *DSM* completely leaves out — so you're not helped in deciding on treatment almost at all by figuring out what category the person belongs in, and more seriously, if what you know about them is which template in the *DSM* they match, you don't know most of what you ought to know about that person. You don't know about their strengths, you don't know about their resources, you don't know about the situation in which they live. You don't know who they are, but you think you do because you know which *DSM* category they match.

[Recording Ends – DVD 2 Begins Here]

AR – Okay, so why don't we pick up where we left off in terms of diagnosis?

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PC – Yes, I think it's really important that people understand a couple of other things about psychiatric diagnosis. One is that although yes, ideally, psychiatric diagnosis would give us a common language and would help us know if a person has this label, then this is the kind of treatment that will be most helpful, and this is the kind of outcome we can expect. The fact is that the research shows that that isn't the case with psychiatric diagnosis. And people will say, "Oh yeah, sure, because if somebody's Borderline then you don't do this," but I'm just telling you: It's just not there in the research.

AR – Right.

{0:48}

PC – And the reason is pretty clear. And that is that almost no matter what kind of emotional problems somebody is having, what tends to be helpful are the same kinds of things; I think I mentioned that before. And so we delude ourselves when we think that there's some kind of scientific reason, that we get more information if we can just plug the person into the right category. So a) it's not helpful, b) it's harmful, not only because we tend to operate very often as though if we get the diagnosis, that's the most important thing, but also because getting just about any diagnosis, even the ones that seem to be the milder ones, can have devastating life consequences. I learned about some of these before I wrote the book, and some of them, people have told me about afterward.

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AR – Right.

PC – So it can include not only plummeting self-confidence – just about every therapist I know has had somebody come to see her who has been to another therapist and they'll say, "Hi, my name's Mary. I'm Borderline." And that becomes their identity. So plummeting self-confidence, pathologizing of oneself, and therefore misinterpreting all kinds of things in disturbing ways. Also, you can fail to get a job, or you can get fired. Now of course, it's illegal for somebody to refuse to hire you or to fire you because you have a mental illness diagnosis, but an attorney said to me, "You just try proving that that's why they did it. Because usually they're not stupid enough to put that in writing or to tell you; they'll say, 'Oh, it was a personality problem, or whatever'." You can lose the right to make decisions about your medical and legal affairs. There was a very high-profile case; it became high profile because Lily Tomlin became involved.

AR – Okay.

PC - There was an old woman who had some physical problems, and most of the people she was close to had died, and she was understandably feeling down, and so of course, you know, the word depression gets applied to everything from feeling a little blue to being suicidal. So she was diagnosed as depressed, and the professionals recommended electroshock. She said, "I don't want to have it," and they said, "Ah, by virtue of saying you don't want to have it, you show that you're out of touch with reality, and therefore we can order it against your will."

AR – Wow.

{3:40}

PC – Now, because Lily Tomlin got involved, and because this woman from somewhere had the energy and the resources to hire an attorney, she was able to avoid that. But of course most people in that position aren't. You can, in the States, you can lose your health insurance, or you can have skyrocketing premiums, similarly in Canada with secondary insurance; you can be refused because now you have a pre-existing condition. I'll tell you one quick story. I had an attorney from one of the states call me and say he had a client who moved to his state to do an MSW program. She signed up for health insurance in that state, got the insurance. She went to class the first day and was told that "If you have never been a therapy patient, go to a walk-in clinic and get some therapy, so you'll see what it's like." So she went to a walk-in clinic, she was seeing a woman who was a psychiatrist, and the psychiatrist diagnosed her with Adjustment Disorder; she'd just moved, she was lonely. She was in a bicycling accident, was injured, and was taken to the hospital where she had seen the psychiatrist. Well, it turned out that her insurance company refused to pay her medical bills for the accident on the grounds that she had lied when she applied for health insurance. She said, "What do you mean, I lied?" They said, "Well, there's a question on there, 'Do you have a mental illness?' and you said 'no.'" And she said, "I don't," and they said, "Well it's right here in your chart, Adjustment Disorder."

AR – Wow.

PC – And my first thought was, I said to the lawyer, "Well have you spoken to the psychiatrist? Maybe she can explain.? And as I was saying it, I thought, "No, the psychiatrist? What is she going to say? 'This woman isn't mentally ill but I gave her a diagnosis, so her insurance would pay for it, because she doesn't have any money?'"

AR – Which is what happens in reality. Adjustment Disorder is what you give people when they're not —

PC – When there isn't anything major going on.

AR – But you need to, to get them covered.

PC – That's right. And so you would think, Well this is going to be harmless, because it's such a mild label." People have lost custody of their children. I know of cases in which the father would sue for custody and say, "My ex-wife was diagnosed with Premenstrual Dysphoric Disorder." So there are lots of very serious consequences. I also know of people who had serious physical problems, but because they had been given just about any psychiatric diagnosis, ADD in one case, the problems that were physically based, very serious potentially fatal illness – in one case that I know of, they had behavioural consequences. She was very distractible, she was very agitated, and they said, "Oh she has ADD." She almost died; there were hospital bills for hundreds of thousands of dollars, because they weren't treating this real physical illness that she had. So that's why I have a website, psychdiagnosis.net, on which there are 53 extremely varied stories of people who have suffered because of getting a psychiatric label — not even because of a drug reaction, or because they had a bad therapist, but because of getting the label.

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{7:18}

AR – Right.

PC – And that's something that most people don't realize. I have issued a call for Congressional hearings about psychiatric diagnosis, because I think people need to be educated, we need a national conversation about it. Most people assume that diagnosis a) is scientific, and b) is regulated: "Doesn't the FDA, doesn't the American Psychiatric Association [regulate it]?" No, nobody is regulating it at all. And so I think we need to have people have a chance to testify if they've been hurt by being given a diagnosis, if they feel they've been helped by it, if they have been, sure, and do some very public brainstorming about how to protect people from the dangers of getting a psychiatric diagnosis.

AR – Is there any use, in your opinion, of trying to also educate psychiatrists and psychologists about their use of diagnosis?

PC – Well, one of the things that's on the website is six ways to work toward solutions. And one is called honesty, openness, about the unscientific nature of psychiatric diagnosis. Another is that yes, if somebody is an oncologist, and they say I'm treating this patient for cancer X, you expect them to have not only read the research about what cancer X is, is there proof that it's real, what's helpful, but you expect them to be able to think critically about it. And somehow we don't expect psychiatrists, psychologists, social workers, or the many others, the GPs, the OBGYNs who use psychiatric diagnoses all the time, we don't expect them to know anything about the science or lack of science behind psychiatric diagnosis.

AR – Right.

PC – And I think that is appalling. It's unprofessional. We should at least make sure that our professional associations and that the licensing bodies require this. But you know it's really difficult because even the American Psychological Association, which used to express reservations about the *DSM*, now offers continuing education courses and videos that they sell, and so on, with no critical component, no questioning component at all. And so not only are the professional associations not educating people, but they seem to be actively avoiding it, and I think that's really shocking. I think there should be lawsuits against the American Psychiatric Association for false advertising; the *DSM* is not a scientific document. And they sort of have it both ways in there; they say, "Oh it's scientific," and they have all these books that are the reviews of the literature, which are abominably done.

AR – Yeah.

{10:15}

PC – My undergraduates would fail if they did lit reviews that were so badly done. But they look very impressive in these books produced by the APA. So they are falsely advertising that this is science. And I think that individual practitioners who use psychiatric diagnoses ought to be held liable for any harm that comes from using a diagnostic label that has not been shown to

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represent a real entity, and has not been studied with good science. But if you suggest these things people look at you like you're crazy, or that what you're suggesting is totally unreasonable. But if you look at it within the realm of physical problems, they would say, Well of course!"

AR – Right. Can you talk a little bit about how these problems specifically affect women?

PC – Yes, here is how these problems affect women in particular. If you imagine the whole enterprise of psychiatric diagnosis as a sphere, and if you imagine taking out of that sphere what is supposed to be good science, and leaving a vacuum where good science is supposed to be and is not, what whooshes in to take up that space? Well, obviously, if you don't have science, then what comes in is every conceivable kind of bias. And that includes sexism, and it includes racism, and classicism, and homophobia, and ageism, and ableism, and cultural issues. And so anybody who already is in some ways oppressed, undervalued, demeaned, mistreated, is more likely to suffer. They'll suffer disproportionately, and that has been shown to be the case.

AR – Right. I'm curious about your position on what is becoming a huge movement within psychology. Evidence-based, or empirically-validated, or whatever phrase happens to be in fashion. What is your take on that development?

PC – It makes me crazy, and here's the reason: So much of research in psychology is bad research. Published research, peer-reviewed journals, I don't care, it's terrible research. When I was an undergraduate at Radcliffe in Harvard, back in the late 60s, Bruce Baker, who is now at UCLA, taught a course, and he would give us published articles, and he would say, "Write a three page critique of everything that's wrong with it." And we would say, "Oh my God, this is the Rosenthal experimenter bias research! There won't be anything wrong with this; this is the truth, this is a classic." And he would say, "Just look at it." And we would say, "Oh!" and we would find things, because when you're trying to do research on human behaviour, it's extremely hard to do good research. So I'm not saying that to trash people who do psychological research, but it's extremely hard to do good research. You either do it in the laboratory, which isn't a realistic situation, so there are those limitations, and people do not always take care to make clear how limiting those factors are. They just say here's what we found, and then everybody thinks oh they found the truth.

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AR – Right.

{13:50}

PC – Or if you don't do it in a laboratory, if you do it in a natural setting, then you cannot control most of the important variables, and so you don't really know a lot about what you're finding. And then yes, there are some people who do research as though they've never taken a research methodology course, and it gets published. And so trying to take the field of research that relates to the practice of psychotherapy and figure out how do we use what in what situation – somebody comes to see me and they're having a problem — this is an entire, complex, nuanced person, nobody's ever done research on them, there's probably very little research on their particular problems in their particular contexts, with whatever strengths and resources they have,

and so the question of who is going to get to decide what is good enough research…you don't find perfect studies in psychology. So who is going to decide what's good enough research, who is going to decide, "All right, this study for evidence-based psychotherapy, this study we should take with a grain of salt, this with three gains of salt, what can we learn?" I have undergraduates write papers in which I say, "Take the last ten studies published on this topic area, or take one from each of the last ten years, whatever, and then say, 'Study number one, here are the pros and cons; here's what's good about the study, here are the problems with it. Study number two,' and go through those, and then make a state-of-the-art summary comment at the end, and say in light of these problems, here is what we do know."

AR – Yeah.

PC – "Now compare it to what those authors say they found and what people think to be the truth; very big difference." And so who is going to decide what the standards are supposed to be? Who is going to sit there with you and see if you're applying it correctly? I think in principle it's an absolutely wonderful idea, but it is based on the very false premise that there is a lot of really well done research in psychology that has results that clearly apply in very obvious ways to what we should be doing with particular therapy patients.

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AR – Right, okay. You know a lot of what you've just been talking about has been expressed through one of the plays that you wrote, "Call Me Crazy". Can you tell me how you became a playwright? How did that all happen?

PC – Well when I was a kid, my father was an actor early on until the Depression came — the economic depression, he wasn't depressed — and my parents both adore theatre. I grew up acting when I was a kid and when I was in high school, and just always loved theatre. So when the second of my two kids had left for college, I thought, "Oh, I really miss theatre." And I had left Toronto, but I went back, and the Fringe Festival was going on, and I went to see a play about Zelda Fitzgerald, whom I was very interested in, in a Sanatorium. And I remember thinking, "It's not a very good play, but hmmm." And my book about the DSM, *They say you're crazy*, had recently been published, and I'd written a bunch of books before that, and they all got quite a few reviews, and I had thought, "Boy, am I lucky that these books are getting quite so many reviews!" This one got almost no reviews anywhere.

{17:37}

AR – Really.

PC – And I would mention it to people, and they would say, "Oh well, obviously, look, you're going up against this huge very powerful system." And I thought, "Oh, come on! But that wouldn't explain why people aren't even reviewing the book. Why wouldn't they just trash it?" And I said, "No, it's just luck of the draw. I was lucky that my previous books got reviewed a lot." But I was concerned, because I wrote that book after having been on two *DSM* committees and being so horrified, when I was at OISE I used to teach the *DSM* as an advocate, then when I was on their committees, and I saw how they ignored and distorted and even lied about the research, I thought, "This is appalling, and the public needs to be informed about this, because

you walk into a therapist's office. and you think science is going to be the basis of what's happening there. And you trust someone; you're not there if you're not already having a rough time."

AR – Yeah.

PC – The public needs to know. So I thought, "I've never written a play, and probably it'll turn out that I can't write plays, but I think I'd like to. Now that the kids are out of the house, I can do something just for fun, and I bet I'll learn a lot by trying." So I mentioned this to my daughter, and she got me a book for my next birthday called *How to write a play*, or something like that, and I wrote a little bit. I showed it to her, she was about 19, but my kids are very knowledgeable about theatre. And she said, "Well Mom, it's good." And I said, "Come on, Emily, tell me the truth." And she said, "Well, it's a play, and with a play you're not supposed to tell it; you're supposed to show it." And I said, "Oh right, right! I remember hearing that." And then I said, "How do I do that?" And she kind of turned pale, and she said, "Well I think that's sort of the whole thing, figuring out how to do that." And that has continued to be a struggle.

AR – Yeah.

PC – But I wrote a play called "Call me Crazy," and I call it a comedy-drama with music, and it was done in New York, actually. It won second place in this [Arlene and William P. Lewis] National Women's Playwriting Contest [for Women], to my amazement, because at that point I wasn't even sure it was a play. How do you define a play? Anyway, so that's what it's about. There are four therapists having serious case conferences, and there are four patients who — are you ready for the symbolism? — who are invisible to the therapists, but they can see the therapists, and they're listening to what the therapists are saying, and they're just not getting it. And so periodically they run out and do a vaudeville routine, or a skit, or a quiz show, or a song. And then there's one other character who is Freud's mother, and she speaks, because we never got to hear from her.

{20:32}

AR – Right.

PC – So that was a great experience. And we did a performance of it at one of the annual conferences of the Association for Women in Psychology. Oh, talk about the perfect audience! Oh it was wonderful, it was wonderful. Because parts of it are really funny, parts of it are very serious, and they of course got everything.

AR – Yeah. Well tell me a little bit then about your involvement in the Association for Women in Psychology.

PC – Oh, well, it is so wonderful, because there were some people who sort of broke away from Division 35 of APA, and a lot of people are members of both, but Division 35 started out being very activist and very feminist, and in my view and that of many other people, has gotten farther

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and farther away from that over the years; it's been very sad. AWP has consistently been activist, much more radical, and I mean that as a compliment. I got involved with them years ago when I first started some of the protest against the *DSM* stuff. I was at an APA conference, I had just been to this meeting at APA headquarters, and then I was supposed to go out to, I think it was in California, to this AWP conference. I got there, and we were talking about "Isn't it terrible that they're talking about putting Masochistic Personality Disorder and Premenstrual Dysphoric Disorder in the *DSM*?" and we said we should do something. And I thought, "Everybody is so busy, if we have a committee, and then we wait and try, nothing will happen." So I just wrote this note at the top saying, "This is what they're proposing, and just sign here if you want to express concern." And that was where it started, and then we ended up with a huge number of petitions and letters representing huge organizations. And the National Action Committee on the Status of Women in Canada, which was sort of the equivalent of NOW in the States, but it was in a way different because it was an umbrella organization for all different kinds of women's organizations; it was amazing, it was huge. And NOW, they sent letters of support. We ended up having letters and petitions representing more than six million people.

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AR – Wow.

{23:15}

PC – So that was my first little activity in connection with AWP. Then over the years, periodically, I would attend, and then at some point I was asked if I would be the spokesperson for AWP, and I was delighted to be. There were a couple of things that I wanted to do. One was to use that as a platform for working on the *DSM* issues, and we did that. I should just say that for years I've been trying to work with Division 35; they had a task force that Janet Hyde appointed me to head on sexism in diagnosis. I wanted Division 35 to publish just a few little two- or three-page papers about various issues related to sexism and diagnosis and make them available to clinicians' training programs. And Division 35, not under Janet Hyde but under some other people, just consistently refused, gave weird reasons, and so I had just gotten disheartened and I gave up. And then Joan Chrisler, a wonderful feminist psychologist at Connecticut College, I mentioned that to her, and she said, "Well, wait." She checked with Maureen McHugh, who was then the head of AWP, and they took it on as an AWP project. So that enabled me to go to publishers and say, "This is a project of AWP"; it wasn't just me with a few authors, it was "This is a project of AWP." They gave us some financial support to hire an assistant to help pull this all together, and then I got a whole bunch of more people to write chapters, and we came out with this book *Bias in Psychiatric Diagnosis*, and could not have done it without Joan's and Maureen's help. It was really wonderful.

AR – Neat.

PC – The other main thing I wanted to do as spokesperson, I mean we sent letters when George W. Bush appointed horrible people to FDA committees, and a lot of other things, but the other major project was this: at an APA conference, it was right before we knew that Bush was going to start this war in Iraq, and I remember Maureen McHugh saying, "Is there anything we can do about this as psychologists?" And her asking the question that way made me think, "Yes. What we can do is we can say, as psychologists, 'There's only so much of the emotional carnage of

war that psychologists can fix, and don't think they'll clean it up.'" I wrote a white paper in which I was saying we should have learned from Vietnam and the first Gulf War, if not from previous wars, that diagnosing everybody who is upset from their war experiences as having a mental illness that we call PTSD and sending them to talk to therapists behind closed doors is not going to work. How many homeless people now, how many suicides, have been vets for whom that didn't work?

AR – Right.

PC – And I said that if we're going to say that people who are devastated because they saw somebody get blown to bits, or because they realized they killed a child, if we're going to say that their anguish, their terror, their rage, is a mental illness, then what exactly would be a healthy response to the horrors of war? So it's wrong, it covers up the damage done by war if we say, "Oh they have PTSD."

AR – Yeah

{26:55}

PC - And it's bad enough when they come back, and they realize we haven't been through what they've been through; they can't even begin to tell us. They think they should protect us from those horrors. The women think they've got to be macho to prove that they deserved to be there, the men have to be macho because they're men, and if we say, "Go talk to a therapist about it, and please close the door behind you," we isolate them even more, and we compound the problem. And then on a national scale, we protect ourselves from seeing what war does, and that makes it more likely that we'll go to war faster the next time. And that is exactly what is happening in 2007. Now that they're starting to say, "Oh look, suicide rates in vets are up, the VA isn't dealing with these emotional problems very well," but everybody is saying we need to be doing more about PTSD, and it's the wrong way to go. Yes, they need help, but diagnosing them and sending them – now, that's not to say that some therapists aren't helpful to vets to some degree. But to just leave it at that and call it a mental illness, I think, does damage. Arthur Kleinman, who is a psychiatrist at Harvard, who is wonderful, calls these kinds of responses "moral disorders," not mental disorders.

AR – I totally agree with everything you said. You know, you said earlier, with the book that "Call Me Crazy" was based on, that you're taking on a huge industry. What do you think can be done to change the way psychologists, anyway, let's not even go to psychiatry, what can be done to help psychologists think differently about these issues?

PC – Well, it has to start with undergraduates, or even in high school, where it has to start on a lot of different fronts, and it's not happening in any of these. It needs to happen in the media with the way that psychologists and psychiatrists knowledge is presented, and it has to happen – Autumn Wiley, who was an undergraduate at Brandeis, did her undergraduate thesis looking at the most used undergraduate abnormal psych textbooks. She said, "Look, for decades we've had this wonderful feminist critique by a lot of people of the *DSM*. Now, how much of that is even

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mentioned in the textbooks?" And even in one textbook that is co-authored by a very powerful, a very well-known feminist, it's not in there. And so that's pretty scary.

AR – What do you think keeps people from publishing these things? Like what are the forces that are impinging upon people to keep this kind of stuff quiet?

PC – I have no idea, and I'll tell you something else. Thomson Publishing in Canada had some communication with me, in fact very extensive communication, for none of which I was paid, of course. They wanted to write something about premenstrual dysphoric disorder in this textbook, and they said would you give us feedback on it. And I looked at it and my heart sank.

AR – Yeah.

{30:30}

PC – They made all the same major, serious errors that are made by most of the media. There's a whole chapter in my book,*They say you're crazy*, about media coverage of these diagnosis issues and how terrible most of it is. Michelle Landsberg in Canada is one sterling exception to that, and there have been a couple, but not many. And so I wrote extensively not only "Here are the errors in this section of the textbook" but "Here's why it matters so desperately that you not make these errors." Well, they took some of them out, I mean drafts went back and forth, and I kept dropping everything to respond, because I thought this was so important, and you should have seen what they came out with. It still had serious errors in it. I contacted them subsequently to say, "You need to fix these in the next edition," and they will not communicate with me. I am now cast as a troublemaker instead of their wanting to get it right.

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AR – Right. I'm not surprised.

PC – Well, you know the drug companies are influential, the APA is influential. People don't want to have to go through a major paradigm shift in their thinking. But when they're told, "But you've got the facts wrong," I have no idea what makes them feel comfortable saying, "We don't care." I don't know what goes on in their heads; I wish I did. I think that psychologists should be talked to in a much more honest way, and psychiatrists and social workers, in their training. This is more likely to happen in social work than in psychology or psychiatry right now. But one thing that I say every chance I get is when I started graduate school, I had just turned 22, and all of a sudden it seemed like I was expected to help people, and I wanted to, and I was expected to know more about them than they know about themselves; that's what the message seemed to be. So you go in to try to help a patient, and you think, "Who am I, what do I know?" And you're scared, and you want to do the right thing, the helpful thing, and so it's the most natural thing in the world to listen to your teachers, read the books, read the experts, and do what they say.

AR – Yeah.

PC – Then that means that's what happens to the next generation and the next generation, instead of people saying, "We know very little." That's the truth. And yes it's hard to live with but we have to be honest with ourselves, we have to be honest with each other, and we have to be honest

with our patients. And that is I think where it should start. Now when I speak to groups and I say this, that gets such a strong reaction, and it is almost invariably positive. They're saying, "We've never heard anybody say this before." Well, isn't that sad, and isn't that scandalous that that isn't said all the time?

AR – Yeah. It strikes me though that what you're saying is that we have to relinquish our status as experts.

PC – Yes.

{33:58}

AR – Which I have no problem with. In fact, a lot of really good therapy is based on the notion that you aren't the expert; feminist therapy is based on that notion. But I imagine for a lot of people that is extremely threatening.

PC – It's very scary.

AR – And strikes at the heart of whether there will be anything called clinical psychology or not.

PC – Yes that's right.

AR – Yeah, interesting. You mentioned earlier that you wanted to get back to something about your mother. So I want to make sure we do that.

PC – Yes, very much related to the whole mess of psychiatric diagnosis. I mentioned earlier about my mother having said that she had a mental illness. Well this was in Springfield, Missouri, in the '50s, in the early '50s, the mid-'50s, and there were very few therapists around at all. The one that she started seeing, I think he was the one psychiatrist in town, who later lost his hospital privileges for sexually abusing patients. Fortunately he did not do that with my mother, but he did just about everything else that was horrible. He told her to divorce her mother, cut off contact with her mother. Why was that? Well, because isn't that who is always blamed by traditional therapists. And I said to my mother, "Did you?" She said, "No," and I said, "Why not?" and she said, "Because my mother was so wonderful, and we were so close, and it just didn't seem to me to make any sense." But how amazing was that that my mother, in that era, where she was "mentally ill," and here was this psychiatrist, and he was telling her what to do, that she was able to resist that instruction!

AR – Yeah.

PC – He also diagnosed her with Obsessive Compulsive Disorder. Now that diagnosis is still used a lot, and you know what, almost invariably, if you talk to someone who does repetitive kinds of things, cleaning rituals, counting, whatever, you can almost always find that there was either some trauma that led to it, or that there were what we now call panic attacks. And that when somebody has a panic attack, I mean what most people still don't realize is that you can be sitting there and be perfectly calm, and it's just like a chemical, something happens that makes

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your heart start to pound. And you have all of the physical reactions that you have when there is a tiger charging at you, or you're about to be hit by a truck. And if you don't know that that's what's happened, that it was just a physiological thing and then it'll go away, well, then, being human, you try to make sense of "I'm terrified! What's wrong with me?" And you try to find a way to make that stop. Well, of course, people just know something repetitive tends to reduce anxiety, and a lot of women especially, tend to be cleaning. I mean the chances are that when they have a panic attack they will be cleaning

{37:08}

AR – Yeah.

PC - And so if they go on cleaning, washing their hands, then the panic attack subsides, and they understandably but mistakenly draw a cause-effect connection: "It stopped, that feeling stopped, because I kept washing my hands 16 times." And so that's how these rituals get started, or in response to a trauma, where again you're trying to reduce the tension and the panic and the fear. But if you diagnose the person as having Obsessive Compulsive Disorder, people don't usually assume that we need to look behind the rituals. It's like diagnosing you with a runny nose when what you have is a cold virus. And so people stop thinking, and they say, "What drug do we use for OCD? Okay, put them on it." If it doesn't work, which it didn't with my mom, what do you do? I don't know; try behaviour modification, try this, try that, just throw various things at them. And so as a result of the failure of many therapists that she saw, actually, to think carefully and clearly, she did not get help. Now that's tragic, and she's an amazing woman, but there were parts of her life that were ruined because of that failure.

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AR – Yeah, yeah. I was going to ask this earlier, but it follows nicely on this, too. One of the things that you've really brought to light is all of these cases and the stories of people for whom diagnosis has led to incredible harm. And I know that you are involved in the committees and so on, and you saw firsthand how little science had to do with it, good science had to do with it. But when did you start getting interested in the stories of people who had been harmed? How did that kind of start happening?

PC – Well, there's a long history in my family of storytelling, actually. When my uncle Billy and my grandma Esther used to drive from Springfield, Missouri, to St. Louis to visit her sister, they would come back and when you would hear, "Gram and Billy are back from St. Louis!" you'd know we're going over to the house tonight, and we'll hear the stories. And my Uncle Billy was a hilarious storyteller, and we would just laugh and laugh, and it was great. And so I've always been interested in stories. As a feminist, I think that hearing what people have to say themselves is extremely important instead of just stepping back and doing research on them and analyzing them and that sort of thing. I mean I'm not saying they have to be mutually exclusive at all, but I'm very interested for that reason. I think it's part of the reason I love writing plays as well and acting.

AR – Yeah.

{39:57}

PC - But what happened was that when I first went to speak to the *DSM* people about why I was concerned about the masochism diagnosis, it was because of stories that I knew, some about patients, some about friends or family, some my own. You know, you're going through a divorce, and you're having a difficult time and people say, "You wanted the divorce." Yes, I wanted the upsetting parts of the marriage to stop. I didn't want the fear of being a single mother, the difficulties of raising kids alone, I didn't want that; that wasn't why I took on going through the divorce. And so there were just so many experiences that I had heard about or that had happened to me, and that was one reason for the intensity of my concern about this category and then others. And then the same thing with the Premenstrual Dysphoric Disorder: I would hear about a woman who said, "My husband brought this up in a custody case." And so it was through that, and then once the book came out, I did a book tour all across the country, and I did a lot of phone-in shows, and people would call and tell me stories.

AR – Wow.

PC – And I just felt like most people don't hear these stories, and we need to put some of them together and have them be accessible. One woman I remember, there's a wonderful talk show host in California, in LA, named Michael Jackson, but it's not the singer and dancer. I was on his show, and a woman called and said, "My husband reached mid-life, had a mid life crisis, went to see a psychiatrist. The psychiatrist said oh he's schizophrenic and put him on anti-psychotic medication and called me in and said he's never going to be better, you should leave him."

AR – Wow.

PC – And she said, "Well I wasn't going to leave him. He was my husband, I loved him, he was having a rough time. One day he decided he didn't like the way he felt on this medication; he stopped taking it and he was fine." So you just wonder how much of that kind of thing goes on. Oh, I'll tell you another story. This is not in the book, because I heard it much later. I lived in Providence for a while and I happened to be having lunch with some women I never met before, one day. And one of them said, "Why does your name sound familiar?" And I mentioned something about my play, which was just being done at that point, and she said, "Oh diagnosis!" I think she was a bio-statistician, or something like that, and she said, "I used to work for Robert Spitzer," who was in charge of the *DSM-III-R* committee." And she said, "I worked in his office right when you were sending all those petitions and letters. And there were a bunch of women working in that office and every time another batch would come we would cheer."

AR – Yeah.

{43:15}

PC – Well, I just about wept because I felt very isolated doing that work and periodically would feel like "I'm a fool. Why am I doing this? Nobody cares." And then hearing all these years later that this happened was really wonderful. And then she said, "Well, tell me about your play." So I described, there was this one scene near the beginning, and it's a quiz show, and it's very broad comedy; the comedic parts are purposely very broad. It's a quiz show called "What's my

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diagnosis?" and I said the quiz show host says, "Here are our guest psychiatrists today, Dr. Grip and Dr. Slip, and what we're going to do is, we're going to have a patient come out here, and as in many real mental health facilities, you two psychiatrists will have just a few minutes to assign your diagnosis." And this woman said, "Oh wait, I have to tell you something." She said, "One day we had a temp working there answering phones. And the phone rang, and we heard her say, 'Hello,' and 'Uh, no, Dr. Spitzer's not here right now. No, he went up on the ward to do a diagnostic.' Which was what he called it, when a new patient came in he had to go and give a diagnosis. She said, 'He went up on the ward to do a diagnostic. Oh I'm sure he won't be back for at least an hour and a half.'" And this woman who was telling me this story said, "The other women in the office went, 'No no no, ten minutes!' He prided himself," she said, "on being able to give somebody a diagnosis after just ten minutes." Now is that scary or what?

AR – Yeah. This is an aside that I'll probably edit out later, but I worked at the North York General Hospital in one of my practicum placements, and I overheard two psychiatrists talking to each other, and they were joking but kind of in a competitive way about how quickly they could make a diagnosis. It was like a competition; "I can do it in four minutes, you can do it in three minutes." I was just appalled. It was like a parlour game they were talking about.

PC – Yeah, that's terrifying. And I had a call from a psychiatrist in one of the Maritime provinces saying that a psychiatrist had diagnosed a client of his after one 40-minute session, as a result of which she lost custody of her child. And let me just tell you one other story about diagnosis, and this is in the play, my play called "Call Me Crazy", it became a monologue. I had a graduate student who was doing an internship at one of the major hospitals in Toronto, and you don't have to edit this out. She was seeing a young woman who had been married, and when the woman got pregnant, her husband started beating her and told her she was a fat pig and he didn't want to have sex with her anymore. And then when the baby was born, and it was a girl, he left. The woman met another man who was so sweet and so gentle and so good to her and so good to her daughter, and she was crazy about him and he wanted to marry her. And she started binge eating, and then she would feel so horrible she would make herself throw up, and her throat was raw from that. So this graduate student was telling the psychiatrist who supervised her at the hospital about this, and he said, "Well, you have to diagnose her as having Self-defeating Personality Disorder, because obviously she's doing this because she enjoys the suffering. Now that her ex-husband isn't around to beat her, she has to make herself suffer pain." And the graduate student refused to do that, and she was told that "You will be kicked out of your internship if you don't give her that diagnosis." And she refused anyway.

{47:43}

AR – Good for her.

PC – But I just find that terrifying. And a lot of that happens. I was a psychologist at the Toronto Family Court Clinic. That was my first job after I got my PhD and did my post-doc, and I had a team leader named Harvey Armstrong, who is still in practice in Toronto. And I was seeing a woman who was Native Canadian. She had a child who had a severe physical disability, and she was devoted to his child. Periodically she would go out and get roaring drunk, maybe every three or four months, for a weekend. She would leave her daughter with her sister and her

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sister's husband — she was very careful about that — get roaring drunk, sober up, come back, and then on her own take care of, fulltime, this very disabled child. One day, she saw her child on the floor eating cockroaches, and she thought, "I've got to find a better place for us to live." She was going to go to Ontario housing. She dropped her child off at her sister and brother in-law's and left. The sister and brother in-law had a fight; the sister goes out, the guy's there with a kid. What's he going to do with a kid with a disability *[he wonders], so* he calls the Children's Aid Society; they pick up the child. So I'm seeing this woman while the Children's Aid Society is saying, "Well, you have to get on antabuse, you have to prove that you're a good enough mother to have this child." She had been a fabulous mother, and I saw as my role to support her through this hellish court process, so she could get her child back. And it went on and on. Well, every week I was supposed to go to Harvey for supervision, and I told him what I was doing, and he said, 'Well, no, no, you're wrong. Your job should be to help her express the negative side of the ambivalence she surely feels for having a disabled child, so she can willingly give her up."

AR – Wow.

PC – And I felt like my team leader, who is much more experienced than I am, and who is much more senior, is telling me that I'm a bad clinician if I don't do what he says. But it didn't feel like the right thing to do. But I know that that happens a lot to therapists: They're put in a position where you do what the boss says, or we'll say you're not a good professional. And then you do start to doubt yourself. And I was very glad at that point that I was a feminist, and I could go and talk to other feminists about what had just happened, because otherwise it would have been completely horrible.

AR – Yeah. Do you have any advice for feminists who are now entering psychology, and what they can kind of do to maintain their feminism in the face of a lot of backlash?

{50:50}

PC – Well, it's really hard because first of all, there are so many people who don't know what feminism really is. They believe the distortions in the media. There're so many people who are scared to say that they're feminist now, but I think that it's absolutely essential to be in touch with other women psychologists or otherwise who think from a feminist perspective, to read good feminist journals like *Women and Therapy*, *Feminism & Psychology*, like the *Journal of the Association for Research on Mothering,* like *Sex Roles*, to make sure that you get the kind of support for what you're thinking and what you're feeling. There are far too few therapist training programs that even allow for a feminist perspective as a legitimate one, never mind incorporating it as a regular part of the training. And so I think that's really scary. So I always tell students, "Do what you have to do to get through, to get your degree, or if you're going into academia, get tenure first and then do what you want." Not everybody has the luxury of saying, "It's okay, I can go and do something entirely different if I can't get through."

AR – Yeah. And is there anything that I haven't asked about that you would like to contribute to the project and get on tape?

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PC – Yes, I want to say something about politics and feminism and psychology. I consider it a compliment if somebody calls me a radical feminist, because as Mildred Rice, my Latin teacher taught us in eighth grade, radical means at the root. And so a radical feminism is about the radical idea that women are people. Was that Gloria Steinem?

AR – I think so.

PC - Feminism is the radical notion that women are people. And whenever I get a chance to, if I know that there are people in the audience who are a little wary about the word feminism, I always say, "Look, as I told my kids when they first heard me use the word and asked me, 'What is a feminist?' I said 'A feminist is somebody who thinks that you shouldn't be telling people what they should do, or how they should feel, just because they're a girl or just because they're a boy.' And my little kids said, 'You mean some people *don't* believe that?' That that's what feminism is. And I say if a woman could take a bus and get off at eleven o'clock a night and walk four blocks to her home alone without being scared, that would be a radical difference in her life. If a woman knew that when she got hired for a job, that she would be paid the same that a man would be paid, and she wouldn't have to have any more qualifications than he would have, that would be a radical change. And I just go through a few things like that and I say I believe by those standards that we really all are radical feminists; how could you not be? I wish I were braver, I wish I were more radical in my activism, I wish I had more time and energy and resources to do stuff, but here's what worries me: I see radical feminism within the area of mental health as being utterly reasonable, rational, and humane, not as being extremist in the sense of too far out or at one end of the spectrum in a dangerous or harmful way. Because I'm talking about speaking the truth, about respecting what your patients tell you, about being responsible about awareness of various sources of harm, to your patients, to other therapists, to yourself, to society, and looking at the research with a questioning approach. And isn't that just good science, and isn't that just good practice? Of course it is. So imagine my surprise when in the course of doing public education, which I spend a lot of time doing – so if just about anybody asks if they can interview me I will say yes, because that's part of what I feel I want to spend my time on.

{55:33}

AR – Right.

PC – I got a call a few years ago from somebody saying, "We're from the Citizens Commission on Human Rights." Now, I hadn't heard of them, but I thought, "That sounds good!" "And we're familiar with your work on psychiatric diagnosis, and we're doing a series of filmed interviews and we would like to come and interview you. Would that be alright?" And I said, "Sure." They said, "Here's our phone number if you need to reach us," and we arranged a time for them to come to my house and tape an interview. And after I hung up I looked at it and I thought, "Oh, they're in Southern California." And then later something made me think, "They like my work on diagnosis and they're from Southern California." I actually picked up the phone and called and said, "Are you by any chance connected with the Church of Scientology?" And they said. "No, absolutely not." I said, "Okay good, I just wanted to check." Now today, of course, I would go to the computer and google Citizens Commission on Human Rights. I didn't

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know about google then, I was so intimidated by the computer, by the internet, and so I didn't even think to do that. They show up at my house, and it turns out the cameraman and interviewer says he's a Scientologist. And I thought, "Well, I guess he would gravitate toward a project like this." It still, they had told me they weren't connected. Later I found out that the Citizens Commission on Human Rights is part of the Church of Scientology, and it says that on their website. Now, there's a whole long, horrible story about how it took me a year or a year and a half to get a copy of what they were going to use. And in the meantime I found out that they opened a museum in Los Angeles called Psychiatry: An Industry of Death. They created a film that's on DVD that has Hollywood production values, it's a full-length film, and it's called "Psychiatry: An Industry of Death, and I'm on it.

AR – Oh.

PC – And what they did, they had asked me to sign a release, and something made me write on the release "not to be taken out of context in any important way." They did not even ever tell me outright that I was in this film. They said "Here's what we're showing at the museum," and it was a couple of clips with some other people's clips in there. One of the clips shows me saying "There is no such thing as mental illness." Totally out of context.

{58:20

AR – Right, right.

PC – And all I could think of was somebody who is seriously, emotionally, troubled, watches this and sees Paula Caplan, Harvard University, saying there's no such thing as mental illness. How are they going to interpret that? I was teaching at Harvard, and I said to my students, "If somebody showed you a film, and it showed me saying there's no such thing as mental illness, what would your response be?" And they rolled their eyes and they said, "We'd say she's talking about how mental illness is a construct like love or intelligence, and there are different ways to define it and there's nothing hard and fast, but of course people suffer."

AR – Right.

PC – I said, "There's the context, and of course that was what I said." So I contacted them, because I found out through someone else that that was in this film, and I saw it in the context of the film, and it's terrifying; it's done like a horror film. And there's enough that's true in there, like the insulin comas and all of that stuff, and they really play up the horror of it. I mean it was real horror, but they really play it up, but then they make it look like, and…and everything else in it is supposed to be equally true. So I contacted them, and I said, "First of all, you obtained that interview fraudulently." Well, I can't prove that I asked them if they were part of Scientology because it was on the phone, and I didn't tape it; I didn't think I needed to. So I said for that reason alone I should be out of the film. "Secondly, you're in breach of contract. That release I signed, you're taking this out of context." And they got mad at me because they had misapplied, they didn't misquote, they mischaracterized and misapplied something I had written about diagnosis not being scientific. In an *amicus* brief they wrote, in a Supreme Court case in

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the US, and Justice Souter, who wrote the majority decision, took what they said, even though it really wasn't applicable, but he used it as though it applied, with disastrous consequences.

AR – Oh.

PC - So I wrote an article about that, and it was published online in Counterpunch, and I guess the Scientologists saw that. The article was about how you don't know how your work is being used, how the Supreme Court probably didn't know who the Citizens Commission on Human Rights was and probably didn't check. Nor did they check with me about does what they quoted me as saying apply in this case. And so it was horrible. Well, they said that they wanted me to sign an agreement saying that I would never say anything negative about them publicly or privately anymore.

AR – Wow.

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PC – I said, "I'm not going to sign away my First Amendment right." And they basically said, "We'll take you out of the film if you'll do that." And I just ignored it, and I couldn't afford to pay my lawyer any more to communicate with them, but that was what they wanted me to do. And then they threatened, they thought it was a threat, I hope they do it, they threatened to put the entire footage that they filmed with me online with appropriate comments. And I thought, "Well, good, because if you put the whole thing online everybody can see that it's taken out of context."

AR – Yeah, wow.

PC – So the reason I brought this up is because the Scientologists have used my stuff on their website for ages. I can't do anything about that. They like some of what I say, because it's critical of psychiatry and the mental health system. But if you ask me do I think all therapists are bad, all psychiatrists are bad? Of course not. Of course there are therapists who are wonderfully helpful, and of course everybody's therapy should be paid for by a government health insurance system. I mean, I lived in Canada for 19 years; it's wonderful in that way. So I feel like I am absolutely middle of the road. I don't think everybody needs to be diagnosed and put on medication, and sent to therapists, but I also don't think

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[Recording Ends – DVD 3 Starts]

PC – So I feel I've pretty much alienated everybody with very much power. On the one hand the American Psychiatric Association and the *DSM* people, and the American Psychological Association, which is furious at me for calling for Congressional hearings about diagnosis, because it will give the rightwingers in Congress ammunition. And I'm saying, "Wait a minute, what we want to do is to minimize problems within the system." I'm not saying, "Get rid of it; the right wingers will always find stuff to use or make stuff up, but does that mean we have to keep quiet when there are people being hurt?"

AR – Right.

PC - So they're all mad at me, and then at the other end of the spectrum are the Scientologists, who are mad that I'm not letting myself be used by them. Although that film is out there, it's being shown all over the place in Europe. It's very strange. They're very, very dangerous, I know that to be a fact. I know that they tried to, I know this will sound paranoid, but when I told them that they were in breach of contract, in rapid succession three people got in touch with me without saying that's who they were from, just supposedly out of the clear blue sky, and what all those three contacts had in common with each other – actually no. One I knew was from the Citizens Commission on Human Rights, the other two supposedly not. But all three were trying to either find out when I was going to be in a particular location at a particular time, or to get me to a particular location at a particular time. And at first I was thinking, "Oh they want to have me served with notice of some sort of lawsuit," and then I thought "Wait, they know where I live, they taped me here, so it can't be that." And I was kind of puzzled. Then I saw online there was someone who put online one of the Scientology contracts they have people sign, that essentially says, "I'll do whatever they tell me even if it means that I am seriously harmed or die. And I won't hold them responsible nor will my heirs." So this guy put that contract online, and the Scientologists, he says — and I'm inclined to believe him, because this fits with what happened to me — he says that they found out when he was going to be at a particular place and time, that was not in California where they are based, and they brought a lawsuit and managed to have a hearing date set at the time they knew he wasn't going to be in California. They presented what they said was evidence that he had been served, and here he didn't show up here today, therefore the judge should enter a judgment against him. Now, he was able to prove that he hadn't been served; I think they showed like an envelope that was this big and he said, "Look at the papers that they're saying I was served with. They've never been folded." You know, it was something like that. But I thought, "Oh my gosh, that fits with why they were trying to get me at a particular place at a particular time."

AR – Yeah, yeah.

PC - I can't prove that, but it's just been a very strange, creepy experience. Somebody wrote to me, emailed me from Harvard saying, "I'm an undergraduate here, and so is my girlfriend, and I happened to see this absolutely wonderful new film called Psychiatry: An Industry of Death, and I think everyone should know about it and we want to organize a screening of it at Harvard on such and such a date and time. Will you come and do some comments on it afterward?" But you know what happened. I just didn't write back, and heard nothing.

AR – Sometimes that's the best response.

PC – Yeah, but I mean if they weren't sent by the Scientologists, why did they not give me a call or email again and say, "Gee, we would really love to have you, did you not get the email?" Something like that. It was just very strange and there were several incidents like that.

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