

Psychiatry Under the Influence

Institutional Corruption, Social Injury, and Prescriptions for Reform

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palgrave
macmillan

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CHAPTER ONE

A Case Study of Institutional Corruption

Institutional corruption, as a field of inquiry, does not shy away from challenging powerful institutions—from Congress and the professions to the academy itself...and it leads us to interrogate them in important ways.

—Jonathan H. Marks, 2012¹

In a democratic society, we hope and expect that institutions that serve a public interest will adhere to ethical and legal standards. However, in recent years, we have seen numerous institutions failing to meet that obligation. Greed on Wall Street nearly led to the collapse of our public banking system. Congress is beholden to special interests. We have seen a religious institution, the Catholic Church, systematically fail to protect children from sexual abuse. What these scandals share in common is that they cause social harm and erode the public's faith in its institutions, and thus weaken the democratic core of society.

In this book, we put the spotlight on a medical discipline, organized psychiatry, that has transformed our society in the past 30 years.

Our society thinks of medicine as a noble pursuit, and thus it expects a medical profession to rise above financial influences that might lead it astray. The public expects that medical researchers will be objective in their design of studies and their analysis of the data; that the results will be reported in an accurate and balanced way; and that the medical profession will put the interests of patients first. However, in recent years, there has been a steady flow of reports, both in the mainstream media and in academic journals, detailing the corrupting influence that pharmaceutical money has had on modern medicine. In a 2009 essay, Daniel Wikler, a professor of ethics at Harvard School of Public Health, wrote of how this is undermining societal confidence in the medical profession:

Erosion of medical integrity is not a mere detail, but rather strikes at the heart of what it is to practice medicine. The basis for medicine's claim to be a profession rather than a trade, exchanging a degree of

self-governance and autonomy to be trusted experts, is the assurance that this trust will not be misplaced.²

Or as Giovanni Fava, editor of *Psychotherapy and Psychosomatics*, wrote in 2007: “The issue of conflicts of interest in medicine has brought clinical medicine to an unprecedented crisis of credibility.”³

While conflicts of interest may bedevil many medical disciplines, psychiatry is often seen at the epicenter of this “crisis of credibility.” In a 2000 editorial titled “Is Academic Medicine for Sale,” *New England Journal of Medicine* editor Marcia Angell told of how her journal, when it sought to find an expert to write a review of an article on the treatment of depression, “found very few who did not have financial ties to drug companies that make antidepressants.”⁴ More recently, in 2008, Senator Charles Grassley sent a letter to the American Psychiatric Association (APA), expressing his concerns about industry influence over the APA and all of organized psychiatry. The social peril is that undue industry influence may be compromising organized psychiatry’s public health mission in subtle but far-reaching ways.

Although our society today is focused on the possible corrupting influence of pharmaceutical money on medical disciplines, it is important to recognize that guild interests may also affect their behavior. As Kerianne Quanstrum, a physician at the University of Michigan, noted in a 2010 letter in the *New England Journal of Medicine*:

Although it is true that individual medical providers care deeply about their patients, the guild of health care professionals—including their specialty societies—has a primary responsibility to promote its members’ interests. Now, self-interest is not in itself a bad thing; indeed it is a force for productivity and efficiency in a well-functioning market. But it is a fool’s dream to expect the guild of any service industry to harness its self-interest and to act according to beneficence alone—to compete on true value when the opportunity to inflate perceived value is readily available.⁵

Like all medical specialty organizations, the APA is not immune to such ethical challenges. It may be characterized as both a professional organization and a guild, and in this latter function it is expected to further the interests of the profession and its members. Thus, it may feel a strong need to promote a societal belief in the merits of treatments prescribed by psychiatrists, even if science is raising questions about those treatments. As a result, the APA may struggle to provide unbiased information and guidance for the treatment of mental disorders. APA’s guild interests may conflict with its public health mission, providing a fertile ground for institutional corruption.

Such worries raise a profound set of questions that, given psychiatry’s pervasive influence over our society today, need to be answered. Over the

past 35 years, has organized psychiatry met its societal obligation to conduct objective research? Has it disseminated fully accurate information on the efficacy and safety of psychotropic medications? Has it produced truly evidence-based diagnostic and clinical practice guidelines? And if organized psychiatry has not fully met those ethical obligations, what has been the resulting social harm?

Conceptually, we see the APA and academic psychiatry as the twin pillars of organized psychiatry in the United States, and thus jointly the “institution” we are studying. Together, they produce the diagnostic and treatment guidelines that determine psychiatric care in the United States. The psychiatric nosology that the APA produces, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), is often referred to as the “bible” of psychiatric disorders; the nomenclature, criteria, and standardization of psychiatric disorders codified in the DSM affect a diverse set of areas ranging from insurance claims to jurisprudence. Moreover, through its relationship to the International Classification of Diseases, the system used for classification by many countries around the world, the DSM has a global reach.

For this reason, the influence of American psychiatry extends beyond US borders. Numerous other societies—particularly in Western Europe, Canada, Australia, and New Zealand—have embraced the medical model of care promoted by American psychiatry, and this has led to a marked increase in the diagnosis of mental disorders in those societies too, and in their use of psychiatric medications. Much of the Western world has reason to inquire about the ethics of organized psychiatry.

Studying Institutional Corruption

This book arose out of a year that we, the two authors of this book, spent as fellows at the Edmond J. Safra Center for Ethics at Harvard University. The center has sought to develop an intellectual framework for identifying, investigating, and understanding institutional corruption, with the hope that this process ultimately illuminates solutions for remedying the problem. We are exploring this topic, the ethics of modern psychiatry, through that ethical lens.

First and foremost, institutional corruption is to be distinguished from individual corruption. When we speak about “corrupt behavior,” we usually think about how individuals may have acted in immoral or even illegal ways, and have done so for personal gain. That is a story of “bad people” doing “bad things.” In those instances, individuals within an institution may have behaved in a corrupt manner, but the institution itself, in its “normative” practices, may not have become corrupt. For instance, we think of Bernie Madoff as a financial manager who acted in a criminal manner, that is, outside the norm, and thus we don’t necessarily see, in his behavior, evidence of institutional corruption within the larger financial investment community.

Institutional corruption is different. The problem does not arise from a few corrupt individuals who are hurting an organization, even though the organization's integrity remains intact. Instead, as Lawrence Lessig, director of the Edmond J. Safra Center for Ethics has observed, institutional corruption refers to the systemic and usually legal practices that cause the institution to act in ways that undermine its public mission and effectiveness, and ultimately weaken public trust in the institution. There is a "bending" of the original mission, which results from the normalization of behaviors that compromise truth-seeking. Such practices and behaviors may arise when there are financial incentives at work that encourage the members of the institution to *regularly* behave in ways that undermine the institution's integrity and its capacity to fulfill its public mission. Moreover, the leaders of the organization will likely be unaware that their institution has become "corrupted," and protest against those who have come to see their institutional behavior as being at odds with the organization's intended mission.

Indeed, within this framework of institutional corruption, there is the assumption the individuals within the institution are "good" people. Lessig made this point in his writings on Congress: "These are not bad souls bending the public weal to private ends... We can presume that individuals within the institution are innocent; the economy of influence that they have allowed to evolve is not."⁶

As can be seen, thinking of institutional corruption in this manner focuses attention on the larger social, political, and cultural factors that affect the institution. Institutions exist within a larger socio-political context. Thus, there is a need to identify the "economies of influence" that create the potential for improper dependencies to develop. Whereas individual quid pro quo corruption assumes that there is a "bad apple" problem, the framework of institutional corruption seeks to understand whether there is a "bad barrel" problem. This understanding in turn leads to a framework for identifying proposed solutions, as they must neutralize the financial influences that have corrupted the institution in a systematic way.

A Case Study of Institutional Corruption

We see this book as a case study of institutional corruption. The APA's stated mission is to provide "humane care and effective treatment for all persons with mental disorders," and we examine its past 35-year history to assess whether it has stayed true to that mission. First, we document how two "economies of influence" over the field—pharmaceutical funds and guild interests—arose and became entrenched. Then we look at how these influences have led to a distortion of "scientific truths" and to significant social injury. Next, having laid out this story of institutional corruption, we investigate whether organized psychiatry, on the whole,

recognizes that its behavior may have undermined its public mission and led to a loss of the public's trust. This inquiry leads us to delve into the science of "cognitive dissonance," and how difficult it can be for a medical profession, operating under two "economies of influence," to see itself as compromised. Finally, we explore strategies for reform and remedies for institutional corruption in organized psychiatry.

Given this focus, we are not interested in identifying instances where individuals within psychiatry may have behaved in corrupt or fraudulent ways. Instead, we presume that individuals within psychiatry want to serve their patients well, and that they seek to engage in research that will improve treatments for psychiatric disorders.

Ours is an academic inquiry. Yet, we believe it is of critical importance to American society, and, in fact, to many societies around the world. During the past 35 years, psychiatry has transformed American culture. It has changed our view of childhood and what is expected of "normal" children, so much so that more than 5 percent of school-age youth now take a psychotropic drug daily.⁷ It has changed our behavior as adults, and in particular, how we seek to cope with emotional distress and difficulties in our lives. It has changed our philosophy of being too, as we have come to see ourselves as less responsible for ourselves, and instead more under the control of brain chemicals that may or may not be in "balance." Our use of psychiatric medications could even be said to range from womb to grave: An increasing number of infants born today are exposed to an antidepressant in utero, and psychiatric drugs are regularly given to the elderly in nursing homes to individuals without psychiatric disorders. As such, our society has a compelling interest in the investigation that is at the heart of this book.

In addition, we hope that our book will serve as a "case study" for investigating institutional corruption and for developing solutions that could neutralize the "improper dependencies" that fostered the corruption. In that way, we hope that it can contribute to the discussion of how democratic societies can encourage its public institutions to behave in ways that serve the public good.

CHAPTER TWO

Psychiatry Adopts a Disease Model

The struggle over the drafting and publication of the DSM-III appeared to be a clinical debate, but underlying it all was a vehement political struggle for professional status and direction.

—Rick Mayes, 2005¹

The modern era of psychiatry, in terms of its classification of mental disorders, dates to 1980, when the American Psychiatric Association (APA) published the third edition of its *Diagnostic and Statistical Manual (DSM-III)*. This marked the moment that the APA moved away from psychoanalytic explanations for mental disorders and adopted what it considered to be a more scientific way to think about psychiatric difficulties. The disorders were to be diagnosed based on characteristic “symptoms,” a model that other medical specialties, when faced with illnesses of unknown causes, had long used. The public was encouraged to think of mental disorders as “diseases,” and very soon, with this concept in mind and the arrival of new psychiatric medications on the market, the use of these drugs soared. In the United States, spending on psychiatric drugs increased from around \$800 million in 1985 to more than \$40 billion in 2011, evidence of how the diagnosis of mental disorders and the prescribing of psychiatric medications have dramatically expanded since the publication of *DSM-III*.²

Since our focus is on the behavior of the APA and organized psychiatry in this modern era, we need to begin our inquiry with a review of the various forces that led to the creation of *DSM-III*. It is easy to see both a scientific impulse and guild impulse at work, and in that second impulse, the seed for possible corruption of the scientific enterprise.

The Historical Path to DSM-I

The history of psychiatric nosology in the United States is a complicated one, partly because mental and emotional difficulties appear in such disparate forms, and partly because of the long-running philosophical argument over whether they are biological or psychological in nature. The

architects of *DSM-III* spoke of wanting to “remedicalize” the field, which reflects the fact that the diagnostic approach they adopted—classifying disorders based on symptoms—was not a novel idea, but rather one that had been employed in psychiatric texts before.

In 1812, Benjamin Rush, who is remembered today as the father of American psychiatry, authored what might be considered the first US text on mental disorders. In *Medical Inquiries and Observations upon the Diseases of the Mind*, Rush sought to classify psychiatric illnesses, and he theorized about their possible causes and proper treatment. Rush believed that madness was “seated in the blood vessels,” and that, broadly speaking, mania, delusions, and other agitated states were the result of too much blood flowing to the head, while states of inactivity and torpor were the result of too little blood to the brain. His recommended treatments were designed to repair this circulatory imbalance, either by increasing or decreasing blood flow to the head.

Shortly after Rush’s book appeared, Quakers in the United States began building small asylums in pastoral settings for treatment of the “mad.” Whereas Rush, who had studied at the University of Edinburgh, conceived of mental disorders as medical illnesses, the Quakers, steeped in a religious approach, professed not to know the causes of madness, but they were certain that the mad should be treated as “brethren.” Their pastoral retreats were designed to be places that could “assist nature” in helping the mad heal.

Even so, a medical approach to treating madness was not altogether absent from these asylums. Physicians were hired to serve as superintendents of the small private asylums, and they professed an interest in trying to identify different forms of insanity. In 1844, 13 asylum physicians formed the Association of Medical Superintendents of American Institutions for the Insane, which would later evolve into the American Psychiatric Association, and one of the group’s first discussions focused on the classification of mental disorders. But when they looked around their wards, they did not see patients who could easily be grouped together into diagnostic types. “Insanity,” said the association’s first president, Samuel Woodward, is “easily recognized . . . [but] not always easily classified.”³

In the second half of the nineteenth century, the patient pool in asylums grew even more diverse. In the 1840s and 1850s, the reformer Dorothea Dix, impressed with the kind care offered by the small Quaker asylums, urged states to build such pastoral retreats for the general public. States responded to her entreaties in an admirable way, providing funding for this endeavor, and the number of mental hospitals in the United States, private and public, increased from 18 in 1840 to 139 in 1880.⁴ However, as these new asylums were built, communities began dumping people with all kinds of illnesses into them. Syphilitics, alcoholics, the mentally disabled, and the senile elderly joined the newly insane in these hospitals.

In 1885, a small group of alienists, as psychiatrists were then called, identified eight categories of insanity: mania, melancholia, monomania,

dementia, general paralysis of the insane, epilepsy, toxic insanity, and congenital mental deficiency.⁵ While several of these forms of madness were clearly due to physical illnesses, diagnosis still depended on identifying differences in symptoms, noted Pliny Earle, one of the founders of AMSAII. “In the present state of our knowledge, no classification of insanity can be erected upon a pathological basis, for the simple reason that, with but slight exceptions, the pathology of the disease is unknown. Hence, for the most apparent, the most clearly defined, and the best understood foundation for a nosological scheme for insanity, we are forced to fall back upon the symptoms of the disease—the *apparent mental condition*, as judged from the outward manifestations.”⁶

In Europe, German psychiatrist Emil Kraepelin soon provided psychiatry with a more developed scheme for classifying functional psychotic disorders (i.e., psychosis without an apparent somatic cause), one that grew out of his study of the long-term course of psychotic patients at a mental hospital at the University of Dorpat in Estonia (the University of Tartu today). Those psychotic patients who presented with affect—mania, depression, etc.—were likely to get better, and their long-term course was fairly benign. These patients, he said, suffered from manic-depressive illness. Those psychotic patients who presented with a lack of affect, and who often exhibited a striking physical deterioration (and had difficulty making willed movements, much like Parkinson’s patients), would likely become chronically ill and experience early dementia. These patients, he said, suffered from *dementia praecox*.

Kraepelin’s work marked a clear step forward for the field. His was a classification system that, at least for psychotic patients, linked presenting symptoms with clinical course. For that reason, Kraepelin provided psychiatry with its first classification system that was both reliable, in that these two types of patients could be distinguished with some consistency, and valid, in that the differential diagnosis led to a different prognosis.

However, only a fraction of the patients committed to US mental hospitals in the early 1900s fell neatly into one of these two categories. The hospital wards were also crowded with demented patients, epileptics, imbeciles, and patients ill with syphilis, Huntington’s chorea, alcoholic psychosis, and other such ailments. Diagnostic uncertainty reigned. In 1908, the US Census Bureau, which for 70 years had regularly sought to tally up the number of insane people in the country, asked the American Medico-Psychological Association to help with the gathering of data on the nation’s mentally ill (AMSAII had evolved into the American-Medico Psychological Association by this time). The association, as it contemplated this request, admitted that it lacked a proper diagnostic manual. “The present condition with respect to the classification of mental diseases is chaotic,” it confessed. “This condition of affairs discredits the science of psychiatry and reflects unfavorably upon our association.”⁷

In 1918, the American Medico-Psychological Association, in collaboration with the National Committee for Mental Hygiene, issued the field’s

first standardized psychiatric nosology, a *Statistical Manual for the Use of Institutions for the Insane*. The manual divided mental disorders into 22 principal groups. Twenty were for disorders that were presumed to have a biological cause (syphilis, alcoholism, Huntington's chorea, cerebral arteriosclerosis, etc.) and the remaining two groups were for disorders without a presumed biological cause: one for psychotic patients and the other for disturbed patients without psychosis.

For the next two decades, this manual, with its categorization of institutionalized patients, provided psychiatry with an adequate nosology. Psychiatry was a discipline firmly rooted in the asylum, such that by the beginning of World War II, more than two-thirds of the APA's 2,300 members still worked in mental hospitals.⁸ However, during the war, psychiatrists and other physicians assigned to neuropsychiatric units treated soldiers traumatized by battle. In that setting, the physicians discovered that psychotherapy plus rest often worked miracles; 60 percent of soldiers identified as "neuropsychiatric casualties" returned to duty within five days.⁹ The war physicians saw that people could descend into a highly disturbed state and quickly become well again, which was an experience that psychiatrists working in asylums did not frequently have.

"Our experiences with therapy in war neuroses have left us with an optimistic attitude," Roy Grinker wrote. "The lessons we have learned in the combat zone can well be applied in rehabilitation at home."¹⁰

This wartime experience led many psychiatrists to reconsider the nature of mental disorders. Clearly, environmental stresses and other psychological challenges could trigger symptoms of mental illness. This was a conception that fit with Freudian conceptions of mental disorders, which were being popularized after the war. In 1946, William Menninger, a psychiatrist who had risen to the rank of brigadier general during the war, and a group of younger psychiatrists formed the Group for the Advancement of Psychiatry, which sought to remake the field. They saw a need for American psychiatry to help people in the community who were not so seriously ill that they needed to be hospitalized, but were struggling with anxiety, or other "neurotic" conditions.

With many in the profession now adopting Freudian beliefs and focused on treating a broader group of patients, the field clearly needed a new diagnostic text. "Current nosologies and diagnostic nomenclature," Menninger argued, "are not only useless but restrictive and obstructive."¹¹ In 1950, the APA formed a committee to create a new nosology, and two years later, the APA published the first edition of its *Diagnostic and Statistical Manual (DSM-I)*.

A spiral bound, 130-page book, *DSM-I* divided patients into two broad groups. The first was composed of patients whose mental disturbances arose from an evident biological cause: infection, poisons, alcohol intoxication, circulatory illnesses, metabolic problems, brain cancers, multiple sclerosis, and other hereditary diseases were common ones. These patients were familiar to asylum doctors, and such diagnostic categories could have

been found in the *Statistical Manual for the Use of Institutions for the Insane*. What was new in *DSM-I* was the second broad diagnostic grouping. It identified disorders resulting from the individual's inability to adjust well to his or her environment. This second diagnostic group, which clearly reflected Freudian ideas, was then subdivided into psychotic and psychoneurotic disorders. The psychotic conditions included manic-depressive, paranoid, and schizophrenic "reactions." The psychoneurotic disorders were diagnoses for people in the community who struggled with anxiety, obsessive-compulsive behavior, depression, emotional instability, and other such problems.

Ever since Rush had published his *Medical Inquiries and Observations upon the Diseases of the Mind*, the field had mostly relied on a "medical model" for classifying mental disorders. Diagnosis was based on presenting symptoms. The one exception to this practice had been during the first half of the nineteenth century, when the moral therapy pioneered by the Quakers was popularized. But with the publication of *DSM-I*, the APA had moved away from a medical orientation, particularly when it came to diagnosing patients living in the community. Anxiety, depression, and even psychosis were not to be seen as symptoms of a disease, but rather emotional distress that arose from internal psychological conflicts and the particulars of a person's life story. There was no longer a clear line that divided the mentally well from the mentally ill, and, if anything, it seemed that unresolved psychological conflicts probably plagued most people, at least to some degree.

Psychiatry now had a diagnostic text that enabled it to move out of the asylum and provide care for a larger segment of the American population. This transformation happened quickly; by 1956, only 17 percent of the APA's 10,000 members were employed in mental hospitals.¹² The couch, employed as part of a Freudian talking cure, was the new symbol of psychiatry's workplace, as opposed to the asylum. "It does not seem possible that Kraepelin so recently dominated psychiatry," Harvard Medical School psychiatrist Stanley Cobb marveled in 1961, in an *Atlantic Monthly* article titled "Psychiatry in American Life."¹³

Psychiatry's Reliability Problem

Many of the psychoanalysts who came to dominate American psychiatry in the 1950s did not see diagnosis as particularly important. The etiology of all nonorganic mental disorders was presumed to be the same—a psychological failure to adapt to one's environment—and psychotherapy was a treatment that was supposed to help remedy that failure. As such, there was no need to put "so much emphasis on different kinds and clinical pictures of illness," Menninger wrote.¹⁴ Still, psychiatry was a branch of medicine, which understood good diagnostics as essential to good care, and not everyone in the APA agreed with Menninger that diagnostic

categories were not particularly important. When *DSM-I* was introduced, George Raines, chair of the APA committee that produced the manual, declared that “accurate diagnosis is the keystone of appropriate treatment and competent prognosis.”¹⁵ At the very least, Raines and others wanted the manual to be a reliable method for sorting psychiatric patients into different categories, which could then facilitate research into those diagnoses.

During the next decade, it became evident that *DSM-I* did not provide psychiatry with a taxonomy that fulfilled that goal. In 1962, Aaron Beck reviewed nine studies assessing reliability of functional disorders (those without an apparent organic cause), and found that diagnostic agreement among psychiatrists ranged from 32 to 42 percent, which was little better than chance.¹⁶ Five years later, Robert Spitzer, who would soon be named to head the task force that would develop *DSM-III*, introduced into psychiatry a new mathematical method for assessing diagnostic reliability, called kappa scores, and he subsequently determined, in a review of the scientific literature, that “the reliability of psychiatric diagnosis as it has been practiced since at least the late 1950s is not good.”¹⁷

Psychiatry’s reliability problem burst into public view in 1973, when Stanford University psychologist David Rosenhan reported on a novel experiment he had conducted. He and seven of his students had shown up at 12 different mental hospitals (some went to more than one hospital), complaining that they heard voices, vague in nature, which said such things as “thud,” “empty,” or “hollow.” Those were the only symptoms they gave, and yet in every instance they were admitted to the hospital, and in every case but one, they were diagnosed as ill with schizophrenia. Once admitted, the pseudopatients stopped complaining of any symptoms and behaved normally, but in spite of this, none of the hospital staff ever spotted them as imposters. The only ones in the hospital who didn’t fall for their ruse were the “real” patients in the hospital. “The facts of the matter are that we have known for a long time that diagnoses are often not useful or reliable, but we have nevertheless continued to use them,” Rosenhan wrote in *Science*. “We now know that we cannot distinguish insanity from sanity.”¹⁸

Although Spitzer and the APA’s leadership bristled at this conclusion, the field nevertheless acknowledged that, with the use of *DSM-I* and then *DSM-II* (published in 1968), it had a reliability problem. Now it had erupted into the public domain, and this complaint—that psychiatry lacked a way to reliably distinguish between normal behavior and illness—began to be regularly voiced by insurance companies and in government circles, too. As US Senator Jacob Javits declared in 1977: “Unfortunately, I share a congressional consensus that our existing mental health care delivery system does not provide clear lines of clinical accountability.”¹⁹

In other areas of medicine, it was understood that in order for a diagnostic manual to be useful, it should enable physicians to regularly come to the same diagnosis, and that different diagnoses should be valid, meaning

that the underlying pathology of an illness had become known, or that at least research had identified a characteristic course for the illness, which distinguished one diagnosis from another. *DSM-I* and *DSM-II* hadn't provided psychiatry with a reliable diagnostic manual, and as Spitzer and others knew, the disorders in the manual couldn't be said to be validated either. Although Freudian theories posited an etiology for mental disorders—that they arose from unconscious conflicts in the mind and a failure to adapt to stressful environments—these theories couldn't be empirically tested. From a medical perspective, psychiatry's existing taxonomy was inadequate and needed to be rethought.

The Scientific Impulse for Reform

Although psychiatrists schooled in psychoanalysis or psychodynamic therapy led most psychiatry departments at US medical schools in the 1950s, there were still a small number of psychiatrists who remained loyal to Kraepelinian ideas that serious mental disorders were discrete illnesses. In this classification scheme, schizophrenia was seen as different from manic-depressive illness as tuberculosis was from malaria. The premier academic home for such contrarians was Washington University in St. Louis, where the department was led by Eli Robins, Samuel Guze, and George Winokur. The Washington group derided Freudian concepts as “unscientific” and lacking in empirical support, and argued that *DSM-I*, because of its reliability problem, had hindered research into the etiology of psychiatric disorders and how they might be better treated.

In 1967, the Washington University group began meeting regularly to discuss developing new diagnostic criteria, for use in research, and they took Kraepelin as their guide. Kraepelin had linked different presenting symptoms to different diagnoses, which had differing prognoses, and he had done so by following patients for a longer period of time. The Washington University group decided that for a diagnostic category to have some validity, it should provide a detailed clinical description of presenting symptoms, with explicit criteria for making a diagnosis, and it should be informed by research. The necessary science included laboratory studies of patients with the presenting symptoms; studies of their long-term outcomes; and family studies, to determine whether there might be a genetic component. The Washington University group sought to develop diagnoses supported by empirical data, rather than solely by clinical wisdom.²⁰

With these validity criteria in mind, a psychiatric resident at Washington University, John Feighner, scoured the medical literature for evidence that could support psychiatric diagnoses. He found such evidence, even to a limited degree, for only 16 psychiatric illnesses. When Feighner published his paper, he noted that this was but a first step for the field. He and his Washington University collaborators had not conducted any long-term

studies of their own. They had not performed studies to assess whether the explicit criteria for making a diagnosis—for instance, requiring that five of eight symptoms said to be characteristic of depression be present before making the diagnosis—was meaningful. They had developed the diagnostic criteria in order to group patients into homogeneous samples for research, and not as a diagnostic scheme for clinicians. “All [these] diagnostic criteria are tentative in the sense that they [will] change and become more precise with new data,” Feighner wrote.²¹

There was a clear scientific reasoning in Feighner’s work. In order to study patients who presented with differing symptoms, the field needed diagnostic categories that would provide adequate “reliability” and might also have at least a limited “validity,” arising from studies that included data on long-term outcomes (which was the data that Kraepelin had relied upon to divide psychotic patients into two broad groups). But given the limitations of existing data on psychiatric disorders, the Washington University group understood that considerable research would be required before the field had a diagnostic manual that clinicians could use, confident that it was both reliable and valid.

Psychiatry’s Legitimacy Crisis

Even as Rosenhan’s study illuminated the fact that psychiatry had a reliability problem, the field was also having to confront two much larger problems: societal questions about its legitimacy, and competition in the marketplace for patients. Together, these twin problems created a crisis for the field in the early 1970s, and, ultimately, provided the APA with powerful guild reasons for redoing its diagnostic manual.

For a long time, psychiatry’s public image had been a muddled one. In the late 1800s, the psychiatrists were “superintendents” of mental hospitals, and thus they were often seen more as caretakers of those institutions, as opposed to physicians who treated diseases. Then, in the first half of the twentieth century, they practiced in an environment that was mostly forgotten about by the American public. In the late 1930s and 1940s, there were a flurry of reports in the media about new wonder treatments for the mad—insulin coma therapy, convulsive therapies, and finally frontal lobotomy—but that good press came to an abrupt halt at the finish of World War II, when the American public was shocked by newspaper and magazine exposes of the horrendous conditions in many of the nation’s mental hospitals. In his book *The Shame of the States*, Albert Deutsch even compared what he had seen in such institutions to what he had witnessed when the Nazi concentration camps were liberated. More than ever, psychiatry was seen as a medical backwater, a discipline that needed to be remade and provided with a new scientific foundation. In 1946, Congress created the National Institute of Mental Health (NIMH) to direct this task.

That postwar era of shame soon turned into a decade of growth and success. During the 1950s, Freudian theories of the mind captured the American imagination, and psychiatry also regularly announced the discovery of new drugs that were remaking the field. In 1954, chlorpromazine came to market, and *Time* magazine described this major tranquilizer—which was soon to be renamed an antipsychotic—as a “wonder drug.”²² Next the magazines were telling of a miraculous new pill, iproniazid, for rousing depressed patients, and then Miltown, a drug for anxiety, took the nation by storm. This drug was dubbed a “happiness” pill, which, *Time* reported, was for “walk-in neurotics rather than locked-in psychotics,” and demand was so great that pharmacies, when they were able to have it in stock, would put up announcements that shouted, “Yes, we have Miltown!”²³

Psychiatry was suddenly a popular discipline. From 1946 to 1956, the number of slots at medical schools for psychiatry residents quadrupled, from 758 to 2,983, and a long-spurned specialty began to attract some of the top medical students.²⁴ Moreover, during the 1950s, psychiatrists who treated patients in the community saw their incomes notably increase. Whereas an asylum psychiatrist, by the end of the decade, was earning on average only \$9,000 per year, the Freudian analyst in private practice was earning more than twice that, \$22,000 per year. The top-earning psychiatrists were those with a biological orientation who focused on prescribing the new wonder drugs to walk-in patients. They were making \$25,000 a year.²⁵

Yet, as psychiatry moved out of the asylum and expanded its influence over American society in the 1950s, new criticisms arose. There was a faction within psychiatry who began arguing that the field needed to address the many social problems—poverty, etc.—that could stir mental distress, but, critics asked, if social factors were the source of many psychiatric ailments, then why was treating mental illness a task for psychiatry? Wasn't it the responsibility of society to fix such problems? Psychological explanations for severe mental illnesses, such as schizophrenia, also raised new questions about the legitimacy of mental hospitals. Were they places for the “ill,” or simply warehouses for rebels, misfits and malcontents whose behaviors, formed by reactions to a difficult environment, could be offensive to others? Did the hospitals function as institutions for social control?

The opening salvo against psychiatry was fired in 1961 by Thomas Szasz. In his book *The Myth of Mental Illness*, he dismissed the idea of psychiatric disorders as “scientifically worthless and socially harmful.”²⁶ Psychiatrists, he said, functioned more as police and ministers than as medical doctors. His book was favorably reviewed by mainstream publications, such as the *Atlantic* and *Science*, evidence that his critique tapped into a larger societal concern. *Science* described his book as “enormously courageous and highly informative...bold and often brilliant.”²⁷

Critiques of psychiatry, mostly arising from the halls of academia, gained a larger readership, and together these writers stirred an “antipsychiatry” movement. Sociologist Erving Goffman, in *Asylums*, argued that mental hospitals infantilized people and turned them into chronic patients. David Cooper, R. D. Laing, and others wrote similar criticisms. In the world of fiction, Ken Kesey and his book *The Cuckoo’s Nest* introduced America to Randle McMurphy, a rebel and rogue who had been hospitalized because of his anti-authoritarian ways. In the early 1970s, a civil rights lawyer, Bruce Ennis, penned *Prisoners of Psychiatry*, a title that told all about the societal function he believed psychiatry served.

At this time, ex-patients also began organizing, dubbing themselves “survivors” of psychiatry. The Insane Liberation Front formed in Portland; the Mental Patients’ Liberation Project in New York City; and the Network Against Psychiatric Assault in San Francisco. They held demonstrations, organized human rights conferences, and spoke of their struggle as a fight for civil rights. They described antipsychotics as tools of suppression, rather than as healing agents, and even took their fight to state courts, where they argued that forced drug treatment was a form of medical assault, and a violation of their constitutional rights to due process and freedom of speech. Gay rights groups added their voices to the mix, demanding that psychiatry remove homosexuality from its diagnostic manual. Yet, when the APA voted to amend this diagnosis in 1974, creating in its place a disorder called ego dystonic homosexuality, which was to be diagnosed only if being homosexual caused one distress, the critics of psychiatry had another round of ammunition: were psychiatry’s diagnoses so uncertain that they could be changed in response to political pressure?

Even as psychiatry’s public image was being battered, it was fighting in the marketplace with psychologists, social workers, and counselors over control of psychotherapy. Psychiatry had been battling psychologists since the end of World War II, when psychologists, who previously had focused on developing mental tests and studying the human personality, began providing clinical services. Their move into the psychotherapy market accelerated after Carl Rogers published *Client-Centered Therapy* in 1951. In response, the American Psychiatric Association, with support from the American Medical Association, sought to block psychologists by invoking state medical licensing laws, which prohibited nonphysicians from practicing medicine. Clinical psychologists could provide psychotherapy services only under the supervision of a medical doctor, the APA argued. “Psychotherapy is a medical treatment and does not form the basis of a separate profession,” the APA stated in 1958.²⁸

Throughout the 1950s and 1960s, psychologists waged a state-by-state struggle to get out from under psychiatry’s yoke, seeking state licensure to provide psychotherapy without being supervised. One by one, the states agreed. Psychotherapy was not a “medical procedure” that could be provided only under the supervision of a physician, they decided. By 1962,

18 states had granted psychologists the right to practice psychotherapy without such supervision, and by 1977, every state had.²⁹

Even worse for psychiatry, competing therapists were popping up in every corner of American society. By 1980, there were more clinical psychologists in the United States than there were psychiatrists (50,000 to 28,000), and there was a much greater number of social workers, family therapists, marriage counselors, and other “healers” offering help to America’s walking wounded.³⁰ Psychiatrists providing talk therapy were in competition for patients with a multitude of professionals and even nonprofessionals, and what was particularly galling for the field was that it lacked evidence that its preferred brand of psychotherapy, psychoanalysis, was any more effective than the many other types of psychotherapy that were being offered.

This finding had first surfaced in 1952, when Hans Eysenck, a British behaviorist, reported that two-thirds of neurotic patients improved, regardless of how they were treated, or whether they were treated at all. Other studies found that while psychotherapy may be better than no treatment at all, no specific treatment was better than another, leading one scholar to later quip that such research had produced a “Dodo bird’s verdict,” in which “everybody won and all must have prizes.”³¹

Given this fact, medical insurance companies began questioning why they should provide coverage for talk therapy. From 1965 to 1980, the percentage of Americans with private medical insurance rose from 38 to 68 percent and, as the result of the enactment of Medicare and Medicaid in 1965, federal and state expenditures for mental services also rose dramatically during this period.³² Both the private insurers and the government were beginning to perceive psychiatry, APA medical director Melvin Sabshin later recalled, as a financial “bottomless pit,” uncertain whether their rising expenditures were producing a benefit.³³ The problem, complained a Blue Cross executive in 1975, was that “compared to other types of [medical] services, there is less clarity and uniformity of terminology concerning mental diagnoses, treatment modalities and types of facilities providing care.”³⁴

In 1977, Harvard Medical School psychiatrist Thomas Hackett summed up psychiatry’s understandable anxiety over its place in the talk therapy marketplace: “Apart from their training in medicine, psychiatrists have nothing unique to offer that cannot be provided by psychologists, the clergy, or lay psychotherapists. Our bread and butter—the practice of psychotherapy—has fragmented into multiple schools, all with uncertain boundaries.”³⁵

Such were the many challenges that confronted psychiatry in the late 1960s and 1970s. An antipsychiatry movement challenged its legitimacy. Ex-patients told of having “survived” psychiatric hospitals and drug treatments. Psychiatrists providing talk therapy were now in competition with an ever-growing multitude of therapists tending to the psychic wounds of Americans. Insurance companies were balking at paying for mental health

services. Its own reliability studies revealed that its diagnostic practices were problematic. Efficacy studies hadn't shown that its brand of psychotherapy was any better than that offered by its competitors. Faced with so many problems, APA leaders spoke of how psychiatry was under "siege," and a few prominent psychiatrists even worried that psychiatry, as a field, could be headed for "extinction."³⁶

The Guild Impulse for Remaking the DSM

Ever since *DSM-II* had been published in 1968, the APA had a bureaucratic reason to at least slightly amend it. The United States was a member of the World Health Organization, which required that the APA's classification of mental disorders be compatible with the taxonomy set forth in the WHO's *International Classification of Diseases (ICD)*. *DSM-II*, because of its Freudian description of psychotic disorders with unknown somatic causes as "reactions," was incongruent with the *ICD*, which assumed that all psychotic disorders had a biological cause, even if the cause was unknown. The reliability problem with *DSM-I* and *DSM-II* provided a scientific rationale for redoing it as well. But, as historian Hannah Decker noted in her book *The Making of DSM III*, it was Rosenhan's report in *Science*, detailing how he and his quite-normal students had been diagnosed as schizophrenic, that prompted the APA to push this initiative to the front burner.

Shortly after Rosenhan's article was published, the trustees of the APA convened a meeting in Atlanta. For three days, they discussed the "rampant criticisms" of psychiatry, lamented the fact that the public did not have a "strong conception of psychiatry as a medical specialty," and failed "to recognize a psychiatrist's special competence in mental health care."³⁷ At the end of their meeting, the trustees decided that *DSM-II* should be fundamentally revised, and urged that this task be completed in two years. The trustees also recommended the formation of a task force that would "define mental illness and what is a psychiatrist," which could then be used as a preamble to *DSM-III*.³⁸

At this moment of *DSM-III*'s conception, the APA trustees saw that creating a new diagnostic manual could serve a guild interest. Freudian ideas had shaped *DSM-I* and *DSM-II*, but that diagnostic approach had ultimately produced a crisis for psychiatry. Remaking psychiatric diagnoses could be part of a larger effort by psychiatry to put forth a new image, which, metaphorically speaking, would emphasize that psychiatrists were doctors, and that they treated real "diseases."

Over the next six years, as the *DSM-III* task force labored to produce the new manual, Spitzer, Samuel Guze, APA medical director Melvin Sabshin, and others sounded this theme again and again. *DSM-III*, Spitzer said, would serve as a "defense of the medical model as applied to psychiatric problems."³⁹ Sabshin told the APA members that a "vigorous effort

to remedicalize psychiatry should be strongly supported.”⁴⁰ Harvard psychiatrist Seymour Kety argued that the “medical model is as appropriate for the major psychoses as it is for diabetes.”⁴¹ “The basic premise,” noted Arnold Ludwig, a psychiatrist at the University of Kentucky, is “that the primary identity of the psychiatrist is as a physician.”⁴² Guze, in an article titled “Nature of Psychiatric Illness: Why Psychiatry is a Branch of Medicine,” wrote that, with the new model, the focus would be on “the symptoms and signs of illness . . . the medical model is clearly related to the concept of disease.” Psychiatrists, he wrote, would now focus on reducing those symptoms, which was a task that psychiatrists could do best. “Medical training is necessary for the optimal application of the most effective treatments available today for psychiatric patients: psychoactive drugs and ECT.”⁴³

This last sentiment told of a financial incentive lurking in the background as the APA remade its diagnostic manual. Adopting a disease model would lead to a focus on treatments that allayed symptoms, and it would only be psychiatrists, thanks to their prescribing powers, that could provide patients with access to psychiatric drugs. Psychiatry might cede talk therapy to its competitors, but it would have this corner of the therapeutic marketplace to itself. A 1975 survey found that there were very few psychiatrists who didn’t prescribe drugs, and that “psychiatrists almost routinely prescribed drugs for patients who were treated by other mental health professionals not licensed to administer drugs.”⁴⁴ Psychiatry was following a financial path to this role in the therapy marketplace, and adopting a medical model that focused on the “symptoms of a disease” would obviously enhance the value of psychiatrists’ prescribing powers.

The Making of *DSM-III*

By naming Robert Spitzer to head the task force, the APA trustees could expect that he would take the profession in a new direction. Although Spitzer, after graduating from NYU School of Medicine, had subsequently trained as a psychoanalyst, he had never really embraced Freudian ideas, and, in his position at the New York Psychiatric Institute in New York City, he had embraced the neo-Kraepelin ideas of the Washington University group. He had written several papers criticizing the reliability of *DSM-I* and *DSM-II*, and he had followed up on Feighner’s work to create his own Research Diagnostic Criteria, which had expanded Feighner’s list of 16 categories of psychiatric illnesses to 25.⁴⁵

As Spitzer set up his task force, he picked others who shared his belief that Freudian ideas needed to be abandoned. More than half of the task force members had a current or past affiliation with Washington University in St. Louis. At least at first, the task force looked to Feighner’s criteria as a standard for creating a diagnostic category. “There will be fewer assignments to diagnostic categories on the basis of probable correctness,

and more diagnoses which force the clinician to admit what he does not know," Spitzer said, adding that "the sense of the committee is that mental disorder should be defined narrowly rather than broadly, that a definition which permits false negatives is preferable to one that encourages false positives."⁴⁶ Moreover, Spitzer acknowledged that the clinical utility of the new manual was certain to be quite limited, given that the diagnostic categories could best be described as "hypotheses" that would need to be further researched before they could be considered validated. The *DSM-III* criteria, he said in 1975, "would be 'suggested' only, and any clinician would be free to use them or ignore them as he saw fit."⁴⁷

There was a caution and humility in such comments, which arose from an understanding that the field suffered from a lack of high-quality research on psychiatric disorders. The Washington University group, as it developed the Feighner criteria, had noted that long-term studies were needed to create discrete diagnostic categories, and as Guze later recalled, he proposed to the task force that "until there had been at least two long-term follow-up studies from different institutions with similar results, we shouldn't give the entity a status in *DSM III*... that would put us on a stronger scientific basis and it would constantly remind psychiatrists of our ignorance and what kinds of questions needed to be studied."

This was a key moment for the task force. Guze was proposing that the *DSM-III* diagnoses be informed by research, and if such data weren't available, that the group avoid creating a diagnosis. However, his proposal was rejected. "I couldn't get that group to vote in favor of my suggestions," he recalled. "The response that I was given was that they said we have enough trouble getting the legitimacy of psychiatric problems accepted by our colleagues, insurance companies, and other agencies. If we do what you are proposing, which makes sense to us scientifically, we think that not only will we weaken what we are trying to do but we will have given the insurance companies an excuse not to pay us."⁴⁸

Guild interests, it seemed, would have to trump scientific concerns. The task force may have wanted *DSM-III* categories to be based on empirical data, but the science to provide such data hadn't yet been done. "There was very little systematic research" to draw on, said task force member Theodore Millon. "And much of the research that existed was really a hodgepodge, scattered, inconsistent, and ambiguous."⁴⁹

The committee's initial caution soon gave way to a policy of "syndromal inclusiveness," with the thought being that *DSM-III* would provide a diagnosis for all of the patients that psychiatrists now saw. Indeed, Spitzer understood that psychiatry, with its new manual, would be staking a claim to a potential market for its services. "It defines what is the reality," he later said. "It's the thing that says, 'this is our professional responsibility, this is what we deal with.'"⁵⁰

Once this guild interest became paramount, the basis for creating a new diagnostic category became "expert opinion." Spitzer and others would meet, and they would discuss possible criteria for making a diagnosis.

The final criteria, said Allen Frances, who worked on *DSM-III*, “would usually be some combination of the accepted wisdom of the group, as interpreted by Bob [Spitzer], with a little added weight to the people he respected most, and a little bit to whoever got there last.”⁵¹

Millon, in his later review of this process, said that it wasn’t just that the APA task force had little good science to draw upon, but that the task force didn’t even incorporate the limited empirical research that had been done. As such, it “failed to construct an instrument that reflected previous research.”⁵² Toward the end of the process, many with a Freudian perspective began to voice objections to the new manual, and that battle further affected the drawing up of diagnostic criteria. “The entire process,” Spitzer later confessed, “seemed more appropriate to the encounter of political rivals than to the orderly pursuit of scientific knowledge.”⁵³

The task force completed a preliminary draft of *DSM-III* by 1976, and beginning in 1977, the APA, with a grant from the NIMH, began field trials of the new manual. Four hundred sixty-seven clinicians assessed the symptoms of 12,667 patients to make a diagnosis based on the new categories. However, the initial phase of the field trials was not done to *assess* reliability, but rather to *improve* it. Spitzer relied on the results and the feedback from the participating psychiatrists to revise the diagnostic criteria so that the categories’ reliability would be better, and thus subsequent field trials would produce a better kappa score. The major purpose of this first phase of the field trials, Spitzer told the NIMH, was “to identify and solve potential problems with the *DSM III* draft.”⁵⁴

Spitzer and his collaborators then conducted a phase II trial of the redrawn categories, but this study was not particularly scientific in its methodology. People who had been on the task force participated in the trial; the sites that participated were not a representative sample of sites in the country; and there was no comparison made to another classification system, such as *DSM-II*. Although Spitzer published five articles on the field trials, he reported raw data in only one, and there is an inconsistency in the reports on the number of patients that were studied. As Decker concluded in her study of *DSM-III*, given the conflicting data, “it is no simple matter to write about the reliability portion of the NIMH trial.”⁵⁵ Perhaps reliability would be better with *DSM-III* than with *DSM-II*, and perhaps not; when the methodology of the field trials was carefully assessed, and the published data carefully parsed, it became clear that there was a lack of convincing evidence on the matter.

A Guild Triumph

While there had been a clear scientific impulse behind the APA’s remaking of its diagnostic manual, that impulse did not translate into a rigorous scientific process for creating diagnostic categories. On the other hand, the making of this new 494-page manual, which was published in 1980

and listed 265 disorders, did serve the APA's guild interests in a brilliant way.

By adopting a disease model and asserting that psychiatric disorders were discrete illnesses, the APA had addressed both antipsychiatry critiques and its image problem. Metaphorically speaking, psychiatry had donned a white coat. It was presenting itself to the public as a *medical specialty*, which served as a reply to Thomas Szasz and others who argued that psychiatrists functioned "more as police and ministers" than as doctors. This was also an image that resonated with the public. "The medical model," wrote Tufts Medical School psychiatrist David Adler after *DSM-III* was published, "is most strongly linked in the popular mind to scientific truth."⁵⁶

Next, the new manual enabled psychiatry to lay medical claim to the very patients that had enabled the field to leave the asylum. Freudian conceptions of psychiatric distress, including its concept of "neurosis," provided psychiatry with a rationale for treating people with everyday problems, which, in fact, often did arise to such stresses as failing marriages, family conflicts, job difficulties, and other such difficulties in life. However, in the 1970s, psychiatry was losing the battle to treat these patients—the "walking wounded"—with psychotherapy, but *DSM-III*, with its listing of 265 separate disorders, turned the walking wounded into patients with *illnesses*, whose symptoms needed to be treated. That was a model that would support the regular use of psychiatric drugs, which only physicians could prescribe.

At the same time, *DSM-III* solved the profession's difficulties with the insurance companies. As it remade the DSM, Spitzer and others met with the medical directors of major insurance companies, and the medical directors informed Spitzer and the APA that insurance "was meant to pay for the sick, not the discontented who are seeking an improved lifestyle. We need your help in differentiating between those who have mental disorders and those who simply have a problem."⁵⁷ If the *DSM-III* task force had followed Guze's lead, then the manual would have drawn an illness boundary that incorporated a much smaller number of people, and the insurance companies would have reimbursed only for the treatment of that smaller group of patients. By insisting that all disorders in the *DSM* were illnesses, the APA could now expect that insurance companies would pay for the treatment of nearly everyone who came to a psychiatrist's office, regardless of the person's problem. The APA, with its new diagnostic manual, had helped the insurance companies differentiate "between those who have mental disorders and those who simply have a problem" by asserting, in essence, that those who had a problem—e.g. the "discontented"—were "ill."

Other new financial opportunities that arose from the publication of *DSM-III* were easy to see. The APA, with its insistence that the 265 disorders were diseases, had asserted a new authority over research into those ailments. If psychiatric problems were psychological in nature, then

psychologists and other nonphysicians could easily compete with psychiatrists for grants from the National Institute of Mental Health to study such difficulties. But if such problems were discrete diseases, then research would focus on identifying their underlying pathologies and on developing treatments for the symptoms of these diseases, which was research that physicians could be expected to lead.

Finally, the new manual provided pharmaceutical companies with the opportunity to develop new drug treatments, and that, in turn, could be expected to benefit the psychiatric profession. The 1962 Kefauver-Harris Amendments to the Food, Drugs, and Cosmetics Act required that pharmaceutical companies prove that their new drugs were effective for *specific disorders*. Whereas no drug company could market a drug for “neurosis,” which was seen as a psychological problem, it could market a drug for panic disorder, or posttraumatic stress disorder, or any of the other 263 disorders listed in *DSM-III*, now that they had been conceptualized as discrete illnesses. Academic psychiatrists could be involved in conducting the trials of the new drugs, and once they came to market, the field would have new products that could be expected to bring new patients to their offices.

A Seed for Corruption

With the light of hindsight, it is easy today to see the ethical peril for the APA that arose with its publication of *DSM-III*. The APA had devised a new manual that helped remake its image, and in a way that promised to benefit it in the marketplace, and the peril was that guild interests might now affect the story it told to the public about the nature of mental disorders, and the efficacy of somatic treatments for them. Science might have one story to tell, and yet the APA, because of guild interests, would have a need to tell another. That conflict, if it were not resolved in a manner that honored the science, had the potential to lead psychiatry seriously astray.