Psychiatry's Fear Of Analysis

By David L. Bazelon

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IN THE EARLY stages of a profession's development, a certain mystique is perhaps necessary to foster public trust. This was surely the case with psychiatrists, who were long protected from too much criticism by the general feeling that they just might be the ultimate wizards.

But for some time now psychiatrists have been legitimately pressed to end this Age of Mystique, to come out from their protected world and open to public scrutiny certain hidden agendas that affect the general welfare. Psychiatry, unfortunately, has responded poorly, appearing to be a profession that wishes to judge but be not judged, examine but be not examined. It will be exceedingly sad, and indeed generate greater mistrust of the profession, if psychiatrists continue this tendency to withdraw into their protective shells.

The "Crazy" Rights Worker

I WAS PARTICULARLY struck by this tendency early last year, when the American Psychiatric Association decided to study abuses of psychiatry in the Soviet Union but studiously avoided analysis of possible misuses of psychiatry at home.

Specifically, because I had been a member of the 1967 U.S. mission on mental health to the Soviet Union, I was asked by the APA to join a special committee examining evidence that Soviet psychiatric facilities were being used to suppress political dissent. Case studies of persons in Russian prison hospitals had reached the West, provoking intense criticism of Soviet actions. The Russian studies illustrated how the medical model of "sickness" can be perverted to include socially and politically unacceptable behavior, in these cases highly visible political dissent. They clearly suggested that the Russian doctors were acting neither in their patients' medical interests nor in their own direct self-interest. Rather, they were using psychiatric terminology and techniques to serve the state.

It seemed important to me to examine analogous situations in this country. My 20 years in the courts had persuaded me that psychiatrists here could also make judgments that took them beyond their traditional roles and expertise and into the social and political arena.

A young black psychiatrist told me recently, for example, that while working in the civil rights movement in the Deep South, he had been approached by leaders of a march and asked to deal with a problem. One worker seemed to be "crazy." The worker impersonated others, called attention to himself during marches and gave false and often violent interviews to the national press. In short, he was becoming a threat to The Movement.

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The psychiatrist interviewed the man and, after trying unsuccessfully to convince him to leave the South, decided that he was psychotic. Unknown to the worker, the doctor then drugged him with tranquilizers and shipped him secretly out of the state. Some treatment was later provided. But the pyschiatrist now readily admits that he was acting not for the best interests of his so-called patient, but to serve The Movement.

Ultimate Questions

INDEED, WHENEVER psychiatrists apply their knowledge at the request of public and social institutions —the military, state hospitals and penal institutions, among others—they inevitably face conflicts between the therapeutic interests of their patients and the "institutional" interests of their employers. I suspect these conflicts are not resolved by either medical training or the Hippocratic Oath.

The APA trustees extended the life of our committee for a year so that we could study whether the conflicts in this country were in seed or in blossom. But after eight months of developing a research project, we were suddenly discharged under a barrage of *ad hominem* criticism. Study of the problem was shifted to a Council on Research, with instructions from the APA's medical director to "get a firm grip on the tail of this tiger."

Why was the APA reaction so negative? It was not because it just didn't care about the issues. Everyone we spoke with recognized the conflicts and the potential abuses of psychiatry's power and prestige, and they were deeply worried about the effect on their professional authority and the public's trust.

Their inability to initiate self-analysis may be related in part to the institutional interests the psychiatrists represent. After all, it is not often that a powerful professional establishment will take a critical look at itself. I can't think of one that has. But I think they also sensed that our study would lead to ultimate questions: What is psychiatry? What does it do? What can it do?

The idea of exploring the *raison d'etre* of one's profession is understandably threatening, particularly in a profession like psychiatry. Psychiatrists work alone. Even in groups or in hospital settings, communication about private, day-to-day therapeutic functioning is minimal. Although psychiatrists complain about this isolation, they do little to change it. Peer criticism is considered inappropriate. Indeed, the concept of peer review is unused, since there are as yet no commonly accepted standards of good work, or ways to prove that changes in a patient's life are in fact due to his clinical sessions. Success can always be imputed to the psychiatrist's impact, and failure can always be attributed to the patient.

I have always believed that the process of testing expert opinion must start from within. The law has a standard stock of tools to recommend. Open up your decisions and make them public, if only to your colleagues. Record your staff conferences, keep your files.

Initiate communication among yourselves by calling on a second or a third decision-maker to advise you on crucial issues. When institutional interests come into play, take note of them—talk about them. Only then can you establish tentative criteria for resolving them.

Psychiatry and the Law

MY CONCERN here is not with the private practice of psychiatry or with long-term psychoanalysis. But when public money is spent on training, salaries and facilities for psychiatrists, the public has every right to subject the recipients to rigorous questioning. Moreover, when psychiatric decisions lie behind the power of the state to confine people against their will and to treat people in ways they don't ask for, these issues will ultimately find their way into court. Those of us whose judicial duty it is to scrutinize governmental intrusions into liberty cannot keep silent.

Already psychiatry has been called upon to help answer a number of questions concerning the balance of power between the state and the individual: Who can morally be convicted of a crime? Who can be ordered into a hospital for compulsory treatment? What kinds of treatment can be imposed involuntarily, and for how long?

At the beginning of my judicial career I had hoped that the decision-makers in psychiatry would willingly open up the reservoirs of their knowledge in the courtroom, and that this knowledge would have a significant impact on the law. What I saw instead was that psychiatrists in court quickly adopted a protective stance: They refused to submit their opinions to the scrutiny which the adversary process demands.

Challenging an expert, and questioning his expertise, is the lifeblood of our legal system, whether it is a psychiatrist discussing mental disturbance, a physicist testifying on the environmental impact of a nuclear power plant, or a General Motors executive insisting on the impossibility of meeting federal auto pollution standards by 1975. It is the only way a judge or a jury can decide whom to trust.

In the early 1950s psychiatry and the law were at a standstill on the issue of criminal responsibility, the so-called insanity defense. The traditional legal test permitted psychiatric testimony to focus only on a single narrow issue—whether the defendant knew what he was doing, and knew whether it was right or wrong. Strictly construed, this might mean whether he knew that a knife in his hand was not a toothbrush.

The psychiatric profession was critical of this test. It seemed to ignore the modern theories of man as an integrated personality; it concentrated on one aspect of that personality, cognitive reason, as being the sole determinant of conduct. Psychiatrists publicly claimed that, if the law would let them, they could give a more adequate account of psychic realities and present a vast array of scientific knowledge. Prominent psychiatrists also complained that the legal test forced the doctor to decide the issue of moral responsibility which should be left to the jury. They insisted that psychiatrists should should be allowed to address the issue of responsibility in terms relevant to their medical discipline.

The law recognizes that the question of guilt or innocence is essentially a moral one. I believe that morality cannot be determined solely by abstract philosophical principles, without the facts which generate human behavior in the real world.

A War of Words

TO HELP OBTAIN these facts, I formulated a new test of criminal responsibility in 1954 in the *Durham* case, which held that an accused is not criminally responsible if his unlawful act was the "product" of a mental disease or defect. The announced purpose was to unfreeze psychiatric knowledge, to irrigate a field parched by a lack of information, and to restore to the jury its traditional function of applying "our inherited ideas of moral responsibility" to those accused of crimes.

Initial psychiatric reaction was enthusiastic. Dr. Karl Menninger, for one, described the decision as "more revolutionary in its total effect than the Supreme Court decision (of the same year) regarding segregation."

But there were problems from the

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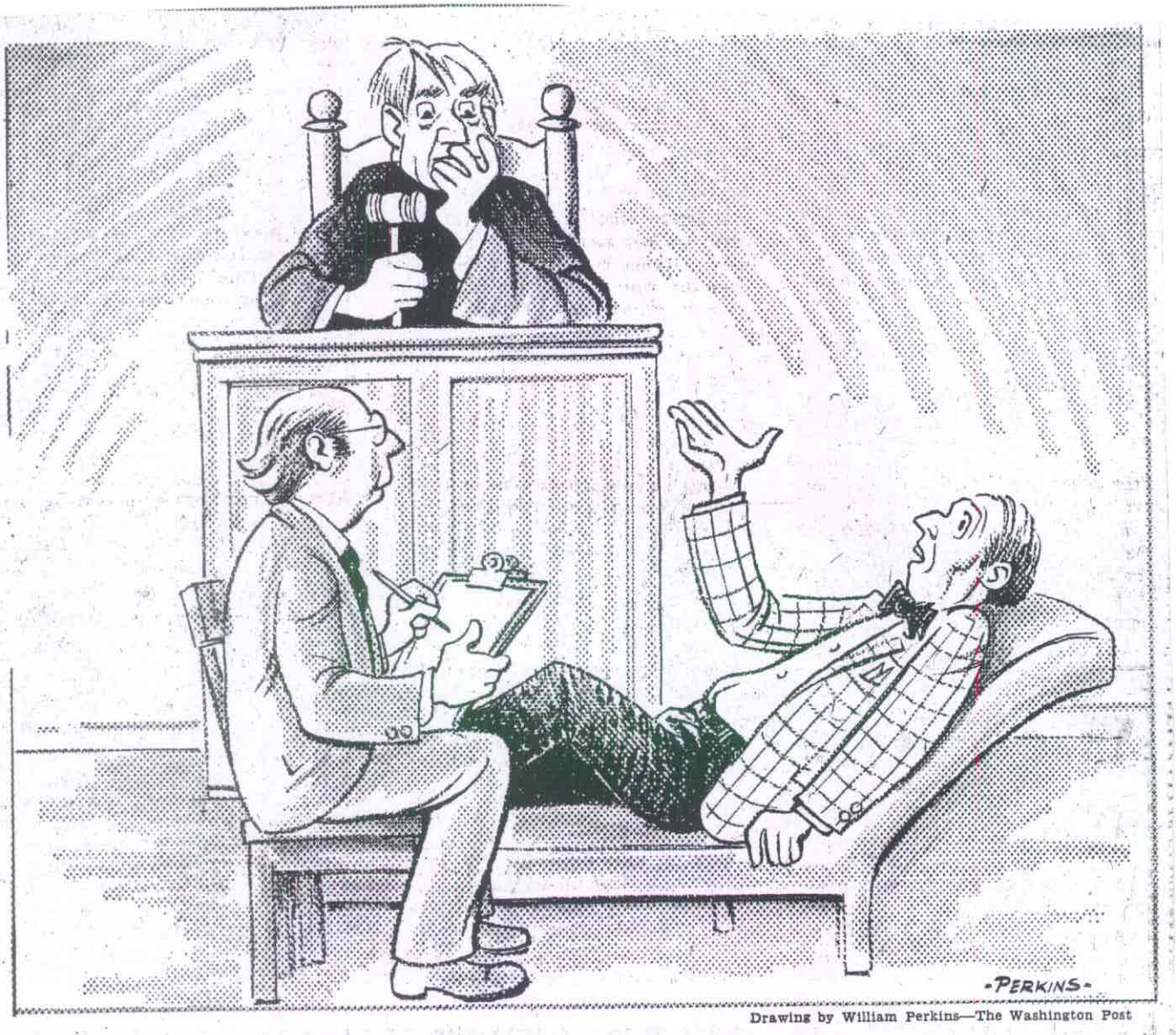

Drawing by William Perkins—The Washington Post

start. Psychiatrists continued to use conclusory labels without explaining the origin, development or manifestations of a disease in terms meaningful to the jury. A war of words began to be waged in the courtroom. Psychiatrists argued about whether a defendant had a "personality defect," a "personality problem," a "personality disorder," a "disease," an "illness" or simply a "type of personality." How could a jury make any sense out of this?

Before long, the psychiatric profession turned against the *Durham* rule, and many of its leaders were delighted when my court abandoned it last year.

At one point, I discussed the problems with the late Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital and one of the foremost forensic psychiatrists of his day. He told me that the kind of information sought by *Durham* would take from 50 to 100 man-hours of interviewing and investigation, and that the hospital simply could not provide these resources.

I told him that psychiatrists should then frankly explain on the witness

stand how their opinions were affected by the limitations of time and facilities. This would cast no aspersions on their expertise. It was a far greater disservice to the legal process and the administration of justice for them to create the distorted impression that they had learned substantially all that could be known about someone on the basis of admittedly insufficient exploration and study.

Differing Diagnoses

MOREOVER, PSYCHIATRISTS failed to disclose the differences of opinion and outright conflicts involved in psychiatric diagnosis. Attempts by my court to obtain records or tapes of clinical conferences were consistently frustrated by the psychiatric staff at St. Elizabeths.

The psychiatric profession assumed such a self-protective stance that the purpose of *Durham* and other related cases was thwarted. In asking them to open up their opinions and decisions, the legal system was not out to "get" psychiatrists. It was asking only that when psychiatric expertise participates in public decisions, it submit to the process by which the shortcomings of all opinion evidence are tested. The potential for bias, distortion and deviation from truth is inevitable, even with a court-appointed "impartial" expert. Every doctor has a permanent emotional bias. Every doctor has an operational identification with an opinion used to support one side of a conflict. Every doctor has an inevitable ego identification with the accuracy of his own findings.

Psychiatry's attempts to procure invulnerability for its medical opinions culminated in the *Jenkins* case in 1962. The issue presented was whether highly qualified and certified clinical psychologists could testify on the mental condition of a defendant and on the relationship between this condition and a crime. The trial court had excluded such testimony because "a psychologist is not competent to give a medical opinion." An appeal was taken, in which the American Psychiatric Association supported the lower court's decision. It asserted that the issue was of "great concern" to the profession, and that in *medical* problems, *medical* opinion can be the only guide. It chose to forget that the problem of criminal responsibility was not the exclusive terrain of psychiatry, and I rejected such guild mentality in my opinion.

Nonmedical Considerations

LATER, WHEN COURTS began to evaluate the treatment in mental hospitals and to establish standards, the APA again panicked. It adopted a position statement which began: "The definition of treatment and the appraisal of its adequacy are matters for medical determination."

Such assumptions and declarations are inevitably questioned whenever psychiatric decisions are exposed in the public sector, whether in the courtroom or in the community. When people are confined by psychiatrists on behalf of the state, this necessarily introduces the potential for misuse of that power, and it is the court's duty, on behalf of society, to scrutinize all governmental intrusions on freedom and liberty.

Time and again one hears frank admissions that factors completely unrelated to a psychiatrist's medical expertise have formed the basis for his decision to commit or release. At the Napa State Hospital in California a few years ago, the superintendent told me in a public meeting that the staff had "Sacramento looking over its shoulder" on all internal decisions. I learned that psychiatric opinions are influenced by the public outcry for "law and order" and by personal fears for safety from patients. In some hospitals, shortages of bed space and manpower override medical considerations. In Veterans Administration hospitals, the need to fill beds produces the opposite result among voluntary patients. I have even been told that psychiatrists believe they are justified in fudging their testimony on "dangerousness" if they are convinced that an individual is too sick to know that he needs help.

All of these problems are ripe for study, but the APA, while feeling competent to evaluate the performance of the Soviets, cut off our examination of how psychiatry may be misused in this country.

Expertise, Not Prestige

THE LONGER PSYCHIATRY keeps its doors closed, the greater will be the public's suspicion and distrust. Outside critics will not leave the profession much breathing space and may seek to impose controls that go beyond what is necessary.

Every branch of medicine used its mystique to help it through periods of uncertainty and of struggling with empiric cures. Admittedly, compared to specialties like cardiology, the behavioral-medical sciences are still young.

But the psychiatric profession has matured, and it has much to gain now from objective evaluation of its accomplishments, especially at a time of major achievements: breakthroughs in drug therapy; an increasing sophistication in examining behavior from a multi-dimensional or eclectic framework; and even an increasing sensitivity to the civil and human rights of patients on the part of some of the youngest practitioners. It is understandable that the public should want to know more about the psychiatrist. In my opinion, psychiatry has far more to gain then to lose if it responds positively to current challenges and undertakes the kind of self-analysis that it teaches others — to ensure that its power rests on its expertise, rather than on its prestige.