Public Skepticism: Forensic Psychiatry's Albatross*

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Many readers will recall a provocative Oliphant cartoon, which was circulated nationally and seen on the editorial pages of our newspapers during the 1976 Patricia Hearst trial. It caricatures the essence of our plight. Consider again its portrayal of a white-bearded defense psychiatrist gliding into the courtroom balanced precariously on roller skates, with a propellered beanie on his head, a long-stemmed flower clenched between his teeth, and a decorative scarf trailing grandly from his scrawny neck. I remember many smiles from my friends, snickers from my surgical and internist acquaintances, and much embarrassed handwringing from my psychiatrist colleagues along with the plaintive remark, "Here we go again. . . ."

The joke has something serious to say to our profession about its general reputation. As recent nationwide public opinion polls have repeatedly demonstrated, psychiatrists have earned less public confidence than physicians in general.[1,2]

TABLE 1

"As far as people running (READ LIST) are concerned, would you say you have a great deal of confidence, only some confidence, or hardly any confidence at all in them?"

TREND OF CONFIDENCE IN INSTITUTIONAL LEADERS

Great Deal of Confidence in	1972 %	1971 %	1966 %
Medicine	48	61	73
Finance	39	36	67
Science	37	32	56
Military	35	27	62
Education	33	37	61
Psychiatry	31	35	51
Religion	30	27	41
Retail business	28	24	48
U.S. Supreme Court	28	23	51
Federal Executive Branch	27	23	41
Major U.S. companies	27	27	55
Congress	21	19	42
The press	18	18	29
Television	17	22	25
Labor	15	14	22
Advertising	12	13	21

The Harris Survey: November 13, 1972. (Psychiatrists have not been included in The Harris Survey on this question since 1972.)

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TABLE 2

How would you rate the honesty and ethical standards of the people in these different fields — very high, high, average, low, or very low?

	Very high, high,	Average	Very low low	Can't say
Doctors	60%	33	5	1
Police officers	49%	40	8	3
University teachers	39%	47	8	6
Engineers	38%	50	4	8
Psychiatrists	28%	52	10	10
Lawyers	26%	48	23	3
Journalists	18%	52	26	4
Business executives	17%	60	17	6
Members of parliament	16%	44	37	3
Building contractors	14%	54	28	4
Labor union leaders	10%	33	54	4
Advertising executives	9%	55	33	3

The Canadian Institute of Public Opinion, August, 1976. National adult sample of 1,064.

This conclusion is predictable, deserved, and, in part, correctable.

Forensic psychiatrists are twice cursed. Not only do we lack significant public credibility along with the rest of our psychiatric colleagues, but our recent public exposure has depicted us frequently as fuzzy thinkers who seek involvement in sensational criminal cases. In truth, the situation is less glamorous. We spend most of our time assisting in the relatively undramatic resolution of civil cases, even though we seem to come to public view most often in the criminal arena.

Let us proceed by examining our difficulties first from the general perspective of our profession and secondly from the restricted purview of forensic psychiatry.

General Perspective:

(1) During the last decade, clinical psychiatry has reentered the mainstream of American medicine. Successful psychiatric units in general hospitals, increasingly effective psychopharmocologic agents, and the growing understanding of the genetic and biochemical contributions to major mental illness have contributed to the solid association of our specialty with general medicine. But this association is the result of remarkable change. Until the summer of 1921, when the *American Journal of Insanity* was renamed the *American Journal of Psychiatry*, psychiatrists were labeled "alienists" (for obvious reasons), and they worked in sanitaria usually considerably removed from the community and equally far removed from the medical mainstream. The general public feared and worried about these sanitaria inmates, who in very recent epochs would have been burned at the stake, hanged, or put in jail. Remember that one of the various original motivations for the creation of American asylums, beginning in the 1820's, was the wish to isolate those who seemed most likely to disrupt or threaten community stability.[3]

New enthusiasm in American psychiatry arrived during the 1930's and 1940's, and good psychiatry became synonymous with private practice psychoanalysis and long-term psychoanalytic psychotherapy. During the late

1950's and early 60's, our profession was swept along by the hope that our new psychopharmacologic agents would be the "answer." The late 60's and early 70's were a decade in which many of us took on the mantle of social activism and called it Community Psychiatry. And then we entered our highly-touted identity crisis.

(2) In 1973 the American Psychiatric Association created a Task Force to Define Mental Illness and "What is a Psychiatrist?" In the 1976-1977 APA roster of Organizational Components, this Task Force was deleted (to be forgotten, many of us hoped). A March, 1977, position statement entitled "What is a Psychiatrist?" now exists; it begins and concludes with the following sentence: "A psychiatrist is a physician whose specialty is the diagnosis and treatment of people with mental and emotional disorders." Such a definition includes practitioners who are neuropsychopharmacologists, family therapists, community consultants, and psychodelic guides. Mental and emotional disorders remain undefined in this document, but we all know about the brouhaha over DSM-III. The theoretical and actual differences in practice among the various special interest groups in our medical specialty seem almost as great as the multitude of differences which exists under the umbrella of the National Council of Churches. Diagnostic concepts vary significantly with the clinician's professional identity, theoretical orientation, and the type of organization (system) in which he practices. It has been shown that diagnosticians jointly conducting a psychiatric interview may disagree on what they observe, what they infer, and how they employ nosology.[4,5] No wonder that during the sixth American Psychiatric Association Institute on Governmental Operations, in March, 1977, our national organization had to struggle for a "fair hearing." I listened as our national professional leaders repeatedly responded to questions from legislators about "What do you want covered under the evolving national health insurance program?" with the answer "Why, everything we do." A more precise answer, which might specify the priorities for reimbursement which the legislators were asking for, would inevitably have alienated some of our colleagues.

The 1973 decision to create the APA Task Force to Define Mental Illness and "What is a Psychiatrist?" was in response to forces from both within and without our profession. Diminishing federal allotments for the education and training of psychiatrists and our society's new allegiance to actuarial approaches to decision-making are now forcing us to become more modest and guarded about our performance promises. Third-party payers and peer review have tempered our enthusiasm for unproven fads. On-going research which carefully and operationally defines psychiatric disorders and then evaluates corresponding treatment approaches continues to identify more clearly the limits of our specialty. Our profession is building a very respectable scientific data base, and yet public skepticism about the all-inclusiveness of our field has already resulted in discriminatory Medicare and Medicaid legislation involving reimbursement for the use of psychiatric services.

(3) As practicing psychiatric physicians, we regularly deal with suicidally depressed and occasionally homicidal patients who are usually described as "dangerous." About 1.6 million Americans will be hospitalized this year

for mental illness, and about one-half of these will be involuntarily committed (*i.e.*, as dangerous to self or others).[6] When we are involved in a petition for an involuntary commitment (usually at considerable inconvenience), we are often portrayed as eager to trample on individual civil rights in order to force the incarceration of resisting patients in a state hospital for treatment.

Restricted Purview of Forensic Psychiatry

Forensic psychiatrists find themselves in special jeopardy of losing further the public confidence and trust because of the nature of our work.

(1) We live in a democratic society which requires that individuals behave responsibly and predictably. This is a basic assumption. As Judge Bazelon has written:

> The legal and moral traditions of the Western world require that those who, of their own free will and with evil intent commit acts which violate the law, shall be criminally responsible for those acts.[7]

Judge Leventhal, in *U.S. v. Brawner,* went even further in remarks intended to clarify his viewpoint when he reported that the court embraced the medical model but rejected a determinist's view of man:

> This is not to be viewed as an exercise in philosophic discourse, but is a governmental fusion of ethics and necessity, which takes into account that a system of rewards and punishments is itself part of the environment that influences and shapes human conduct. Our recognition of an insanity defense for those who lack the essential, threshold free will possessed by those in the normal range is not to be twisted, directly or indirectly, into a device for exculpation of those without an abnormal condition of the mind.[8]

The concepts of threshold free will and evil intent mentioned by Judges Bazelon and Leventhal are not often used in professional psychiatric literature. Many of the ways we conceptualize and treat emotional disorders do not easily translate into the jurisprudential view of man. Parataxic communication is difficult to avoid in the courtroom, especially under the stress of adversarial procedures. Forensic psychiatrists testifying in criminal cases are often viewed as attempting to cloud our moral standards and to ignore the limits of community tolerance.

Remember how the highly restrictive M'Naghten Rule evolved in 1843. Queen Victoria and others were frightened after the attempted murder of Prime Minister Sir Robert Peele (in fact a man by the name of Drummond was killed by mistake). The accused, Daniel M'Naghten, was found not guilty by reason of insanity. The House of Lords was summoned to an Extraordinary Session and instructed to clarify and tighten the concept of criminal responsibility. As a result, a restrictive test was established which made sure that decisions of "not guilty by reason of insanity" would not happen often.

(2) During the last decade several sensational trials, involving the assassination of a public figure, the murder of civilians during wartime, and a bank robbery involving a kidnapped heiress, have brought psychiatric/psychological expertise under careful public scrutiny. Newspaper reports recount disheartening performances. During the 1969 Sirhan Sirhan trial, one expert gave his esteemed opinion – which was recognized immediately as resembling verbatim statements from "Case Work of a Crime Psychiatrist" published in 1968.[9] During the General Court-Martial of Lieutenant William Calley, Jr., *The Washington Post* reported that one defense psychiatrist "was rejected as a witness after the military judge concluded the doctor was on the verge of telling a 'complete falsehood'."[10] During the Hearst trial, a physician expert for the prosecution was described in *The New York Times* as a man "who pictured himself as too proud to call himself a psychiatrist."[11] We all acknowledge that what we say in our professional capacity in public settings lends itself to distortion in the media by reporters who are skeptical or who do not try to understand what we say. But in the examples cited above, the record speaks for itself.

(3) Many people wonder about psychiatric experts "for hire." Although it is usual for medical-legal disputes to have physicians testifying for "both sides," the allegation that expertise is so subjective that almost any supporting opinion can be bought is directly more pointedly at psychiatrists. In instances when non-psychiatric physicians are involved, there seldom is any question about whether a fracture existed or a cardiac arrest, in fact, occurred. When psychiatrists get involved in cases, usually community standards involving individual responsibility and accountability are at stake. This predicament is a special burden for psychiatric testimony. We citizens who need to have our behavioral expectations of one another relatively clear and unambiguous are troubled when psychiatrists seem to "excuse" or "explain" almost everything with their technical jargon and diagnostic labeling. Many people, including Judge Bazelon, have observed that psychiatric experts have in the past seemingly usurped the court's role in decision making.[12] Many times in the past we psychiatrists have justified our quickness to label as a means to rescue patients from perceived unsympathetic systems of justice, and the frequent results have been an abuse of civil rights.[13]

Recommendations:

As general psychiatrists, our professional concern with the mentally ill has traditionally been an unpopular cause. The behaviors of our patients are upsetting and unsettling to a community which depends on predictability and deference to group mores. Because we have made our interest the care and treatment of society's mentally ill deviants, we, by association, are suspect – one law student sheepishly asked me of mental illness, "Is any of it contagious?" Because we have psychotherapeutic skills that are effective and somatic treatment methods that bring about improvement, we play an important if sometimes unacknowledged and uncelebrated role in maintaining the mental health of our fellow citizens and the stability of our society. We will never lead the public list of most trusted professionals

because our professional task remains frightening and unintelligible to most of our non-professional friends and neighbors.

But we can do more to earn the public esteem and credibility we deserve.

General Perspective:

(1) As general psychiatrists we can embrace the evolving requirement for continuing medical education as an effective way of documenting that we are informed about meaningful new developments in our field.

(2) More of us can earn certification by the American Board of Psychiatry and Neurology. At this time, general psychiatrists as a specialty group have the lowest percentage of Board Certified members when compared with the other twenty-one specialty groups with Boards recognized by the American Board of Medical Specialties. Our residency programs vary widely in quality, and, in the past, many incompletely trained physicians were employed in state hospitals and called psychiatrists. We owe it to ourselves and the public to prove acceptable levels of competence.

(3) It is unlikely that "everything we do" will be reimbursed by evolving health insurance plans. Already Medicare and Medicaid do not do so. At this time, Medicare outpatient psychiatric benefits are limited to a maximum payment of $250 or 50% of reasonable charges, whichever is less, after a $50 deductible is met. For other medical conditions, physician reimbursement is 80% of reasonable charges under Medicare. If our national organization does not establish a list of reimbursable priorities and define further how we differ in what we *do* (rather than *who* we *are*) from our non-physician mental health colleagues, we will continue to be viewed as a special interest guild concerned only with protecting our turf. Our strategy up to this point reflects a tardy and incomplete response to a rapidly changing social scene.

(4) Ultimately our testimony will be more valued as our specialty of general psychiatry becomes more precise about the descriptive characteristics and prognoses of the various mental illnesses we treat. Careful attention to family (genetic) studies, increasing use of descriptive and operationally defined criteria, and the use of double blind longitudinal studies of various treatment approaches will continue to increase the data base and credibility of our specialty. The DSM-III multiaxial approach will likely increase the clarity of what we mean by what we say with our jargon.

Restricted Purview of Forensic Psychiatry

As forensic psychiatrists we will continue to straddle the worlds of fact and fantasy. But specific changes are in order:

(1) As participants in civil and criminal proceedings, we can prepare ourselves better by thorough, organized, detailed clinical evaluations and reports. We must resist the seduction of "Come on, Doc, what should I do with him?" We should accept the court's invitation to "explain . . . how the development, adaptation, and functioning of (the) defendant's behavioral processes may have influenced his conduct."[14] We must do far more than testify with diagnostic labels.

(2) The development of an American Board of Forensic Psychiatry with

a certification process may significantly influence the development of a cadre of highly skilled, well informed forensic specialists. These professional standards for establishing expertise will supplement the usual legal process of "qualifying the expert."

(3) Not enough of us are actively involved in preventive forensic psychiatry, *i.e.,* taking part in study groups with law makers, presenting a psychiatric viewpoint in undergraduate law school education, and trying to become informed about the public concerns that generate what we view as restrictive legal guidelines. Initiatives from our own AAPL group Task Forces should develop proposals for the amendment of laws we find inadequate or even harmful. More of us should teach in law schools and teach relevant law to our psychiatry residents. The resulting cross-fertilization and sharing of perspectives could lead to the germination of new ideas in our field.

(4) Forensic psychiatrists participate in an arena in which medicine, sociology, individual ethics, case law, community morals, fiscal priorities, and administrative law all exercise influence. It is not reasonable to assume that what we have to say is the most important or the most relevant contribution to decision-making. We should be team players to a greater extent than our other physician colleagues, because society's stake in the decisions in which we participate is far greater. A dash of humility on our part is in order. Anthropologists, sociologists, and others also have useful expertise to share as our society searches for just decisions in its courts.

(5) The skepticism we meet in the public forum seems to come from the *mystification* of the knowledge we possess about mental illness and the *all-inclusiveness* some of us claim as our own medical turf. Contemporary American psychiatrists espouse a variety of theoretical models and pursue a multitude of (often covert) social, medical, and moral tasks. Some psychiatrists claim objective scientific validity for their testimony; others claim to be teachers of jurors; while others encourage us to enter the fracas as persuasive psychiatric advocates.

Our professional expertise has been sought and valued because as psychiatrists we share a socially sanctioned "Aesculapean Authority" with our fellow physicians. When we speak other than as physicians who are psychiatrists, *why* should courts or the public give preeminence to our testimony? Clinical psychologists, social philosophers, and many social revolutionaries also have something important to say about human behavior. What has given psychiatry "the edge"?

Curran has already formulated the challenge:

> We need to improve *vastly* the quality of legal medicine and forensic science in the United States, for the safety of all of us and for the sake of effective justice for all, victims and defendants alike, in our courts.[15]

Forensic psychiatry's contributions will remain only as valid as the data base and assumptions used. We must be explicit about our own assumptions, demonstrate our expertise with clinical data, and carefully acknowledge our limitations. Skepticism must yield to such a forthright effort.

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