

# Ambivalence, Alliance, and Advocacy: Misunderstood Dualities in Psychiatry and Law

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*It takes two people to speak the truth. Thoreau*

Law and psychiatry operate through differing models of reasoning, understanding, even of reality.<sup>1</sup> For the clinician first encountering the legal system, the fundamental concept of the law perhaps most difficult to grasp is the nature of the adversary process. Whether such a first encounter occurs during a commitment proceeding on a manifestly psychotic patient, in the preliminaries or dispositions of a divorce or other civil action, or in the confrontations of the courtroom, the uninitiated psychiatrist will be in an environment built around alien modes of thinking and perceiving often antithetical to his or her own psychiatric perceptions and views. As a witness, for example, the psychiatrist may be subject to an attack on the stand such as he or she has never encountered outside of psychotic transferences.<sup>2</sup> The energy and occasionally abusive intensity of the cross-examination, in this example, derives in part from the underlying principle that the attorney for the "other side" owes his client the most zealous, "thrusty" efforts in the service of advancing that side of the case. At the heart of this issue lies the assumption offering the central justification of the adversary system: that the truth can best be determined, and justice served, by drawing the substance of the case upon the rack of disputation, by examination and cross-examination, by selective admissibility of evidence, and by other long-established rules and procedures.\*

In playing a role in these proceedings, the trial attorney is an advocate for his/her side of the case. In common with the qualities expected of the advocate in other settings (for example, patient advocate in a hospital), the attorney is expected to present a view that might be termed unambivalent; that is, to function successfully in litigation, the attorney must present a unified and unqualified, even unrestrained version of the client's view, be the client plaintiff or defendant.

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\*This view, no matter how realistic, often leaves clinicians with a familiar concern: that the adversary process, strictly followed, can at very best lead only to justice but not necessarily to truth; and that the opposing attorneys are actually seeking neither justice nor truth but only triumph for the present case. This matter is both too complex and lengthy for discussion in the present context.

An attorney who told the court, in effect, "My client is suing because he might possibly have sustained damages, but it isn't clear," would certainly fail to convince the court and to win the case. The attorney's view, rather, must be: "My client *has* sustained damages and I plan to prove it!" Any questions, weaknesses, or elements of doubt or uncertainty on one side are the legitimate responsibility of the other side of the case to bring out by presentation of opposing testimony, contradictory witnesses — in short, by the whole panoply of procedures of the trial itself; thus, uncertainties or doubts are "delegated" to the other side of the case.

Some popular sense of this model of legal functioning is captured in the term for attorney drawn from convict argot, "mouthpiece." This term captures the manner in which the attorney is supposed to place his/her forensic skills in the service of saying what the client wants; one facet of the attorney's expertise is giving legally convincing voice to the client's expressed wishes.

We might contrast this view with that of the psychiatrist working with a patient. Note that the psychiatrist expects to deal with and reconcile within him- or herself the contradictions and ambiguities of the clinical situation. The clinician would regard it as naive and unprofessional to be "taken in" by one or the other aspect of ambivalence or element of the personality to the exclusion of others. Clinical training teaches distrust of any unilateral and hence unbalanced view of motivations and feelings. The clinician, instead, weighs opposing feelings and seeks them out within the patient to obtain a complete view.

Two dualities of clinical work often lead to misunderstanding between medicine and law. They are the notion of ambivalence and the notion of alliance. These two clinical entities have one thing in common that contrasts them with the adversary system. The adversary system has one separate representative (attorney) presenting *each* side of the case, a total of two people. In contrast, the "two sides" of both ambivalence and alliance reside within the *same* person. We may now consider the implications of this difference.

One caveat must be stated. Psychiatry and law possess an *inherent* incongruity; the most Procrustean efforts will not alter this fact. This discussion aims more at bridging the space between the two fields and clarifying the nature of the discontinuities within the commonality of helping relationships.

### **Clinical Implications of Ambivalence**

It is a clinical truism that many relationships, especially intense and intimate ones, are ambivalent in nature; the capacity of human beings to feel for the same object emotions that are polar opposites is one of the "trade secrets" of psychiatry. Psychiatrists do not disagree with or contradict the patient who avers, "I love my spouse, parent, or child," yet they remain cognizant of the buried converse — hostility or hatred — in all such relationships. It might be said that the patient's ambivalence is his/her "internal adversary system." This view affords the clinician perspective on the complexities of the human condition and understanding of how and when relationships go awry.

A problematic issue at the medicolegal juncture is the common clinical obser-

vation that ambivalence often must be inferred since it is not always explicit. In the case of voluntary hospitalization or voluntary treatment, for example, many patients mean what they say when they express the wish to enter or leave the hospital, to accept or refuse treatment; but another population, largely composed of those with paranoid traits, may be saying one thing and meaning quite another. Thus, when some paranoid patients appear to insist they wish to leave the hospital, clinical experience indicates this may be a more complex (because ambivalent) communication: "I would be glad to stay in the hospital if we can be perfectly clear that it is your idea, if you take responsibility for it, and I can blame you, thus ignoring my own role in getting myself into the hospital and my own dependent wishes to stay."

While to the layperson this sort of reasoning is obscure and counterintuitive, empirical evidence is not that difficult to find. For instance, in the context of a drug refusal study, one of us found<sup>3</sup> that even highly paranoid drug-refusing patients unhesitatingly took their medication when told the consent of the just-appointed guardian made it a requirement. In that situation the patients did not, as might perhaps be expected, express doubts about this, demand to see the papers of appointment, question whether the man in black robes was really a judge, and so on. Instead, as patients with paranoid syndromes often do, these patients acquiesced calmly and comfortably to the statement, "You have to."

Looking at the structure of this interaction, we grasp an important and ubiquitous point: in some situations a patient may be voicing half their ambivalence about a particular decision, leaving the other side to the environment or to others around them. This might be expressed as follows: the patient plays out an internal process (ambivalent wishes) between two persons in what is tantamount to an adversary situation! Each of two persons, in other words, "wears" half the mixed feeling in one person's mind. Again, while commonly encountered in the inpatient milieu, such phenomena are not universally recognized or understood.

A related issue is the manner in which a patient may say one thing and mean another, as in the case of the patient who complains of a situation and yet remains in it — voting with his/her feet, as it were. The way in which the experienced clinician must learn to read between the lines of the clinical material is often confusing to inexperienced attorneys trained to observe "testimony" in a strictly literal manner. The seasoned hospital attorney, in contrast, is familiar with the often glaring discrepancies between patients' overt expressions and actual intent, as well as with the rapidly fluctuating clinical presentation that can result.

### **Projection and Splitting**

Before moving on to the second problem duality, the alliance, we might briefly touch on two other dynamic dualities related to ambivalence and similarly problematic for naive attorneys coming to the inpatient ward. As with ambivalence, the situation in projection involves two elements, but here the same feeling is divided, as it were, between two persons. The patient who attributes his or her feelings to, say, the treating physician may cloud the clarity of the interaction, as in this case example:

A paranoid patient vehemently complained to his advocate that the doctor was trying to punish him for causing disturbances on the ward by denying him passes. Failing to see this as a projection of the patient's guilt, the attorney took this at face value and challenged the doctor, who had, in reality, never been asked for a pass. The doctor then clarified where the feelings of guilt, punitive impulses, and the like had originated, namely, from within the patient.

An even more subtle form of confusion, related to both ambivalence and projection, is that created by the phenomenon of splitting, seen in borderline patients most commonly, but not unknown with other entities. This phenomenon is, strictly speaking, an *intrapsychic* process; however, its power, especially in inpatient milieus, derives from the fact that actual people in the patient's environment are often mobilized in complementarity to the patient's psychic state. Moreover, this particular form of duality involves the patient's attempt to tolerate irreconcilably ambivalent feelings by a process of polarization, as it were, in which one party becomes all positive and the other, all negative. At times the patient is one of the parties, but equally commonly two caretakers are the recipients of these projected feelings. Predictably the therapist and the patient's attorney may play these roles as well, as in this example:

A severely ill borderline woman idealized and seductively praised her attorney for his exceptional understanding and empathic ability in relation to her case. To him she characterized her therapist as "sadistic, vicious, and full of rage." The flattered attorney, incensed at this depiction of the therapist, began to agitate for a new therapist for this patient based on a presumed incompatibility. At the threatened loss of the therapist, however, the patient turned savagely on the bewildered lawyer, berating him for sabotaging her treatment; the lawyer was quite baffled at this "change of heart."

The clinician, of course, recognizes that the idealized object may swiftly become, on little apparent grounds, the depreciated one; but for the attorney it is difficult to grasp that the feelings toward him or her are, with such patients, covertly influenced by simultaneous feelings toward another party in the patient's social field, as though some Newtonian law of "equal and opposite" applied here.

### Therapeutic Alliance

The second major duality to consider relates to the therapeutic alliance. While this clinical phenomenon can exist in a variety of forms,<sup>4</sup> we here focus on the most commonly seen version, the "rational alliance." In an extremely condensed form, we may describe this form of the alliance as one in which the healthier, more rational or mature aspects of the person work in collaboration with the therapist to attain the desired goals. Extending this metaphor, we see that the patient may be heuristically considered to be divided within himself or to contain within himself two distinguishable forces or two categories of phenomena, both dynamically evolving. It may be less obvious that one implication of the foregoing model is that at certain points the clinician will be working "against" something in the patient; this may create the illusion of the clinician working against the patient as a whole, that is, the illusion that the clinician is working in an adversary relation with the patient. For example, the therapist treating a gam-

bling addiction is "against" the patient's gambling, thus against the part of the patient that wants to gamble.†

The area of contrast between this model and the model of advocacy earlier described is a common ground for confusion in communications between physicians and lawyers. Lawyers frequently visualize the idea of the doctor working in an alliance with the patient as if it were comparable to the "mouthpiece" model: the doctor tries to get for the patient what the patient says he wants, for example, to leave the hospital or to stop taking medication. The notion of working for *part* of the patient is difficult enough to comprehend, much less working with that part *against* another part of that same human being! To summarize this point, alliance may be viewed by lawyers as if it were synonymous with advocacy, in an adversary framework. From the clinician's viewpoint, in contrast, "the adversary stance is an alliance problem to be resolved."<sup>5</sup>

One derivative of this puzzle is the fact that the treating physician is sometimes described as being in conflict of interests with his patient. While this doubtless occurs, the very idea raises the hackles of the ethical practitioner. We wonder if the possible misunderstanding just cited may account for this perception of the situation in a number of instances; that is, the physician's "failure" to be the patient's mouthpiece may be seen as placing the former in opposition to the latter, hence, in conflict of interests.

### **Problem Areas**

We turn now to the way these abstract constructs may play themselves out in areas of probable misunderstanding between representatives of the two disciplines.

A paradigmatic incident that captures the functional difficulties occasioned by these nonaligned models is the issue of involuntary commitment. Let us, for the sake of vividness, picture the scene in which the patient's attorney or patient advocate is standing with the patient's psychiatrist in the hospital corridor. Let us imagine the patient has said he wants to leave the hospital and the physician thinks it is too soon for this to occur safely. Besides, this patient has no residence, having been brought in from the streets where he was sleeping in doorways. Thus, our imaginary dialogue might take the form of the clinician arguing that the patient should stay and the attorney arguing that the patient's statement of a wish to leave should be honored.

The problem here is not, as might be presumed, the average clinician's ignorance of statute and legal procedures; rather, it is the discrepancy noted as follows.

Looking at the encounter in overview we might see that the patient is ambivalent, since he wants to leave the hospital, yet he has no place to go except the street; the clinician is ambivalent in that he/she wants the patient, indeed, to leave the hospital (preferably cured) yet must act to keep him for reasons of safety and

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†It should be noted that this is not the same as the therapist's being judgmental or leaving the position of neutrality. Rather, "against" here connotes, not ideologic opposition, but the vector of therapeutic effort.

survival; and, as a conscientious advocate, the attorney undertakes the task of presenting the patient's wish to leave as if it were unambivalent. In consequence, the attorney is acting unambivalently as an advocate for one side of the patient's ambivalence against one side of the physician's. Note further that attorneys and advocates routinely seek out the treating physician to discuss the case, and occasionally convert the office or hallway where the conversation is occurring into a mini-courtroom, complete with loud cross examination and energetic, even scathing, disagreement.

The essential inappropriateness of this all-too-common scenario now becomes clear: the dialogue that should ensue should occur, not between the patient's attorney and the physician, but between the patient's attorney and the physician's *attorney*. (This point has been addressed by Stone.<sup>6</sup>) That confrontation permits the hospital's (physician's) attorney to advocate, as it were, the hospital's position unambivalently and effectively in the contested matter, in addition to providing an advocate with full knowledge of any relevant procedural considerations. Such an arrangement further prevents the common phenomenon of weak advocacy for the mental health side, a result in part of the fact that many psychiatrists are temperamentally unsuited to the advocate's role.

The inappropriateness of the lawyer-to-doctor interchange derives in part from the fact that, in practical terms, the ambivalence of treatment staff tends to predispose them to go along with the attorney's recommendation, absent their strong convictions to the contrary. The psychology of this trend derives from the fact that the ambivalence-free force of the attorney's argument overwhelms the clinician's lack of intense enthusiasm for the struggle, since psychiatrists, historically, have been quite reluctant to fight to keep patients in hospitals against strong pressures to get them out. Thus in doubtful cases (as contested above), the patient may be released more often than not, as indicated empirically in the New York experience,<sup>7</sup> where Kumasaka *et al.* discovered that when lawyers were actively involved in the decision making about commitment, the discharge rate dramatically increased, reaching as high, indeed, as 50 percent. While this outcome may satisfy a civil libertarian perspective, it may be inimical to the welfare of the patients involved. Attorneys are notoriously uninterested in follow-up or after-care issues, and the danger then exists that the clinician will mistakenly assume that the future care of the patient, including warning of imminent decompensations, now lies in the attorney's hands. The patient thus may fall through the cracks in the treatment system.

To digress: an interesting consideration enters into this exploration from both the legal and psychiatric sides. We are, of course, aware that many attorneys feel an ethical obligation in the previously described commitment situation to make every attempt to convince their clients to compromise or even accede to the physician's recommendation; others, however, believe this compromising approach saps the force of their pure advocacy role and should be eschewed. The moral and ethical debate on this point can wax acrimonious in legal discussions.

The parallel role ambiguity in psychiatric circles is captured by the fact that some witnesses suggest the psychiatrist accept the inevitable polarization of the

adversary process in which he is immersed and testify in an advocatelike manner, aiding "his side" of the case to his best ability. Halleck,<sup>8</sup> on the other hand, recommends that from the moment the oath is taken the psychiatrist should view himself as an advocate for truth alone, surrendering any partisan allegiances that may predate that moment.

An additional point might be made about the impact of experience on role performance. The young lawyer may set out as a pure advocate and grow, with experience, into a more negotiating posture as an agent of constructive arbitration. In parallel ways, the young psychiatrist may set out to rescue all patients, regardless of their wishes and capacities, and may only later develop a less interventionist position, giving the patient more freedom of self-actualization within the limits of both illness and strengths.

We return now to the hospital corridor scenario about commitment. Needless to remark, the felicitous arrangement suggested earlier, in which the patient's attorney deals with the hospital's attorney presumes the discovery or the creation of a cadre of available, clinically sophisticated attorneys on whom the clinician can call; in many jurisdictions, these possibilities are foreclosed.

Another duality that may pose problems at the juncture of psychiatry and law is the tendency of attorneys to view the psychiatric interaction (perhaps especially the inpatient interaction) as a zero-sum game; this notion requires some elaboration.

In a zero-sum game, there is one winner and one loser; in more complex versions, the sum of the winnings of the winners exactly equals the sum of the losses of the losers, as in a hand of poker. In the adversary setting of a courtroom there, too, is one winner and one loser: one side or the other is proved to be "right" and thus to be the winner by due process.

In the therapeutic setting, however, this is not the case. Both parties gain something from the collaboration. The therapist receives payment and the satisfaction of doing his/her job. The patient receives the benefit of the use of professional skills as well as the satisfactions that pertain to the result, at least, if treatment is successful. The results are additive, even synergistic. There are, so to say, two winners.

This perspective is not always grasped by attorneys, who have often been socialized by their legal training to distrust altruism and to look for specific interests sought by the two parties involved in a case. Consequently, when they regard the doctor-patient relationship, they may be inclined to view it as a zero-sum game; that is, any benefit to one of the parties' interests may be seen as necessarily occurring at the expense of the other. A clinical example may clarify this point.

An inpatient was loud, disruptive, and threatening to a degree that merited the use of seclusion. At a later suit, this episode was presented by the attorney for the patient as though the doctors, wishing only to have a quiet ward, secluded the patient inappropriately, for their convenience, to the latter's detriment.

Absent from this view was the perception that *all* parties stood to benefit from the seclusion: the subject patient, the other ward patients, and the staff. The idea

that seclusion could be "good for the ward" *without* thus simultaneously and necessarily being bad for the patient was lost on the legal advocates. (The objection must perhaps be here addressed that the patient's attorney did not, in fact, necessarily see it that way, but was using a legitimate courtroom tactic to sway the jury; a number of informal conversations, however, have convinced us that the "zero-sum view" does play a significant role in attorneys' thinking about such situations.)‡

## Conclusion

We noted in this survey that certain dualities in both psychiatry and law pose difficulties in cross-disciplinary communication. Understanding of the largely conceptual problems, modified as they are by each discipline's socialization processes as well as by differing data bases, may aid in the smoothness of the interactions between the practitioners of both fields. This review is designed to aid that understanding.

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‡For completeness, note the issue is complicated by the fact that the novice private therapist, as described by Allen<sup>9</sup> in a report of a seminar on beginning private practice, also may struggle with a zero-sum view. The beginner, unsure of the worth of his work, cannot always grasp the idea that if the patient pays the fee, this is not a pure loss, but rather an exchange of money for services where both parties benefit but in different ways.