INSTITUTE OF CURRENT WORLD AFFAIRS

JLS-17 Psychiatric Diagnosis as a Legal Occasion

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Dear Mr. Nolte:

This seems like a good time to pull together some of my work of the past year exploring psychiatric testimony and its influence on the judicial disposition of involuntary patients, and a good time to suggest some directions this work may take in the coming year.

In JLS-9 I catalogued the weaknesses of the current system of psychiatric diagnosis, drawing on a good part of the voluminous literature written on the subject in the past twenty years. But psychiatric testimony is never limited to a simple statement of diagnosis. And as my courtroom reports of the past six months show, there is no direct relationship between psychiatric diagnosis and the legal disposition of patients in New York courts. Sometimes the diagnostic label seems to control the patient's fate; at other times it seems largely irrelevant to legal disposition. (I am in the midst of interviewing the six judges whom I've watched at work, to discover in more detail what aspects of expert psychiatric testimony influence their decisions and how.)

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The New York State commitment statute requires that a patient or prospective patient be mentally ill and so impaired in judgment that he misunderstands his plight, and that hospitalization be essential to his welfare. Nowhere is a diagnostic label explicitly called for in the commitment law--either in court testimony or in the medical papers that precipitate a court hearing. Yet in every hearing I observed but one, a diagnostic label was proffered. In JLS-9 I speculated that one reason for the continuing reliance on a highly vulnerable scheme of psychiatric classification is that diagnosis lends the weight of medical authority to psychiatric judgments. But diagnosis also plays a central part in formulating these judgments. In JLS-15 I listed the information a judge will need to decide whether hospitalization is essential to a given patient's welfare (the key requirement of the commitment statute), and among the most important items were the following:

--the proposed treatment plan and its likely duration
--the probability of success and the criteria for success
--the likely prognosis if the patient were released, either unconditionally or on the condition that he seek outpatient treatment.

Each of these requires of the testifying psychiatrist a judgment about the future prospects of the patient under a variety of circumstances, in the hospital and out.

How are these predictions made? In JLS-14 we observed a diagnostic case conference where the patient's future conduct was a central issue, and we saw how the group's settling upon the appropriate diagnostic label was an indispensible step in their reasoning about how the patient would be likely to act on the outside if he were released from the hospital. In the disease-entity model of mental illness, currently in almost universal use in public psychiatric hospitals, the diagnosis or classification of a patient's disorder is a prerequisite to deciding the most advantageous treatment, the odds of success, and the patient's likely fate if he is not treated. And so psychiatric diagnosis

in its larger sense--not just the label finally assigned to a patient, but the system of investigation, description, classification, and prediction that institutional psychiatrists use--is what psychiatric testimony is made of.[1]

It has long been recognized (see JLS-9) that the diagnosis of an individual patient will vary with the sex, age, social class, and political beliefs of the psychiatrist and the patient. But after attending civil commitment hearings and psychiatric case conferences over the past six months, it has become clear that this variability is only suggestive of the social and moral judgments that afflict several stages in the diagnostic process. The way I've begun to understand the problem is something like this:[2]

Long before the Bellevue psychiatrist interviews his present patient, a list of disease-types (or syndromes or symptom complexes) that cover the overall population of patients has already been formulated, along with the criteria to be used for assigning a given patient to one of these types--as in DSM-II, the Diagnostic and Statistical Manual of the American Psychiatric Association. How is such a list prepared? From the beginning

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[1] Other methods for reasoning about a patient's future from his present condition without identifying his "disease" are possible, as I suggested in JLS-9, and may be more reliable in predicting, for example, how a given patient will respond to drug treatment or to release.

[2] I've found in the legal literature only one comprehensive attempt to relate the medical controversies about diagnosis to the legal issues involved, an article in the May 1974 California Law Review by Ennis and Litwak. After reviewing in great detail a portion of the technical literature on diagnosis, they conclude that since the diagnostic label is invalid and unreliable (that is, variable among different psychiatrists examining the same patient), psychiatrists should not be permitted to testify to their opinions, judgments, or predictions as expert witnesses in court.

of modern psychiatric classification until the present day, disease-types have been inferred from the regular occurrence of symptom patterns. Early classifiers, relying on the success of medical science in identifying and curing infectious ailments, based their listing and description of psychiatric diseases on the symptom patterns they intuitively recognized in large groups of patients; today a range of statistical methods have been applied to symptom data from a variety of patient populations in an attempt to formalize the recognition of symptom patterns and disease-types. And whether intuitive or explicit, the logic of this process includes the following steps:

1. selecting a general patient population whose characteristics (or symptoms) will be measured to determine whether patients fall into disease-types and what these types are;

2. selecting patient characteristics (or symptoms) to be measured;

3. choosing methods to measure the occurrence and intensity of these symptoms;

4. weighting the symptoms by their relative importance (however defined) or for other reasons;

5. choosing among several available definitions of "type";

6. choosing statistical methods (intuitive or explicit) and applying them to the symptom data in order to discover the existence of disease-types;

7. devising a means of assigning future patients to one of the discovered disease-types;

8. testing whether patients who fall into one of the types share any further characteristics, such as prognosis, response to various treatments, etiology, and so forth. If they do, then the list of disease-types arrived at in the previous steps may have use in the understanding and treatment of patients, in the administrative management of hospitalized patients, and possibly in their legal disposition in court.

Once all this research has been completed, whether formally or informally, a list of disease-types, the criteria for type membership, and the implications of type membership can be

drawn up and supplied to practicing psychiatrists. Then, in the case of each new patient he encounters, the practicing psychiatrist will,

> 9. estimate the intensity of each of the symptoms he observes in the patient's history, his conduct on the ward, and his behavior during the very special social situation of the psychiatric interview;
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> 10. use the criteria for type membership to assign the patient to one (sometimes more than one) disease-type;
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> 11. relying on the empirically discovered correlations of type membership, make predictions and find explanations regarding the patient that go beyond a description of the symptoms he displayed to begin with.

This is, briefly, the logic inherent in most classification projects--here applied to psychiatric classification. But unlike disciplines where classification is performed on stable physical variables as in, say, botany or physical anthropology, psychiatric typing is applied to human variables in flux. In physical medicine, few of the logical steps I've listed are heavily dependent on the social interaction between doctor and patient, but social as well as technical judgments are inherent in a majority of the stages of psychiatric classification, at least in 2, 3, 4 (maybe), 5, 6, 8, and 9. In a future newsletter, I'll discuss in greater detail several of these steps with an eye to distinguishing between the technical and social aspects of the judgments required in each. For now two general examples will do.

In step 2 the researcher selects from the full range of human conduct the characteristics he feels will be useful in assigning individual patients to types. A glance at the many symptom lists and rating scales that have been used for this purpose is revealing. Some of the symptoms, most of us would agree, are indisputable signs of disruption in the patient's inner life. Others appear to incorporate social or moral judgments about what conduct is suitable ("patient is hostile to the staff"). Still others seem normal enough, but may eventually be used by a

psychiatric interviewer to support his attribution of pathology to the patient ("patient eats too much"). To call a piece of behavior a symptom is rarely an actuarial judgment of abnormality. An abnormally tall basketball player, for example, is grateful for his "symptom" (as are his fans and his team's owners, who rush to compensate him for it). And while society may highly value (if only in retrospect) the visions of a William Blake or a St. Theresa, it chooses to exorcise them in a Mrs. Esperanza or a Mrs. Paz (JLS-12). This may be as it should, but it is therefore not sufficient to view a symptom simply as an abnormality; it is more accurate to see symptoms as socially devalued abnormalities. In evaluating psychiatric testimony it is important, then, not simply to pass on the expert witness's training and credibility, but to understand the social judgments inherent in the initial characterization of conduct as symptom.

A related example is step 9. The symptoms a doctor at Bellevue may discover in his brief interview with a patient will vary widely with the doctor's purposes and outlook, the social judgments he may be making of the patient's conduct, and the legal disposition he may covertly desire. The patient reacts to these happenings in the doctor's mind and to the legal dilemma he finds himself in, especially if he wants to be released. In JLS-14 and -16 I described how the legal purposes for which diagnosis is made influence the doctor's perception of the patient and the patient's response. Dr. Greenfield's activities in JLS-16 may be an extreme case in which the characterization of elements of a patient's behavior as symptoms can be used to mask the doctor's quite personal judgments about the patient.

It should be pointed out, incidentally, that psychoanalysis (in contrast to most varieties of institutional psychiatry) places great emphasis on understanding the social nature of the interaction between doctor and patient. Thus the central place accorded the clarification and interpretation of the transference (see JLS-3), and, to a lesser extent, the countertransference (that

is, the psychoanalyst's irrational responses to his patient). And it is significant that psychoanalysts from Freud to the present day have paid little attention to either diagnosis or disease-types in their analytic work; it is often said that once one begins to know a patient, diagnosis becomes irrelevant. This is not the case in public mental hospitals where classification becomes a substitute for familiarity with patients.

Judging from my experience of the past six months, moral and social variables and judgments appear to be inevitable, and not necessarily undesirable, concommitants of clinical work with human beings. But bringing them to the surface seems to me useful to a forthright and evenhanded disposition of involuntary patients. If psychiatric disease-types are as fundamental as I believe they are to a psychiatrist's predictions about his patient, and if these disease-types are based in part on moral or social characterizations of behavior, this underlying meaning of court testimony should be made explicit, as I tried to do in JLS-16, unless judges, to whom society has entrusted the task of evaluating what conduct is suitable, are content to delegate these judgments to psychiatric researchers and practicing psychiatrists. Finally, an analysis of psychiatric diagnosis as a social occasion opens the way to understanding diagnosis in its legal contexts--where the legal purposes of the psychiatric interview further distort the process and can produce court testimony which, while masquerading behind a technical facade, may have only a casual relationship to fact.

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