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Psychiatry and Public Policy

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PSYCHIATRY AND PUBLIC POLICY*

BY GEORGE H. DESSION

BROADLY SPEAKING, all aspects of psychiatry may legitimately be considered matters of public or community concern. The development of any intellectual discipline, with such insights and technological applications as may stem from it, is, of course, of some concern to all persons at all times, whether they know it or not. My focus at the moment is, however, more restricted. I propose to concentrate on situations in which the psychiatrist is called upon to make or participate in the making of decisions on behalf of the community as a whole, excluding those situations and decisions where he may properly feel that his profession as such is concerned or that he and his patient are the parties primarily involved. In other words, I am concerned with the impacts and practices of psychiatrists when they function outside the private relation of physician and patient. Such functioning by the psychiatrist is called for by situations in which a person who presents psychiatric problems happens also to be in conflict with other persons to such an extent that the community is involved, either at present or prospectively. In such situations, a significant interaction between the perspectives and practices of medicine and law takes place.

Psychiatry and *law* specify two areas of social process in which members of the society seem to experience exceptional difficulties in the pursuit of their objectives. This is one of the factors which brings together specialists in these disciplines. The overlapping part of the two disciplines which seems to offer the greatest problem of integration is the infliction, under their joint professional auspices—or at least with their joint participation—of negative sanctions (that is, criminal or other severe penalties or measures) on individuals in the name of the community.

There is a significant contemporary effort to compose the differences of perspective and of focus which have distinguished the two disciplines in facing problems of negative sanctioning in the past. For instance, the Group for the Advancement of Psychiatry has recently formulated its consensus on two of the most difficult legislative issues—the psychopathic or unreconstructable offender, and the appropriate legal concept of personal responsibility.¹ The judiciary has also, in two recent decisions, expressed what seems to be a gathering momentum

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1. The Committee on Psychiatry and Law of the Group for the Advancement of Psychiatry, *Criminal Responsibility and Psychiatric Expert Testimony*, Report No. 26; Topeka, Kansas, May, 1954.

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toward action founded on empirically-based enlightenment in regard to deviates and the alternatives open to the community in dealing with them. I refer, of course, to the recent decisions of the United States Court of Appeals for the District of Columbia in the *Durham* and *Stewart*² cases. The Court has reconsidered the old *M'Naghten* decision³ and in my opinion has demonstrated in the process that the judiciary has not lost the vitality which has long been ascribed to our common law. In the light of the scientific knowledge of their time, the English judges who rendered the opinions in the *M'Naghten* case made the same sort of effort as did Judge Bazelon, who wrote the opinions in the *Durham* and *Stewart* cases. And the fact that Mr. Abe Fortas, Mr. Abe Chayes, and other attorneys of the District Bar assigned to prepare and argue these cases, undertook a kind of research and presentation transcending the normal obligations of *amici curiae* is another expression of the same effort to put to use, within the legal context, the scientific advances of the day. The *M'Naghten* decision of the nineteenth-century English judges was viewed with alarm by many of their contemporaries, as these are today. I would suggest to contemporary viewers-with-alarm that they search their souls and consider whether, had they been living at the time of the *M'Naghten* case they would not have viewed it with comparable alarm.

The significance of this contemporary effort to compose interdisciplinary differences may, indeed, be critical, for it appears to pose problems of the same nature, if not obviously of the same magnitude, as those posed by any effort toward composing the differences between nations or cultures which do not share the same goals, identifications, and predispositions. In the contemporary world one does not, for example, find *the law*. Rather one finds a diversity of systems of law and public order. Nor does one find *the psychiatry*. One finds quite differing conceptions of the well-ordered or "healthy" personality, and of the institutional patterns most likely to produce such personalities and facilitate their most adaptive functioning. Under these circumstances, the composing of interdisciplinary differences between persons who share the same general culture and hence enjoy exceptional opportunities and facilities for communication may constitute one of the most strategic approaches to realization of the total policy of any given community.

The sanctioning processes which I have mentioned take the form of community responses to individuals who do not conform to community norms or are thought not to. But *nonconformity* is a loaded word; in its application to members of past generations it may refer to martyrs who are now regarded as having rendered their communities exceptional service, as well as to persons whose

2. *Durham v. U. S.*, 214 F(2d) 862 (D. C. App. 1954); *Stewart v. U. S.*, 214 F(2d) 879 (D. C. App. 1954).

3. *M'Naghten* case, vol. 10 Clark and Finnelly's Reports, p. 200 (British case, 1843).

contemporary designation as degenerates or criminals has failed to improve through time. For that reason I shall adopt the more neutral term *deviation*. I do not use it synonymously with *crime*. I would broaden it to include all behavior which, if not responded to by recourse to a sanction-equivalent such as a preventive welfare program, or a positive sanction such as the offer of a reward or incentive to do otherwise, touches off severe negative sanctioning of the deviate. By the same token I would exclude deviation which the given community experiences with tolerance or relative indifference.

Deviation may sometimes refer to a large continuing complex of past events—for example, a public nuisance condition such as a metropolitan slum subject to a sudden influx of rural or small-town immigrants; a home in which children are reared without parental affection or without parental example conforming to the mores of the community; or a market structure characterized by a scarcity of wanted consumer goods coupled with a surplus of consumer dollars. Or the term may refer to a smaller complex of past events, as when one speaks of a deviant personality. Or a single overt act may be described as deviant.

This three-way classification of deviation reflects three very different focuses of attention which imply quite different types of response. Given the first, one is likely to ask: What condition should be abated? Given the second: What individual should be isolated or reconstructed? Given the third: What act should be prohibited, and what deprivation prescribed for the transgressor? The difference between these questions sharpens when one considers that a deviational act may not be symptomatic of a deviational personality (for example, in the case of an accidental, situational, or transitional offender); and that a dangerously deviant personality may exhibit no tendency to overt aggression prior to his ultimate explosion into violence (for example, the overly passive, conforming "good child" who years later goes berserk and commits a few seemingly senseless murders).

There would be no occasion for this discussion if community decision-makers always laid down standards that people would live up to; or, putting it the other way around, if people always lived up to whatever was prescribed by duly constituted authority. But community spokesmen sometimes give way in the face of noncompliance. Deviates sometimes cease struggling in the face of a community's vigorous effort for enforcement. Often a precarious equilibrium is reached in which the level of noncompliance is chronic, and enforcement stays at a constant level, or fluctuates within regular limits.

The psychiatrist, as I see it, is drawn into these problems of community policy and compliance in more than one way. As a scientist, he is asked to explain the factors which significantly affect compliance and noncompliance, and to predict

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future responses to such measures as may be contemplated. As a hospital administrator, he may be put in charge of large numbers of deviates and asked to make his predictions come true. As a citizen as well as a physician, he may take the initiative and recommend that a given course of legislative action be taken by authorities on the federal, state, or local level. What then are the peculiar contributions which have been or can be made by scientific students of human behavior, and especially psychiatrists, through such roles in the making of community policies?

For purposes of such a discussion one must postulate the goal values of a given society—in this case, American society—and consider how these objectives can be implemented. In a garrison-police state, jurists and psychiatrists would presumably be required to apply their knowledge to the task of eliminating nonconformity to the commands of the dominant elite. As Americans, our preoccupation is with the no less provocative and technically difficult task of perfecting and maintaining a relatively free society.

The continuing task of legislative policy, so conceived, entails the assessment of consent and compliance. One should not expect complete accord even in the smallest groups. On a question that concerns the nation, diversity must be taken for granted. Some integration needs to be achieved and maintained among those who would push rapidly in a given direction, and those who either are opposed to the direction or insist upon a relatively retarded tempo. The political unity and strength of the people affect the national security, since disunity spells vulnerability. A decent respect for the opinions and sentiments of others is at stake—an obligation of majorities to respect minorities, and vice versa.

Some of the broad patterns of circumstance under which compliance presents a problem may usefully be distinguished at this point. One is where the deviational conduct is strongly supported by local mores, even though these local attitudes diverge from the mores of the nation as a whole; the opposition of various communities of mountain folk to federal regulation and taxation of the production and sale of distilled spirits is an example of this. A second is where there is an effective demand for legislative action on behalf of ideals of conduct that are very generally agreed upon, but which are also expected to be violated to a considerable extent in fact; gambling, prostitution, and assault with intent to kill are familiar examples of these. The condemnation in such cases is part of the predominant mores, and the deviations are counter-mores; and both are, of course, part of the culture pattern as a whole. A third situation concerns acts which are regarded by all or most of the participants in the culture as shocking and inhuman—for example, kidnapping for ransom, sexual violation, or torture of a small child. Such deviation may be regarded as being outside of the culture.

I should now like to consider some of the ways in which psychiatrists and other specialists on human behavior tend to become involved in the community process of decision in respect to these problems. Such participation by psychiatrists and members of related disciplines has a long history. Acting as individuals or as members of professional associations, they have often added to the stream of intelligence which has formed the basis for the appraisal of the results of policy. The recent *Durham* decision, and the decision in *State v. Jones*⁴ in 1871, are examples of this. Often they have recommended legislative action, as in the case of the report on legislation pertaining to psychiatrically deviated sex offenders by the Group for the Advancement of Psychiatry.⁵ In connection with the public prosecutor, the courts, and institutions of punishment and correction, many psychiatrists have long performed an almost daily role in applying and shaping legal policy prescriptions in particular cases.

The doctrines and findings of psychiatry are peculiarly pertinent to legislative policy in several ways. In some instances, a recommended or prescribed law or policy is flatly contradicted by scientific findings. The punishment of alleged witchcraft is one historic example of this. Today, while the issues tend to be more subtly phrased, there are still occasional demands that the community impose suffering in the name of retribution. If the proposition is advanced that suffering will discourage the recurrence of certain deviations, this can be empirically tested; but often it seems clear that suffering is being advocated as an end in itself. When the sources of authority for such a view are alleged to transcend the data of observation, the scientist can only register agnosticism. He can also raise some doubt about any conception of human dignity which is thought to require a community to impose suffering for retributive rather than purely deterrent ends. Moreover, there is, I understand, considerable clinical data bearing on persons who crave the suffering of others. The psychiatrist is presumably on still firmer ground in clarifying community problems of policy when a claim is put forward that suffering is a more expedient means of modifying deviational behavior than means not involving suffering. It is important that scientific information be made available regarding the consequences of imposing physical pain on people; and the information which the psychiatrist can contribute regarding psychic suffering—if the definition of suffering is enlarged to include guilt feelings and other acutely dysphoric conditions—is even more vital.

When it is claimed that a community is in favor of the policy, within limits,

4. This decision is reported in vol. 50 of the New Hampshire Reports, p. 369.

5. Committee on Forensic Psychiatry of the Group for the Advancement of Psychiatry, *Psychiatrically Deviated Sex Offenders*, Report No. 9; Topeka, Kansas, May, 1949.

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of using physical or psychic suffering as a primary goal of policy—that is, as an end in itself—under various circumstances, the psychiatrist presumably can contribute observations in his scientific role as to the ubiquity, depth, and localization of such alleged demands on the part of the community. While the psychiatrist is unlikely to have conducted recurrent surveys of community attitudes for this purpose, his clinical observations, however unsatisfactory as reliable samples, would seem to entitle him to be heard whenever sweeping assertions are being made about the deeper and more persistent orientations of community attitudes.

At present one of the areas where community enlightenment is called for relates to sexuality. In this domain, as elsewhere, a specific pattern of sexual conduct can be supported by a legislator, or a community, as required by God or nature. Without presuming to adjudicate this claim, the psychiatrist can explore the factors that account for the intensity with which such views are held, and can subject to the scrutiny of research whatever assertions are current about the results of various forms of sexuality.

The psychiatrist may also have a contribution to make regarding conflicts between general and local mores—for instance, a conflict as to the position of ethnic minorities. The general question arises of the conditions under which the sense of right and wrong in the larger community will accept, or cease to accept, local discrimination against such minorities. The issue is sharply focused when federal legislation or judicial action is proposed to curb such discrimination. The cost of coercion from the center in such matters is counter-coercion (and nullification) at the local level. In questions where intensities of sentiment are so great, it may appear that scientists have little to offer. But there are moderating elements in the conflict, and the findings of psychiatrists and psychologists may be counted among them. For one thing, their findings provide a rational basis for compassionate attitudes toward human prejudice. The stress that has been put upon the unconscious, the ego ideal, and the persisting effect of early experience suggests that underlying attitudes are transmitted by a social process that may handicap the person's learning. On the other hand, do not these same considerations suggest the desirability of some assertiveness in putting a stop to environmental intrusions? Such countervailing considerations appear to suggest a policy of continuous moral pressure designed to divide the conscience of the local community against itself.

Most of the everyday problems of penal, correctional, and regulatory law concern deviate individuals who fall within categories which have been intensively studied by the methods usually employed by physicians. The legal and social sanctions involved are positive or negative; they involve deprivations or indulgences in terms of any or all of the major values of the community; they vary in degree of intensity; and they involve practices that are primarily isolative or

constructive. Here as elsewhere, the making and execution of community policy is a decision-making process in which estimates and evaluations of compliance and enforcement are pertinent at every phase. As a scientist, the psychiatrist presumably conceives his special contribution to be limited to, or at least primarily to rest on, statements verifiable by observation, rather than statements of preference, particularly where the latter depend on theological or metaphysical postulates. The prediction of future responses, whether of specific individuals or of groups—up to, and including, the entire community—is therefore the essence of his contribution. Such predictions relate to fundamental questions, such as: (1) What degree of compliance immediately following the announcement of a given prescribed norm and sanction is most probable? and (2) What degree of compliance will most probably follow enforcement activities in which a specified sanction system is employed?

The significance of these questions may be clearer if I rephrase them in reference to the two broad categories of factors thought to affect conduct: the prevailing predispositions of the persons concerned at a given time; and the environment impinging upon the persons with these predispositions. The questions would then be: (1) What is the degree of noncompliance that will probably result from the predispositions which are prevailing among individuals or groups and which are not likely to be modified by any available community action short of permanent exclusion from the community by death, banishment, or detention? (2) To what extent can a given degree of enforcement activity—which is part of the environment of individuals or groups—succeed in modifying predispositions, so that a "normal" range of environmental situations can be met in a manner complying with community norms? (3) What is the probability that the environmental situations described as within the "normal" range will occur?

But perhaps the potential contribution of the psychiatrist needs no further laboring. I think it can be assumed that the greater the flow of relevant information which comes to the focus of attention of a decision-maker, the more appropriate his decision is likely to be. And I suppose it is obvious that psychiatrists and other behavior scientists have a great deal of specialized empirical knowledge and insight which is highly relevant to every phase of the community sanctioning process. What may be worth exploring at this point are a few of the differences of goals, perspectives and value orientations between psychiatrists and community decision-makers. The psychiatrist is therapy-oriented and otherwise professionally conditioned to think of his prime obligation as to his patient. There can be no quarrel with this; and no difficulties arise so long as the patient is not also a respondent in a sanctioning proceeding, or otherwise in serious conflict with others. When he is, however, the situation becomes more complicated. The community, too, is interested in the patient and in health and therapy generally, but

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its resources for the purpose are limited and hence must be used selectively; and besides, the community has a great range of other interests. If total community policy is to be served, a rather complex arbitration may be involved. To take a very simple illustration, I imagine that a psychiatrist in military service may often have to weigh the probable impact on a combat unit's morale of an otherwise indicated release of one of its members from active duty. In this situation the psychiatrist might feel pulled in conflicting directions.

Now let me suggest a situation in which there is no patient-physician relationship, but in which the psychiatrist is called upon to examine and report on a person he has never previously seen—for example, where the issue is court commitment. I shall further assume that after an examination typical under the circumstances, the psychiatrist is satisfied that this person qualifies as a potentially dangerous and aggressive psychopathic sex offender, although he has so far committed no overt offenses beyond indecent exposure. Here again are problems of conflicting values. The community—if it has enacted one of the recent types of sex offender laws—has manifested some interest in the prevention of seriously aggressive sexual offenses and some willingness to rely on expert prophecy; but the same community would, generally speaking, be very loath to authorize the infliction of severe negative sanctions on suspicion, however well-founded the suspicion might appear to be. This interest in civil liberty is manifested by the common law requirements for conviction of an attempt to commit a crime—that is, proof not merely of intent to commit the crime, or of a propensity to do so, but also of overt action reasonably adapted to that end and carried to a point where there is a dangerous probability of success. In the situation I have described—assuming that commitment, even though coercive and indeterminate, is to be to a hospital for treatment—I can imagine that many medically oriented people would be less troubled by the application of the sanction than would many of those who are litigation-oriented. I may be wrong in my supposition in this last instance, and in any event I have no impression that these allegedly preventive laws were primarily sponsored by psychiatrists.

This does, however, suggest another interesting question: Should the laws which undertake to define classes of persons who shall be subject to preventive sanctions—or, for that matter, correctional sanctions—speak in psychiatric or nonpsychiatric terms? And in what terms should the psychiatric witness who is heard on such issues be questioned and in what terms should he speak? Let me try to put it more concretely. Should the psychiatrist be asked whether a person is normal, neurotic, a psychopath or character neurotic, or psychotic? Or should he be asked such questions as the following: (1) What is the probability that this person will behave in such-and-such a fashion in the future, specifying the sorts

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of situations in which your answer assumes that he will find himself? (2) What is the probability that such situations will occur? (3) On what past events do you base these estimates? and (4) What have been your opportunities—as well as those of colleagues whose views you take into account—to validate estimates of this sort?

I raise these questions because I wonder whether the verbal categories which psychiatrists use in describing patients in the therapeutic context may not involve value judgments which, however consistent with total community policy in that context, may not be consistent with community policy in the quite different context of social and legal negative sanctioning. The difference, of course, stems from the absence of coercion in the private medical practice situation and its omnipresence in the social and legal situation.

The coercion now in question goes beyond that applied to the deviate; to the extent that it represents community intervention, it involves everyone. The laws we adopt in respect to the deviate govern us all, and the legal measures we invoke draw, directly or indirectly, on the resources of us all—both psychic and material resources. When the community deals permissively with one who has aroused anxiety in us, we are disciplined and deprived; and when the community deals retributively, there is considerable evidence that guilt feelings are engendered within ourselves. If we subject the deviate to any sort of legal supervision, we assume community responsibilities for intervening in his life. If we commit him to a hospital or correctional type of institution, we inflict him on the inmates and keepers of the institution, in addition to depriving him of the freedom of the larger community and such associations as he might enjoy, or that others might enjoy with him, in the larger community.

If these attributes of community intervention are obvious, I mention them only for their bearing on a point which I believe is less obvious. It is that a report appraising a given deviate couched in conventional medical diagnostic and prognostic terms seems to me to speak in a kind of shorthand which is no doubt appropriate and useful in the decision-making context of the private practice of psychiatry, including research, theory, and therapy. In fact, I suspect that a part of its usefulness in that context depends on its inclusion of some value judgments which, for purposes of expediency, have to be made. The psychiatrist, like everyone else, has to function within the framework of a particular culture; and there seems to be some doubt that our culture has achieved valid absolute concepts and definitions of health and disease.

But the same shorthand, if uncritically lifted over into a penal, correctional, or regulatory context, is likely to cloak a host of value judgments of a quite different

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order. If a deviate is called "psychotic," this is likely to be taken to mean that he should automatically be committed to whatever hospital or similar type of institution is available for the purpose—and presumably should be released back into the community when, thanks to shock therapy, other treatment, or perhaps sheer passage of time, he is diagnosed as no longer "disturbed." If he is arrested for some minor sex offense and called a "psychiatrically deviate personality," this is likely to be taken to mean something more than that he has problems and would benefit from psychotherapy. He may well be committed for an indeterminate period, perhaps for life, to whatever local custodial institution happens to be legally designated for the purpose, whether or not it is in fact in a position effectively to treat persons of his type. If an accused charged with a capital or other major felony who pleads irresponsibility or something less than full responsibility is called "neurotic" or "psycopathic," this is likely to be taken to mean that he is the type who should receive the maximum retributive sentence.

Thus the increasing integration of psychiatric knowledge and insight into the formation of community policy means that the psychiatrist must look at his own value judgments, his own viewpoint, and his own terminology in the light of their implications for the broader social scene. But although many such problems remain to be solved, I think that the expanding knowledge of psychiatry and the increasing participation of psychiatrists in the formation of community policy can only serve to make community decisions more enlightened, more consistent with public mores, and more capable of realistic enforcement.

NEW HAVEN, CONN.