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COMMENTARY

The Power of the Psychiatric Excuse*

SEYMOUR L. HALLECK, M.D.**

The power of the psychiatrist to influence the status quo is not confined to his work with patients or to his public pronouncements regarding abnormality. Sometimes the psychiatrist takes a direct role in helping the society make critical social decisions which effect the stability of the society as well as the privileges and freedom of some of its citizens. One of the most significant ways in which the psychiatrist exerts such influence is by excusing selected individuals from meeting certain obligations.

In a civilized society those who are severely ill are not required to meet all of their obligations. A man with a high fever will not be required to go to work. A boy with a crippling orthopedic condition will not be required to serve in the armed forces. Because our society looks upon some forms of emotional suffering as illness, we are also willing at times to excuse the emotionally disturbed from fulfilling some of their obligations. Sometimes, the psychiatrist is given the power to officially sanction such an excuse. In other instances he only recommends an excuse and the power to officially excuse rests with a judicial agency. In spite of the apparent humanitarian basis of psychiatric excuse-giving, I am convinced that this practice contributes to our social ills. Most often psychiatric excuse-giving tends to strengthen an oppressive status quo.

There are three major characteristics to psychiatric excuse-giving. The first is selectivity. Only certain individuals are offered the opportunity of obtaining a psychiatric excuse. Usually an excuse is not even considered unless the patient complains vehemently about his suffering or behaves in a bizarre or unreasonable manner. The person who suffers quietly or the person who harbors bizarre thoughts and keeps them to himself is not likely to be found eligible for a psychiatric excuse. The very act of requesting preferential treatment requires a certain degree of aggressiveness on the part of the patient or in some cases on the part of his attorney. Those who have most knowledge of the laws and who are most aware of the availability of an excuse are most likely to request an excuse and to receive it. A prestigious social position and lots of money helps. Psychiatric excuses are rarely given to members of lower socio-economic groups.

A second characteristic of psychiatric excuse-giving is that it puts

* This article comprises a chapter in a forthcoming book tentatively entitled THE POLITICAL PSYCHIATRIST (Science House 1971).
** Professor of Psychiatry, University of Wisconsin.
the psychiatrist in a situation in which he must often be dishonest in interpreting his opinions to the public. Most psychiatrists will identify with their patient and will be eager to help him avoid what both parties consider to be an overwhelming or unjust obligation. Such strong partisanship destroys the psychiatrist's objectivity. Sometimes, it is true, the psychiatrist can convince himself that his patient is too sick to assume an obligation. At other times, however, he is not certain that his patient is terribly ill but is tempted to offer a medical excuse simply because it seems to offer a rational and humane solution to the patient's problems. Even when the psychiatrist is convinced his patient is ill, he has no objective means of determining whether the illness is severe enough to have influenced the patient's conduct or capacities so that the patient deserves to be treated in a privileged manner.

The third characteristic of psychiatric excuse-giving is that it strengthens social systems. The person who is given an excuse is likely to be an individual who would have confronted the system if he were not excused. If he had been forced to fulfill his obligation, his plight would have been such that it would have engendered considerable public sentiment and concern. Once a person is excused from an obligation on the basis of being too sick to assume it, society assumes that the issue has been justly settled. And the excused person loses much of his motivation to confront the system which is stressing him. The society is then relieved of pressure to examine the oppressive nature of the obligations which it imposes upon people and can avoid facing the need to change the system which demands such obligations.

When excuses are sought from grave social responsibilities such as carrying a child to term, being punished for a crime or serving in the armed forces, the emotions engendered in all of us are usually so intense as to obscure a rational examination of what is happening. The issues involved in excuse-giving are best clarified by examining the problem from a more or less neutral standpoint. I will try to describe how the process of excuse-giving effects a relatively trivial social system, one in which the consequences of intervention are not profound, either for the system or for the individual.

Some Personal Experiences With Excuse-Giving In A Small Social System

Students at the University of Wisconsin who wish to obtain dormitory housing are required to sign a contract which obliges them to pay for room and board for a full academic year. The contract is made either with the University itself or with private owners of dormitories who have been licensed by the University to provide student housing. A certain number of students in the course of an academic year become dissatisfied with their living arrangements. Sometimes they do not like
the dormitory itself. Sometimes they cannot get along with their roommate or with other individuals on the dormitory floor. Or sometimes they make new friends of the same or opposite sex with whom they prefer to live. The student can change his residence only if he pays off his contract, sells it to another student or obtains a medical excuse from his obligation.

If a student becomes severely ill and has to leave school he is usually excused from his housing contract simply upon his request. If his illness is not severe, however, the situation requires a little more investigation. Sometimes a student will develop a severe allergy or a condition like diabetes and will need special living arrangements or special food. In such situations excuses are generally obtained painlessly. But in general, there are not many medical conditions among young people which justify breaking a housing contract. What happens most frequently is that the student who desperately wants to change his housing arrangements is tempted to argue that he is emotionally disturbed and that being forced to live in a particular dormitory is contributing to his level of emotional disturbance.

When I first began to work as Director of Student Psychiatry at the University of Wisconsin I found that it was the practice of the University Housing Bureau to honor any letter from a psychiatrist recommending that a student be excused from dormitory contract obligations. A student who wanted to change his residence had only to find a psychiatrist who would write a note to the housing authorities stating that the student was mentally ill and that if the student continued to live in that particular dormitory, he would become more disturbed. The Wisconsin situation was not unique. Many other universities have honored psychiatric excuses in a similar manner and some of them still do.

A certain number of students requested excuses directly from the University Psychiatry Clinic rather than from private psychiatrists. In reviewing their cases I began to realize that the possibility of obtaining an excuse was highly dependent upon the social and moral biases of the particular university-employed psychiatrist the student happened to see. I also came to appreciate that psychiatrists who were connected with the University Clinic were more likely to turn down a request for an excuse than psychiatrists in private practice. In effect, students who could afford to see a private practitioner had little trouble in breaking their contracts. Sometimes letters recommending excuses were written by physicians who had never even seen the student. In order to minimize inequities in the excuse-giving process I convinced the administration that all individuals requesting excuses should be examined by one individual. I persuaded them that I should be the only
person who could sanction an excuse. By making this seemingly wise and fair decision I let myself in for some bitter experiences.

When I began reviewing all of the cases I soon appreciated that those students who came to beg my indulgence were a special group. They had taken the time to learn about the housing system and were extremely aggressive in pursuing their own goals. They also seemed to be people who were used to getting their own way. Their determination to be relieved of the obligation of fulfilling their housing contract by any possible means (other than simply meeting the financial obligations to which they had agreed) could be described as relentless or grim.

A certain number of students who requested excuses did seem to be seriously disturbed. Some had been in psychotherapy and some had even been hospitalized for mental disorders. These students aroused my sympathy. But those students who did not appear to be too disturbed also aroused my sympathy. They seemed so unhappy in their surroundings and argued so convincingly that they would be happier if they could live elsewhere, that I was almost tempted to accede to their requests.

At the beginning of my tenure I was quite liberal in writing excuses. I wrote them for students who were experiencing mild depressions and anxiety attacks and because their symptoms did seem to be relieved following a change of environment I felt justified in having told the authorities that these students were sick. Unfortunately, as more and more students requested and received excuses, my policies led to the housing administrator's becoming quite irritated with me. Every time a student was excused from a contract, somebody lost money. The University was able to incur the loss without too much pain but private owners of dormitories were much more incensed.

Eventually I was forced to sharpen my criteria for offering excuses. I decided I would not recommend them unless the patient was suffering from a severe emotional disorder which seemed to be generated or aggravated by his living situation. At this point I found it was very difficult to stick to such criteria. I could not easily decide who was terribly “sick” and who was not. Some students exaggerated the degree of their suffering more than others. Some could present excellent social and humanitarian reasons for being released from an oppressive situation but these students often seemed to have relative stable personalities. I never made a decision to excuse one person or not to excuse another without feeling that it was an arbitrary decision. As I reflect upon my practices of those years, I realize that my recommendations were probably as often based on the patient's charm or aggressiveness or how I was feeling that day as it was upon any psychiatric insight. In short, my recommendations were dishonest. At varied times
I tried to lighten my burden by involving other people in the excuse-giving process so that a committee would make the final decision. These efforts neither simplified my task nor relieved my conscience. Everyone who became involved in the excuse-giving business eventually came to feel as perplexed and dishonest as I did.

In the course of listening to students and administrators I began to realize that there were a number of socially questionable practices going on in our dormitories. Some landlords had set up highly arbitrary and oppressive rules. Some seemed totally unconcerned with the emotional needs of students. Others never gave the students what they promised them. I also began to wonder if it made sense to force a 17 or 18 year old youth who might never have seen a particular dormitory to sign a contract obliging him to remain there for up to a year. Faced with these considerations and the obvious frustrations of trying to select which of many demanding students would be excused I radically altered the policy of the University Psychiatry Service. I simply legislated psychiatric excuses from dormitory contract obligations out of existence. I refused to write an excuse unless the student was so disturbed that he had to leave school. I agreed to provide the housing authorities with a psychiatric evaluation of any student who requested an excuse but I insisted that excuse-giving was not a medical function and refused to word my reports so as to provide direction to the administration.

Before making such a step, I of course discussed the problem with the University housing administrators. I told them of my frustrations and of my feelings that difficult ethical situations were merely being passed off to the psychiatrist. They were sympathetic but unmoved. When I did make my decision to withdraw from the excuse-giving process, the resistance of the housing administrators to my policy was massive. They argued that my own actions were arbitrary and disruptive, and that they could never decide which students could be excused without the benefits of medical judgments. They even for a time considered returning to the policy of honoring excuses from private psychiatrists or from other counseling services on campus. I was able to resist continued involvement in the excuse-giving business only by maintaining an attitude of unrelenting stubborness.

It is my belief that my initial willingness to give excuses to selected students prevented those students from confronting the University administration with their dissatisfaction with dormitory life and prevented the administrators from looking at the conditions which were creating dissatisfaction. When I stopped giving psychiatric excuses, many changes in the management of dormitories began to take place. The housing administrators became more aware of some of the problems in the dormitories. Students began to make more demands for changes
in their dormitories. I realize of course that some of these events were brought about by the concurrent rising militancy of students, but I am also convinced that if I had continued to serve as a source for relieving pressure in the entire student housing system, these changes would have come about more slowly. By performing what had seemed to be a humanitarian function and by disguising a social problem as a medical problem, I had actually helped the dormitory system resist reform. I had served as an agent of the status quo.

**Therapeutic Abortion**

In American society a woman who finds herself carrying an unwanted pregnancy has several alternatives. She can carry the baby to term and make the best of it. Or, she can seek out a criminal abortionist who will terminate her pregnancy for a price. Or, if she can afford it, she might take a brief vacation to a foreign country where she would have little difficulty in obtaining a safe abortion. She can also try to obtain a legal abortion in this country by proving she is sick enough to have her pregnancy terminated on medical grounds.

While the situation is rapidly changing, therapeutic abortions are still for the most part granted in this country only when doctors are willing to make a formal statement that carrying a child to term will seriously threaten the mother's survival. Only a few states, as of this writing, will sanction a therapeutic abortion in situations where the mother's health rather than her very existence is threatened. In most states doctors cannot recommend therapeutic abortions even if they have strong certainties that the child will be born defective. Nor is abortion usually sanctioned if the pregnancy is the result of incest or rape. In practice, doctors are usually willing to recommend therapeutic abortion when a woman has such a severe heart, respiratory or urinary disease that there would be a considerable risk of her dying if she had to carry the child to term. It is much harder to know if abortions are granted when there is reasonable certainty that carrying a child to term will make the mother's health worse, but will not result in her death. It is quite likely that many doctors recommend abortion in such instances, but they usually do so quietly, and also, illegally.

Conceivably a woman might be so emotionally disturbed that there would be a strong possibility of her killing herself if she were forced to carry her child to term. In such instances recommendations for therapeutic abortion are made by the psychiatrist. If the psychiatrist believes abortion is justified, he is only required to submit a written report stating that the patient's life will be gravely threatened by the continuation of her pregnancy. In most hospitals this report is unlikely to be seriously challenged by other psychiatrists, by the obstetrician who does the abortion or any type of review board.
At the present time it is very hard to know what criteria are actually being utilized in granting therapeutic abortions on psychiatric grounds. Policies differ from state to state and from hospital to hospital. Some doctors will recommend therapeutic abortion only when they are absolutely convinced that the patient is gravely ill and suicidal. Others will recommend it when there are far less ominous signs of psychological disturbance. From my own experience and from the anecdotes I have heard from colleagues, it seems clear that women who are granted therapeutic abortions are a special group. Quite frequently they are among the community elite. Not surprisingly, many are relatives of physicians. It takes a certain knowledge of the law and familiarity with psychiatrists to even know how to go about asking for a therapeutic abortion on psychiatric grounds. The poor, the uneducated and the black rarely ever make this request. For the most part, therapeutic abortion on psychiatric grounds is a privilege afforded to upper middle class whites.

When the psychiatrist writes an official report stating that a given woman will endanger her life by carrying a child to term, he is on very shaky grounds. Many women who may be seriously emotionally disturbed and who are reluctant to have a baby will never contemplate suicide. Their lives are in no danger at all. Other emotionally disturbed women who find themselves with an unwanted pregnancy will threaten suicide but it is quite difficult to evaluate the seriousness of their threats. The psychiatrist generally knows that even the woman who is sincerely threatening suicide can be treated by more traditional means without having to resort to abortion. He also appreciates that the suicidal patient, once she knew there were no other alternatives available, would probably respond well to psychotherapy, drug therapy or hospitalization.

A woman who is aware of the laws of her state and is looking for a psychiatric abortion quickly learns that she must “talk suicide” if she is to get her way. It is very easy for a person who sees herself faced with an unwanted event and who knows that illness is a way out of having to endure that event, to convince herself that she is ill. It makes little difference whether she comes to do this consciously or unconsciously. To the extent that the communication of personal suffering becomes a means of avoiding the responsibility of carrying a child to term, such a person is actually likely to feel more depressed and more suicidal. When she assumes the role of illness she will feel more sick. The psychiatrist can accelerate this process by either directly or indirectly communicating to the patient that she must present grave signs of illness before he can recommend abortion.

Many psychiatrists recommend therapeutic abortion for entirely humanitarian reasons even when they are not convinced that the patient
will destroy herself. But to do this they must state somewhere in their report that the patient is suicidal. To salve their professional consciences, such psychiatrists must in effect play a game with the patient in which they subtly teach her (and usually she is an apt pupil) to be as sick as she can and to say the right words ("I'll kill myself if I'm forced to have this baby.") before they are willing to write a psychiatric excuse. Once the patient has gone through a convincing display of her "illness" she can have her abortion. A few doctors who are in a sense more honest about their dishonesty will be even less scrupulous in documenting the need for abortion. They will simply say that a woman is suicidal even when they know she is not.

There are many reasons why a woman might not want to bring a child into this world. Children may be an economic or psychological burden. Sometimes the birth of an additional child within a family or the birth of a single child out of wedlock can make a previously adequate life seem intolerable. Many mothers bring unwanted children into the world. A good many of these mothers if they had been aware enough and determined enough could probably have convinced psychiatrists that they were too sick to carry their child to term. For every woman who receives a psychiatric abortion, there are probably a dozen others whose plight is more tragic and whose emotional handicaps are more serious. Viewed in this light, therapeutic abortion is not a medical problem but a moral problem. No psychiatrist if he is honest with himself will attest to skills which will enable him to distinguish between the selfish, the practical, the idealistic or the irrational motivations which bring a woman to request therapeutic abortion. Nor can he describe any scientific criteria which tell him which unhappy woman should have her pregnancy terminated and which should not. When he recommends that abortion should be granted, he usually lies. It is a kind lie, a dishonesty intended to make the world a little better, but it is still a lie. Consider the following case.

A 24 year old woman came to see me requesting a therapeutic abortion. She was in her third month of pregnancy. The possibility of receiving a therapeutic abortion was brought to her attention by her psychiatrist who had been treating her in conventional psychotherapy for about six months.

She was one of six children raised in a poverty stricken unhappy home. As a child she remembered herself as having been shy and frightened most of the time. Her father drank heavily and at times would beat the children. Her mother was an intensely religious woman who repeatedly harangued her children as to the virtues of piety and chastity. When the patient was 13 years old her father left the home. At this time she came to be even more strongly dominated by the mother's puritanical influence.

Surprisingly, the patient did well as a student and was the
only member of her family who managed to finish high school. She worked as a secretary for two years, saved her money and entered a teachers college. By virtue of continuing to work nights and by saving every penny, she eventually managed to obtain a teaching certificate and began working as an elementary school teacher in a rural district. By this time the other children had left home and the patient was the sole support of her mother. After a year of working as a teacher she began to feel depressed. She had few friends and rarely had the opportunity to go out with members of the opposite sex. When she began to experience crying spells she consulted a psychiatrist. During the course of her therapy she began to feel more confident, overcame some of her shyness and started to date a few men. On one of these dates she encountered an aggressive man who managed to get her intoxicated and proceeded to forcefully have intercourse with her. This was the patient's first and only sexual experience and she became pregnant.

The patient knew that if she carried the baby to term she would lose her job. There was no other source of financial support. She also feared that because of the moralistic attitude prevalent in her community, that it would be extremely difficult for her to ever obtain another teaching job. She had no idea of what she would do with the baby. It seemed unlikely that her mother would help her. In fact she feared that her mother would totally reject her.

When I interviewed the patient I was very much aware that she was experiencing profound emotional anguish. At the same time, however, I was impressed with her character and her psychological strength. At no time did she threaten suicide. She was only mildly demanding and certainly not histrionic. There was little doubt in my mind that she would not commit suicide but I was also concerned with the deep tragedy of her situation.

The position I found myself in with this patient was not too different from that which the psychiatrist usually encounters when he evaluates patients for therapeutic abortion. The most humane and decent thing I could do was to recommend abortion. Yet, this recommendation would have to be a lie. I had the choice of lying outrightly and saying that the patient was suicidal (which she was not) or I could have trained her to talk about suicide and thus have bribed my conscience a little. Whatever I did in this situation would have been morally wrong.

In addition to having to compromise his own morality, the psychiatrist who recommends therapeutic abortion must also be concerned with the effect of his recommendation upon the patient. Many patients who request therapeutic abortion do not have the personality strengths of the patient I have discussed. Granting excuses to emotionally disturbed individuals may, in the long run, be harmful to them. While the danger of depression following a therapeutic abortion is probably not great, the learning experience involved in obtaining a psychiatric excuse from meeting an obligation may be quite damaging. The ex-
cused patient in effect learns to use her "illness" as a means of avoiding similar kinds of obligations. She also learns to view herself as a person who should not be held responsible for her actions.

Even though the psychiatrist who helps a woman obtain a therapeutic abortion may view himself as performing a humane act, the overall impact of such excuse-giving upon the social order does not favor humanistic goals. Helping a few women find an easy way out of a social obligation is of no help whatsoever to the millions of women who risk their lives in the hands of criminal abortionists or who bring unwanted children into the world. Furthermore, the selected granting of therapeutic abortions is in effect a safety valve, or mechanism for neutralizing some of the forces which would otherwise confront the existing system with the need for social change. If the society had to witness the tragedy of highly disturbed women bringing unwanted children into the world, they might examine the total issue of any woman bringing an unwanted child into the world. If women of position, sophistication and power were not able to easily rid themselves of unwanted pregnancies, they would be more tempted to fight to change existing abortion laws. If physicians could not occasionally salve their consciences by legally aborting some of their patients and friends, they too would be more willing to fight to change existing abortion laws. The very presence and use of therapeutic abortion laws serve as a kind of social opiate. Excuse-giving masks the pain but it does nothing to cure a malignant social process.

A number of psychiatrists, social scientists and attorneys have argued that our society should liberalize its laws governing therapeutic abortion. They insist that if abortion were granted when pregnancy represents a threat to the mother's health or when pregnancy was the result of incest or rape, the problem could be handled in a convenient and humane manner. Yet, the experience of a state like Colorado, a state that has initiated such a liberal law, has not been salutary. In Colorado, therapeutic abortion for psychiatric reasons has continued to be available only to a limited segment of the population. Permission for abortion is still dependent on the liberalism and benevolence of the particular examining physician. Sometimes the decision to permit or not permit an abortion has been determined solely by the number of cases which the local hospital could comfortably handle. Psychiatrists have still had to be less honest in speculating as to the effects of childbearing on mental health. And some are completely disillusioned with a liberalized system that may have served to obscure social problems even more powerfully than the older, more restrictive systems.

A number of physicians, attorneys and legislators have come to an obvious conclusion. They believe that every woman should have the right to have an unwanted pregnancy terminated. They insist that
rules governing abortion should not be part of the criminal law but that decision for abortion should simply be made by the patient and a qualified doctor. They recommend (and in a few states have actually passed) legislation which allows for abortion upon the patient's request providing a doctor believes that such a procedure will help and not harm the patient. This seems to be an indirect but effective means of legalizing abortion. Our society is in desperate need of such legislation in all fifty of our states. We are also in need of sufficient facilities to provide the opportunity for abortion to the poor as well as the rich. Unfortunately, even those states that have in effect legalized abortion have not provided the funds or the personnel which would make quick, inexpensive abortions available to all citizens. No woman should have to go through the experience of having a criminal abortion or of bringing an unwanted child into the world. Nor should she have to humiliate herself by labeling herself mentally ill and non-responsible in order to spare herself the first two agonies.

Criminal Responsibility

In order for a person to be found guilty of having committed a crime, there must be proof that he intended to commit a crime. Our society has always been guided by the principal that it will not punish where it cannot impose blame. Without criminal intent or "mens rea" an offender cannot be designated a criminal. Illegal acts can be committed without intent. Sometimes the legal code is violated as a result of accident. Sometimes a person may commit a crime under duress or in self defense. And usually a child under seven is not considered to be mature enough to have developed criminal intent.

Since the 17th century society has accepted the belief that some individuals who break the law are so incapacitated or deranged by mental illness that their criminal behavior cannot be viewed as intentional. An effort has been made to excuse such disturbed offenders from assuming responsibility for their criminal actions. In most jurisdictions the rule by which a mentally disturbed person is adjudged mentally responsible or non-responsible is derived from 19th century English law. The rule enunciated in the McNaughten Case over a hundred years ago states that, "To establish a defense on the grounds of insanity, it must be clearly proved that at the time of committing the act the party accused was laboring under such a defect from disease of the mind as not to know the nature and quality of the act he was doing or if he did know it, that he did not know he was doing wrong."

Various alternatives to the McNaughten Rule have been proposed, the most notable of which was enunciated in 1954 by Judge Bazelon, Chief Justice of the United States Court of Appeals in the District of Columbia. In ruling on the case of Monte Durham, The Court of Appeals
said; "The rule we now hold is simply that an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect. We use 'disease' in the sense of a condition which is considered capable of improving or deteriorating. We use 'defect' in the sense of a condition which is not considered capable of either improving or deteriorating and which may be congenital or the result of an injury or the residual effect of the physical or mental disease."

The Durham Decision although initially hailed as a progressive step by psychiatrists, has never gained much popularity in this country. The McNaughten Rule or the so-called "right or wrong" test is still the commonest rule used to determine whether selected offenders should be given a psychiatric excuse from criminal responsibility.

Psychiatric excuse-giving for criminal responsibility has received a great deal of public attention. In this instance the psychiatrist must appear in court and carry out his work in public. He will be cross examined by hostile attorneys. Often psychiatrists will openly take adversarial positions, some arguing that an offender should be excused and some arguing that he shouldn't. Any disagreement between psychiatrists is likely to receive considerable publicity.

The public spectacle of the insanity trial, in providing superb emotional and intellectual diversion for the public, also exposes the psychiatrist at his worst possible moment. More often than not he ends up looking like a fool or a charlatan. Psychiatrists regularly find themselves forced to take theoretical positions which contradict the conceptual basis of their practices outside of the courtroom. Other participants in the proceedings are equally frustrated. Lawyers and judges find psychiatric pronouncements confusing and sometimes unintelligible. And the disturbed offender rarely receives the kind of treatment that would enable him to return to society as a free and useful citizen. No matter how it comes out, the insanity trial rarely leads to any sort of humanistic accomplishment.

Perhaps the whole system would be more tolerable if the opportunity to obtain a psychiatric excuse for a criminal act were available to all men regardless of race, social or economic status. Unfortunately most disturbed offenders never have the opportunity to raise the plea of not guilty by reason of insanity. Unless there has been a spectacular crime involving murder or extreme violence, even the most disorganized offender is unlikely to be advised to plead not guilty by reason of insanity. Even when the potential consequences of a conviction are grim, the plea of not guilty by reason of insanity will not always be raised. The personality disturbance of the offender is not likely to be the major factor which determines the use of this plea. The availability of forensic psychiatrists, the laws of the state, the attitudes of the community or the offender's social or economic class may be
more critical variables. In many jurisdictions, for example, it would be quite unlikely that an uneducated negro would plead insanity and even more unlikely that he would be found not guilty by reason of insanity.

As in the case of therapeutic abortion, the psychiatrist has no scientific guidelines to help him determine who should be excused and who should not. In the insanity trial the psychiatrist must judge an offender's responsibility for a particular act. The assignment of personal responsibility is more correctly based on philosophical or moral rather than scientific considerations. Every citizen has an opinion about this issue and it is unlikely that psychiatrist's training or experience provides him with any special expertise. In some ways the psychiatrist has more difficulty in making decisions about personal responsibility than the ordinary citizen. As a scientist the psychiatrist may be a hard determinist but in his day to day practice he knows that if he is ever going to help people overcome their difficulties he must constantly implore them to assume responsibility for their actions. When treating patients the psychiatrist tries to teach them to be totally accountable for their thoughts, actions and dreams. This is true even when the patient is considered to be mentally ill and even when his behavior is believed to unconsciously determined. It is only when the psychiatrist enters the courtroom that he is asked questions which tempt him to forget his own teaching.

What seems to happen in the criminal insanity trial is that psychiatrists of different value orientations examine the same patient and agree about psychiatric questions but disagree about moral questions. Psychiatrists generally agree when asked about the nature of the offender's disturbance and about the kind of treatment which might lead to his rehabilitation. When they are asked to comment upon the question of the offender's responsibility for his behavior, however, psychiatrists answer this question in terms of their own belief systems. The psychiatrist who is politically liberal, psychoanalytically oriented and deeply concerned with social justice will be more likely to find a given offender non-responsible than the psychiatrist who is more politically conservative, more biologically oriented and more concerned with individual rights and privileges.

To excuse a criminal offender the psychiatrist must somehow find a way of relating the highly arbitrary concept of mental illness to the philosophical concept of responsibility. The legal rules which are supposed to guide the psychiatrist to a rational definition of this relationship are based on a presumption that mental illness is a clearly definable entity. I and many other psychiatrists have repeatedly emphasized that it is not. Even if we had more objective criteria for determining mental illness we would still have no means whatsoever of determining
whether those we call mentally ill either regularly or even occasionally fail to recognize the moral implications of their behavior. The McNaughten and Durham Rules are based on totally erroneous notions of the nature of human suffering. Actually there is probably a stronger case for arguing that social factors such as poverty or race, whose effects are easier to study and measure, should be given more weight in mitigating responsibility than the weight currently given to psychological factors.

When a psychiatrist testifies in a criminal insanity proceeding he must either deceive himself or he must deceive others. Probably the majority of forensic psychiatrists deceive themselves. Many believe that mental illness is an affliction and have convinced themselves that their expertise in human behavior enables them to determine at precisely what point one is ill enough to be non-responsible. Other psychiatrists know better, but they will participate in insanity proceedings for the sole purpose of pursuing humanistic goals. Sometimes they agree to testify in order to help the offender avoid the death penalty. Usually the psychiatrist who testifies on the side of the defendant has a strong commitment towards tempering the harshness of punishment in general.

As is the case with excuses for pregnancy, the psychiatric excuse for criminal behavior also helps to preserve the status quo. Finding selected offenders non-responsible and sometimes non-punishable is in a sense a "liberal" solution to a social problem. It represents a shabby compromise which permits efforts to temper the harshness of punishment for a few mentally disturbed offenders but which allows the society to ignore the plight of the mass of offenders. Like most compromises with oppressive systems, it has failed to yield much humanistic gain. By investing an incredible amount of energy in trying to help a tiny group of offenders, psychiatrists have done little more than lend our correctional system a deceptive facade of decency. When the psychiatrist helps the insane offender escape punishment, he actually strengthens the current system of correctional justice. The public, spared the agony of watching the mentally ill be punished, is more willing to tolerate the merciless and irrational abuse directed towards the ordinary offender.

An enormous amount of psychiatric zeal and energy has been invested in the issue of criminal responsibility. This unfortunately has drained the profession's attention away from the more critical issues of reforming our current system of correctional justice and of treating offenders. The contribution of psychiatrists to reform in our correctional system is not remarkable. This is largely because we have diverted our attentions to what seems to be a humanitarian pursuit
which turns out to be nothing more than activity which strengthens the status quo.

So much energy has been invested, so much emotion spent and so much talent wasted in dealing with the issue of criminal responsibility that one observer has referred to it as psychiatry's "Viet Nam." The solution of this problem seems little different from what seems to be (at least as I write this in the Spring of 1970) the most expeditious solution to the Viet Nam War. We should immediately withdraw.

If the psychiatrists simply withdrew from any involvement in determining criminal responsibility, neither they, the law, nor the mass of offenders would suffer. Psychiatrists would then have the opportunity to divert their interest to the more important questions of treating offenders and of trying to create a more humane correctional system. Those administrators of our correctional system including attorneys, would have more awareness of and more time to deal with the real issues of crime in our society. Perhaps a few offenders would suffer if they could not find a psychiatrist to testify they were insane. This might be a critical factor in those instances in which criminal conviction could result in the offender's death. But it must be noted that the death penalty has not been carried out in American society for a long time. Nor would those offenders who were given long prison sentences be worse off than they are now. Many offenders who are found insane spend almost as much time in custodial institutions as those who are found criminal. Furthermore, if we tried to make real reforms in our correctional system, no offender would ever have to spend an inordinate amount of time in any dehumanizing environment, whether it be called a hospital or a prison.

Withdrawal from the criminal insanity trial would not deprive the psychiatrist of an important role in the correctional process. If it were assumed the goal of society was to rehabilitate all offenders who could be helped and to control all those who were dangerous to the society, the psychiatrist could be used as a resource person whose advice would serve the judge or jury in the question of disposition. If punishment were not the major issue, all offenders, including those believed to be emotionally disturbed could be tried in court for the sole purpose of determining if they had actually committed an illegal act. Mental illness would not mitigate criminal intent. All persons found to have committed a crime (except for where mens rea does not exist for reasons other than mental illness) would simply be considered fully responsible. Psychiatrists and other behavioral scientists would then be able to confine themselves to the legitimate role of treating offenders and of assisting society in determining what is to be done with the offender.
Psychiatry and the Draft

Decisions to excuse selected individuals from the obligation to serve in the armed forces are generally made by physicians employed by government agencies. These doctors are quite likely, however, to be influenced by communications they receive from other physicians. If the patient's own doctor, for example, sends the induction center a letter stating that the patient has a serious heart ailment, the draft board physician will be likely to respect that advice and examine the patient carefully. A similar situation exists with regard to psychiatric excuses. If a young man appears for a selective service physician examination with a letter stating that he has a mental illness which makes his capacity in the military forces seem questionable, that young man will receive special medical attention. His chances of being excused from military service will be far greater than that of the average "draftee".

There have probably always been questionable uses of medical and psychiatric excuse-giving with regard to military service. The issues raised by such practices however seem most agonizing in the highly unpopular Vietnamese War. In the last five years I have not had a male patient eligible for military service who did not ask me to assist him to stay out of the service. Every day someone comes in to our clinic requesting assistance in avoiding his military obligations. Like any other psychiatric excuse, the excuse from military service is most likely to be granted to the sophisticated, to the aggressive and to the wealthy. To receive such an excuse, one must know something about how draft boards operate, one must be willing to approach a psychiatrist, one must be willing to define some of his problems in living as an illness, and often one must have enough money to stay in therapy long enough to convince the psychiatrist that he is disturbed.

One of my patients who returned from his physical examination and was found unsuitable for military service, at least partly on the basis of the letter I had written for him, expressed the situation as follows: "It was awful. There were about 20 of us who asked to talk to the psychiatrist to try and convince him we were unfit. And some of those guys really looked pretty sick and messed up. But it was only the three of us who had letters who got out. The ones who didn't have a letter from a psychiatrist never had a chance."

It is hard to know what makes a draft board accept one candidate and reject another. It is also difficult to know how they evaluate letters from psychiatrists. Some psychiatrists will write letters in which they plainly state that their patients are too sick to serve in the armed forces. Others, like myself, will rarely say anything more than that a patient is in therapy and that it might be useful for all concerned to have him examined by a psychiatrist. In my own experience, almost
any kind of letter from a reputable psychiatrist seems to have a pronounced effect in helping the young person avoid his military obligation.

The process of excuse-giving with regard to the military services has agonized and corrupted the psychiatric profession. Many psychiatrists strongly oppose the war and will do whatever they can to help their patients from risking their lives in what patient and doctor alike, view as an immoral conflict. It is likely that some psychiatrists have lied in order to help their patients escape the draft. If he is not biased the psychiatrist finds it difficult to make an honest determination that a given individual is too emotionally disturbed to serve in the military. Quite often the patient's emotional disturbance is itself created by a fear of military service. When the patient requests an excuse, the psychiatrist can, as I have chosen to do, write only a very neutral letter suggesting that draft board physicians themselves make a determination of the candidate's suitability. In the words of our youth, however, this is a "cop-out." It does not absolve the psychiatrist's guilt. He is still contributing to the very selective excusing of some individuals who happen to have been born under more fortunate circumstances than others.

While the psychiatrist who provides excuses to young men wishing to avoid military obligations may feel that he is striking a blow against the establishment and furthering radical reform, his efforts actually help the selective service system to function with greater stability and smoothness. The young men who are deferred for psychiatric reasons are those who would have confronted the system. Often they hold radical viewpoints to begin with. When they are deferred those who run the system are able to comfort themselves with the thought that they are simply keeping out people who are unfit for service and they may also feel reassured that it is the radical student who often seems unfit. Our population is large enough so that there are still enough young men who can be drafted to fight the war. By selectively excusing a few, psychiatrists have contributed to the situation in which useful confrontation and dissent have been avoided. There is also reason to question whether we have helped those patients who have used our services. One cannot help but wonder if they would have been better off in the service, in a foreign country or by fighting their cause and going to jail.