# PSYCHIATRY AND BEHAVIORAL SCIENCE SECTION PRIZE WINNING PAPERS

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## Theoretical Difficulties in the Treatment of Mentally Ill Prisoners

**REFERENCE:** Schultz-Ross, R. A., **"Theoretical Difficulties in the Treatment of Mentally Ill Prisoners,"** *Journal of Forensic Sciences*, JFSCA, Vol. 38, No. 2, March 1993, pp. 426–431.

**ABSTRACT:** Work as a psychiatrist in a correctional setting involves a difficult interface of the theories of psychiatry, the law, and corrections. The coexistence of models of punishment, rehabilitation and mental health treatment in this work create ethical and practical challenges for the psychiatrist. The lack of a singular or clear theoretical framework may contribute to a potential for countertransference issues to play a determinant role in psychiatric decisions. These difficulties are based on the intersection of the theoretical issues involved.

**KEYWORDS:** psychiatry

The practice of psychiatry within the criminal-justice system is a particularly difficult one. It is likely that the problems encountered in any given setting have much to do with issues primarily applicable to that locality. Nonetheless, many of the challenges are a result of broader issues that apply to all correctional settings. Work in a prison or forensic hospital involves the interface of psychiatry, law, and corrections. Psychiatry and the law are derived from very different sources, and the theories upon which each is based differ markedly. This paper examines the theoretical basis of difficulties inherent in the work of a psychiatrist in a forensic setting. These difficulties have direct bearing on the performance of clinical and evaluative functions.

### Legal Theory vs. Psychiatric Theory

The first and foremost theoretical gap for the forensic psychiatrist is the difference between law and psychiatry [*1*]. While each of these disciplines has a rich and broad history, some basic differences in outlook may be summarized for the purposes of this paper. American law has its roots predominantly in English common law, which is broadly based on feudal law and Christian doctrine. The law is based on a strict definition on right and wrong, with little allowance for an intermediate zone of partial truths. The defendant is usually found guilty or not guilty, even the existence of the "not guilty by

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reason of insanity" or "guilty but insane" verdicts reveals the difficulty inherent in placing mental-health precepts in legal constructs. While not all psychiatrists who work in a correctional setting testify, those who do observe the structured framework of testimony that is a sharp contrast to the usually informal seminars or team meetings common in clinical psychiatry [*2,3*]. Furthermore, the law is a rigid system that is steeped in the traditions of English procedure. Perhaps most saliently, it is an adversarial system in which two sides take up "arms" and it is hoped that right will prevail [*4–6*]. While there are deep rifts between the psychodynamic and biological outlooks on psychiatry, care is usually provided in a model based on an alliance between the practitioner and the patient, and an attempt at consensus in the staff.

Thus, the law is a system based on absolute judgments. Psychiatry is a more equivocal and abstract science. The law is based on structured procedure, psychiatry is conducted in more informal collegiality. Also, the law pursues a conclusion through the collision of two antithetical sides—only one prevails. Psychiatry may trace some of its roots, through Freud, to the Hegelian dialectic, in which opposing forces may merge to form a synthesis. Clinically, psychiatrists attempt to mobilize the energy of conflict toward a more ambivalent, but productive adaptation. Procedurally, consensus is more valued than absolutism.

Psychiatry is also based in medicine, in which, perhaps, the concept of the restoration of the body to a balanced homeostasis has replaced the previous concept of the removal of "ill humours." Both viewpoints involve the idea that proper treatment will restore the patient to a basic, good state. This is an optimistic framework that differs from the delineation of guilt from innocence in the legal system, a concept perhaps based in the religious traditions of Damnation and Ascension.

More recently, psychiatry has progressed into biological research and theory, using a mechanistic reductionism in which understanding of the crucial part (neurotransmitter imbalance) is hypothesized to explain the whole (psychiatric disorder).

In order to understand the contrast of the approaches of psychiatry and the law, an example may be illustrative. A man, with a known mental illness, steals an apple. A person viewing this event from a strictly legal point of view might find that the man, if subjected to a just and proper trial is guilty (unless legally insane), and deserving of punishment. Note that what is best for the man is not addressed; the law is an arm of the society in this sense. Assuming that the apple was not stolen due to a dire need for nourishment, a Freudian viewpoint might include the observation that punishment for stealing the apple will not get at the root of the stealing, which may be a symptom of an underlying conflict [*7*]. From a biological viewpoint, questions might emerge (if this occurrence is related to the illness) about which medications might reduce this behavior, thus beginning to establish a basis for the behavior within the biological aspects of the mental disorder. While this example may seem out of context and the explanations unlikely, there is well-considered psychodynamic work explaining murder in term of conflict [*8*], and literature on the neurobiological basis of aggression [*9*].

There are two points here that are easy to miss. First, the biological and psychoanalytic viewpoints focus on the abnormal behavior, and are therefore concerned with the offender as an individual. The law, charged with a more global function, is more concerned with the protection of the rest of the citizens. Secondly, the medical position includes a tendency to view abnormal behavior as an illness or symptom, potentially requiring treatment. This statement does not mean that most psychiatrists believe that criminality is an illness. Rather, our teaching and focus is centered on symptoms and illness, so issues that are considered within our framework are viewed in this way. The law, on the other hand, considers criminal behavior illegal, thus requiring punishment or rehabilitation [*10*]. Of course, stealing is usually not considered to be a symptom of illness, except in kleptomania [*11*]. Indeed, the issues of the boundary of the applicability of the

medical model in the criminal system is frequently adjudicated; that is, the forensic psychiatrist is asked to consult with the court about whether a given patient has a mental illness within the definitions supplied by the applicable legislative body and case law.

**Punishment vs. Treatment**

Much of the correctional system is based on a tradition of punishment; many of the nonclinical personnel in correctional settings view all inmates as persons not deserving of treatment [*12*]. Yet, psychiatry is based on a treatment model [*13*]. Indeed, the medical model implies that the patient should be treated so as to improve his or her condition. Yet, the goal of improvement, or easing of suffering is antithetical to punishment. For example, an inmate may wish to be transferred from a crowded prison to a slightly more comfortable secure hospital for anxiety. The psychiatrist may not believe that the person has an anxiety disorder; the anxiety may be a result of the conditions. It is unlikely that the psychiatrist will transfer this man, even though it might be a simple way to treat his anxiety. Of course, triage issues exist here; the hospital may be full of patients with more acute need. Nonetheless, there is a disturbing conflict of interest [*14–17*]. The psychiatrist's job, perhaps, is to remove ills. Many symptoms in such settings are inevitably a result of prison conditions. Furthermore, mental illness is common in prisons, making the numbers of persons susceptible to the stress of such conditions high [*18–20*]. The psychiatrist's inability to change this basic paradigm, and his or her status as an employee or consultant to the correctional system potentially places the doctor dangerously close to an agent of punishment [*21–24*]. Kaufman, in a review of three prison systems about ten years ago, found that prison conditions contributed to mental illness, and that psychiatric care in such settings had major difficulties with conflict of interest [*25*].

**Rehabilitation vs. Treatment**

Conceptually, treatment seems to have more in common with rehabilitation than with punishment. At some level, both medicine and a rehabilitative program hope to restore a homeostatic system of improved behavior. However, the separation of these concepts in their practical application may be more profound. The legal system is focused on the crime, while the psychiatric system focuses on the symptoms or underlying illness. Criminal behavior is a predominant symptom in antisocial personality disorder, which most courts do not consider a mental illness by definition [*26*]. The symptoms of other mental illness do not involve criminality. Thus, theoretically, mental health practitioners may treat a person for their psychiatric symptoms and not for their criminality. The danger here is that an incarcerated person who is mentally ill may receive treatment for his mental condition, and not receive psychiatric treatment for the crime. This situation truly relates to the operative perspective of the individual practitioner involved. The public, it would seem, would have the mental health practitioners treat both the mental illness and criminality of the offender; it is likely that they would see a mentally healthy criminal as a hollow victory for the system. However, the practitioner is trained in the often subtle identification of the symptoms of, and the treatment of mental illness. This professional comes to the prison or forensic hospital trained in terms of these issues, and it is logical for him or her to identify and treat persons according to this training, ignoring the crime, which may or may not be centrally related to the illness. In a person found not guilty by reason of insanity, the treatment of the illness would hopefully remove the insanity, and thus the criminality. Yet, this idea is simplistic. Crime in many defendants is overdetermined, it may be based in both illness and other emotional factors less "insane." A person who hears voices telling him that his sister is an agent of the devil, and that she must be killed may be a "victim" of the psychosis, but it is not ridiculous to imagine that

he is also angry at his sister. In fact, in the traditional psychoanalytic view, psychosis may be a return to an infantile state of primary process thought, in which magical thinking and gross distortions predominate, life while dreaming or awake differ less than one would imagine [27].

These issues are related to what may be the opposite challenge of correctional treatment—that all crime is, in some way, psychologically motivated and, in the abstract, treatable. While the definitions of mental illness are often statutorily defined, and thus limit the scope of the professional's role, a more permissive view of crime is that it is the acting out of psychological conflict, and thus at least potentially remediable by mental health treatment.

The forensic mental health practitioner is caught between two extremes. On the one hand, he or she may serve the public less by limiting treatment to the strictly defined symptoms of illness, treating the insane murderer's hallucinations but not his anger. Or, he or she may feel obliged to uncover all of the psychological motivations for even the hardened career criminal, under the theoretical aegis that the maladaptive approach of crime is representative of psychic conflict.

A number of means can be used to limit the borders of this controversy, outlined here in the extreme. As already mentioned, the Courts limit or rule on the definitions of illness. Also, pragmatic concerns enter into the foray; not all prisoners can be treated by mental health practitioners. In this sense, the concept of triage enters into the argument. Which patients may benefit from the limited resources of the mental health services available?

## Treatability

Triage involves an assessment of treatability. There is little pragmatic value in treating someone who will not benefit, yet, this issue in psychiatry is a matter of judgment. Even the maligned person with antisocial personality disorder, a condition partially defined by the presence of criminality, is potentially treatable, albeit with limited success [28].

It is likely then that the judgment calls in triage may be affected by the perceptions of the individual patient by the practitioner. Any decision made with less than replicable, objective data is subject to countertransference. Correctional treatment is particularly ripe for negative feelings—the patients are people who have literally raped, murdered, and plundered. On the other hand, patients with histories of difficult childhoods, youthful presentations or other characteristics may arouse pity or a sense of caring.

There is a widely open door for countertransference to affect decisions in these settings [29], the psychiatrist may act on negative countertransference by placing the patient within more of a legally based model of deserving punishment (such as rejecting the patient as not mentally ill), or may act on positive countertransference by ensuring treatment.

## Conclusion

The psychiatrist who works in a correctional setting faces a number of challenges based on the theoretical differences between psychiatry and the law. He or she works within a system of punishment; it may be deceptively easy to become an agent of punitive action if the psychiatrist assumes a role in correctional decision-making. Even the interface with the concept of criminal rehabilitation is problematic, the psychiatrist is caught between the extremes of treating only the circumscribed symptoms of overt mental illness, thus ignoring the potential treatment of the crime itself, or attempting to treat the the common psychological antecedents to crime in inmates without actual, discrete mental illness. In attempting to become realistic within these distant extremes, the psychiatrist is forced to use triage, thus treating the most treatable prisoners. However, it is easy for coun-

tertransference issues to enter. The psychiatrist may use a constricted model of mental illness and not treat a patient who evokes negative countertransference, or may invoke a more permissive psychiatric model in order to justify work with a patient who evokes a positive countertransference.

## References


[1] Gibson, J. M. and Schwartz, R. L., "Physicians and Lawyers: Science, Art, and Conflict," *American Journal of Law and Medicine*, Vol. 6, No. 2, 1980, pp. 173–182.

[2] Appelbaum, P. S., "The Role of the Mental Health Professional in Court," *Hospital Community Psychiatry*, Vol. 36, No. 10, 1985, pp. 1043–1044.

[3] Diamond, B. L., "The Psychiatrist As Expert Witness," *Psychiatry Clinics of North America*, Vol. 6, No. 4, pp. 597–609.

[4] van der Vyver, J. D., "A Legal Perspective of the Concept of Life," *Medical Law*, Vol. 9, No. 1, 1990, pp. 675–683.

[5] Mitchell, C. N., "Legal Restraint, Happiness, and Anxiety—Parallels Between Utilitarianism and Psychiatry," *International Journal of Law and Psychiatry*, Vol. 10, No. 3, 1987, pp. 261–281.

[6] Tancredi, L. R. and Weisstub, D. N., "Law, Psychiatry, and Morality: Unpacking the Muddled Prolegomenon," *International Journal of Law and Psychiatry*, Vol. 9, No. 1, 1986, pp. 1–38.

[7] Macklin, R., "A Psychoanalytic Model for Human Freedom and Rationality," *Psychoanal Q*, Vol. 45, No. 3, 1976, pp. 430–454.

[8] Bromberg, W., *The Mold of Murder, A Psychiatric Study of Homicide*, Grune & Stratton, New York, 1961.

[9] Tancredi, L. R. and Volkow, N., "Neural Substrates of Violent Behavior: Implications for Law and Public Policy," *International Journal of Law and Psychiatry*, Vol. 11, No. 1, 1988, pp. 13–49.

[10] Moore, M., "The Relevance of Philosophy to Law and Psychiatry," *International Journal of Law and Psychiatry*, Vol. 6, No. 2, 1983, pp. 177–192.

[11] Goldman, M. J., "Kleptomania: Making Sense of the Nonsensical," *American Journal of Psychiatry*, Vol. 148, No. 8, pp. 986–996.

[12] Kropp, P. R., Cox, D. N., Roesch, R., and Eaves, D., "The Perceptions of Correctional Officers Toward Mentally Disordered Offenders," *International Journal of Law and Psychiatry*, Vol. 12, No. 2–3, 1989, pp. 181–188.

[13] Nelson, S. H. and Berger, V. F., "Current Issues in State Mental Health Forensic Programs," *Bulletin of the American Academy of Psychiatry and Law*, Vol. 16, No. 1, 1988, pp. 67–75.

[14] Liss, R. and Frances, A., "Court-Mandated Treatment: Dilemmas for Hospital Psychiatry," *American Journal of Psychiatry*, Vol. 132, No. 9, 1975, pp. 24–27.

[15] Eisemann, R., "Six Problems of a Prison Psychologist: A Personal Account," *Psychological Reports*, Vol. 67, No. 3, pp. 755–761.

[16] Wilson, G. L., "Psychotherapy with Depressed Incarcerated Felons: A Comparative Evaluation of Treatments," *Psychological Reports*, Vol. 67, No. 3, pp. 1027–1041.

[17] Miller, R. K., Maier, G. J., Van Rybroek, G. J., and Weidemann, J. A., "Treating Patients 'doing time': A Forensic Perspective," *Hospital Community Psychiatry*, Vol. 40, No. 9, 1989, pp. 960–962.

[18] Cote, G. and Hodgins, S., "Co-Occurring Mental Disorders Among Criminal Offenders," *Bulletin of the American Academy of Psychiatry and Law*, Vol. 18, No. 3, 1990, pp. 271–281.

[19] Thorburn, K. M., "The Corrections Department: The Forgotten Branch of the Mental Health System," *Hawaii Medical Journal*, Vol. 48, No. 3, 1989, pp. 91–92.

[20] Arboleda-Florez, J. and Holley, H. L., "Criminalization of the Mentally Ill: Part II. Initial Detention," *Canadian Journal of Psychiatry*, Vol. 33, No. 2, 1988, pp. 87–95.

[21] Tancredi, L. R. and Edlund, M., "Are Conflicts of Interests Endemic to Psychiatric Consultation?" *International Journal of Law and Psychiatry*, Vol. 6, No. 3–4, 1983, pp. 293–316.

[22] Gold, J. A., "Wiser Than the Laws?: The Legal Accountability of the Medical Profession," *American Journal of Law and Medicine*, Vol. 7, No. 2, 1981, pp. 145–181.

[23] Jemelka, R., Trupin, E., and Chiles, J. A., "The Mentally Ill in Prisons: A Review," *Hospital Community Psychiatry*, Vol. 40, No. 5, 1989, pp. 481–491.

[24] Silfen, P., "Prison Psychiatry: Medical or Correctional Discipline?" *Med-Law*, Vol. 4, No. 3, 1985, pp. 239–249.

[25] Kaufman, E., "The Violation of Psychiatric Standards of Care in Prisons," *American Journal of Psychiatry*, Vol. 137, No. 5, 1980, pp. 566–570.

[26] Bloom, J. D. and Rogers, J. L., "The Legal Basis of Forensic Psychiatry: Statutorily Mandated Psychiatric Diagnoses," *American Journal of Psychiatry*, Vol. 144, No. 7, 1987, pp. 847–853.
[27] Menninger, K. A., *Theory of Psychoanalytic Technique, Second Edition*, Basic Books, New York, 1973.
[28] Reid, W. H., "The Antisocial Personality: A Review," *Hospital Community Psychiatry*, Vol. 36, No. 8, 1985, pp. 831–837.
[29] Schetky, D. H. and Colbach, E. M., "Countertransference on the Witness Stand: A Flight from Self?" *Bulletin of the American Academy of Psychiatry and Law*, Vol. 10, No. 2, 1982, pp. 115–121.

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