Divided Loyalties: Tainted Justice and Tardy Truth

Adapted by Margaret Chisolm from a talk given by Paul McHugh in 2014 at Berry College, a version of which is being prepared for submission to a peer-reviewed journal

I

Psychiatrists such as I frequently meet individuals who presume that, through our training and clinical experience, we have acquired unique powers of perception. Often jokingly, but sometimes seriously, they report being awed - even intimidated -by our professional ability to “unmask” the hypocrisies that shape much of individual human behavior, including perhaps their own. Frequently they tell us, “You folks know the real story.”

I thought these views stemmed from such faddish idioms as Freudian slips, mid-life crisis, lifestyle etc. that people of a particular class and subculture use to speak about each other. But, because I knew the feeble foundations of these idioms and assumptions, I quickly wrote them off

I was compelled to re-visit the matter, however, when I encountered psychiatrists who, confident in their own “unmasking” skills, zealously advanced appalling diagnoses and outlandish treatment proposals. As I came to study their views, I discerned two problematic themes in play.

First: In their diagnostic and therapeutic enterprises these psychiatrists strove for justice (as they saw it) more than they strove to establish a sound truth for their actions. Justice they sought; truth they assumed.

Second: The justice these psychiatrists sought for their patients emerged, not from some straight-forward recognition of truth and error- and thus right from wrong – but rather from a subtext of suspicion they held about the fairness of the social order. This subtext often encouraged them to describe their justice-seeking efforts as collaborating with patients in fighting some veiled social oppression clear to them and those who would think similarly.

II
The epidemic of ‘recovered memories’ was my first encounter with therapy dedicated to “justice” based on an assumed “truth”. In essence adult women (and occasionally men), as patients in psychotherapy, were led to believe that their psychological problems rested upon their presumed sexual abuse as children by their parents or guardians. The patients had no memory of this and no physical evidence was presented proving this abuse but they were led to “remember” by psychiatrists and psychotherapists using the most dubious of suggestive methods.

This movement, although having tendrils into the history of Freudian psychoanalysis as Fred Crews has most clearly documented, got a running start from the publication of the book “Sybil” in 1973 in which was recounted a case of “multiple personality disorder” in which the symptoms of “multiplicity” were described as emerging after the patient was sexually abused as a child by her mother. From this one case a set of ideas was launched in psychiatry that held childhood sexual abuse to be common in families and proven by, amongst other things, the frequent presence of multiple personalities in the adults.

This encouraged psychiatrists to ‘bring out’ multiple personalities (also termed ‘alters’) in patients who came for treatment usually for symptoms emerging from standard disorders such as depression, anxiety, anorexia nervosa, and the like. Such diagnosis and treatment rested from the start on two presumptions: 1) the sexual abuse had definitely occurred but remained hidden from the patient’s consciousness by the mind’s capacity to “repress” the memories of such abuse and 2) the goal of therapy was to get those memories, now encapsulated in some of the ‘alter’ personalities, into full consciousness so as to reveal the offenses and help the patient recover both from Multiple Personality Disorder and from her blindness about her victimization.

I’ve given a full review of this strange misdirection of psychiatry in my book “Try to Remember” (Dana Press, 2008) where I concluded that thousands of families in the USA were traduced by these claims and many of the patients suffered years of serious mental disruption because of the mistaken therapy.

It took several decades of effort in clinics and courtrooms to subdue this enterprise. Highlighting its end was the publication, exactly 30 years after “Sybil,” of Richard McNally’s book “Remembering Trauma” (Harvard University Press 2003)
where the author states from evidence: ”The notion that the mind protects itself by repressing or dissociating memories of trauma, rendering them inaccessible to awareness is a piece of psychiatric folklore devoid of convincing empirical support.”

Finally in 2011 Debbie Nathan published “Sybil Unmasked” demonstrating that the book, “Sybil,” which had precipitated this movement in psychiatry was fraudulent. The patient named Sybil had not been abused by her mother and did not have multiple personality.

“Sybil” was the product of the vivid suspicions of a therapist and a collaborating author over injustices and abuse they believed to be inherent in many families. Thousands of parents were tainted by the accusation of incestuous pedophilia and child abuse and were forced to await the tardy truth that almost all of this was a social craze little different from the witch trials of 17th century Salem.

A similar exaggerated clamor for justice based on suspicions spread in an essentially epidemic fashion amongst veterans of the Vietnam War emerged around the diagnosis of Post-traumatic Stress Disorder (PTSD). This misdirection originated in beliefs of psychiatrists that many veterans of the Vietnam conflict were suffering from psychological distress due to their combat experience and that an unfair society and callous militaristic establishment encompassing the Veterans Administration overlooked and discounted this form of military injury. They held that in particular the Veterans Administration (VA) hospitals were remiss in not recognizing these symptoms for what they ‘really were’ and instead ascribing such presenting problems as alcoholism, anger outbursts, and marital/family disharmony to matters “not service related” such as long-standing personality disorders and disruptive habits.

Again the psychiatrists pushed their diagnostic proposals with vigor because they believed that great injustice was being done to American war veterans. In that process they devised a complex diagnostic approach which they pressed into the 3rd edition of the Diagnostic and Statistical Manual (DSM-III) published by the American Psychiatric Association in 1980. This diagnosis of PTSD - with its implications of chronic psychological wounds and impairments - soon became the diagnosis de jour for veterans linked in any way to the Vietnam conflict.
In 1988, using these methods of diagnosis, a National Vietnam Veterans Study carried out with government support claimed that as of that date, 479,000 of the 3.1 million Vietnam veterans still had PTSD even though the war had ended 15 years earlier. Moreover the report claimed that 1 million Vietnam veterans had experienced “full-blown” PTSD at some time since the end of the conflict. These huge numbers of psychiatric casualties provoked surprise especially given the fact that only about 300,000 men had ever seen combat during the Vietnam War.

Suspicions about the soundness of these diagnostic estimates grew when VA hospitals revealed that closer readings of the military records of their patients revealed that many with PTSD symptoms had been exposed to no potentially traumatic experiences at all during their military careers and some, rather surprisingly given that these were patients in “Veteran” hospitals, had never been in the armed forces at all.

None of this is to say that certain events do not have the potential to give rise to psychological problems and that for some these problems can be severe and disabling. It is to note that a sense of an injustice in need of rectification suffered by our veteran soldiers – a sense often accentuated in the principal psychiatrists by their political opposition to American military involvement in Vietnam – led to the overuse of one clinical diagnosis and in the process ignored other sources of mental distress and disorder in these young men and women.

Specifically two problems with the PTSD diagnosis stand out. First, the diagnostic assessment draws on many non-specific and vaguely defined symptoms such as nervousness, apathy, and discouragement. Much depends on how diagnosticians interpret words such as ‘severe’ and ‘persistent’ for the presence or absence of such phenomena.

Second, with each subsequent edition of DSM these non-descript features were so distributed amongst subheadings that many different combinations of them could justify the diagnosis. In fact the recent proposal by the editors of DSM-V suggests that some 24 different symptoms could be used to identify a case of PTSD but, as arranged, any of some 10,000 different combinations of these symptoms would “satisfy criteria” for the diagnosis.

Given these matters of assessment, in practice the diagnosis of PTSD proved prone to bias and can be judged as so common it afflicts all veterans or so rare as to be
unusual – all depending upon how those particular diagnostic modifying terms are employed and how zealous the assessing psychiatrist is as a champion of PTSD.

That zeal shows itself in many ways. The prevalence of PTSD in soldiers can be affected by political, social, and institutional attitudes of a diagnostic team. For example, if the group tends to a political opinion unsupportive of a war effort they may – as after Vietnam – exaggerate the prevalence of the disorder and no one can contradict them given these diagnostic methods. In like way if the group admires the aim and purposes of a war – as when they describe the soldiers who fought World War II as a “greatest generation” – they may minimize post-traumatic symptoms and emphasize the resilience of the veteran.

Zeal can also come from other sources. Financial benefits tied to a diagnosis of service related disability might encourage veterans to make a claim of PTSD for any and all psychological problems. Institutional interests of VA hospitals might render psychiatrists in those institutions supportive of the claims that keep the institution in “business.” This combination of financial interests helps explain why people without a military connection could find their way into the VA hospitals and make claims about combat injuries only apparent with subtle psychological assessment.

Truth was not the concern. Not only did the VA institutions often fail to seek a combat record in these subjects to justify a “trauma” generated condition, they could even fail to look for a record of service itself.

I found the attitude – “justice primarily, truth secondarily” – expressed outright in an award lecture to the American Psychiatry Association by a leading protagonist of the “recovered memory” movement.

Dr. Judith Herman in 1994 on receiving the Guttmann Award for forensic achievements by that Association described what she believes psychiatrists should do once they come to believe and have convinced their patients to believe that they were victims of sexual injuries as children that had been repressed from consciousness.

When after careful reflection our patients make the decision to speak publicly and seek justice, we will be called upon to stand with them. I hope we can show as much courage as our patients do. I hope we will accept the honor of bearing witness and stand with them when they
We remember the crimes committed against us. We remember, we are not alone, and we are not afraid to tell the truth.

This certainly is a stirring call for justice and yet later in the same talk, when she pauses briefly to think about her claims, Dr Herman adds this remarkable description of psychiatric purpose and its relation to fact,

As therapists we are not detectives. We are not fact-finders. Our job is to help our patients make meaning out of their experiences.

“Tell[ing] the truth” has apparently disappeared into some higher calling of Dr Herman – something of a problem for those parents who might want to claim that “remember[ed] crimes” never happened.

The obligation to truth dissolved in the acids of professional conviction about how mental life functions and how injustices are hidden. No one, and certainly not I, claims that Dr. Herman intended to deceive any one. Rather her stance brings to mind a statement made by President Kennedy in a commencement address he gave at Yale in 1962, “The great enemy of truth is very often not the lie - deliberate, contrived, and dishonest - but the myth - persistent, pervasive, and unrealistic.” Even myths though have sources and supports – hence my interest in a “subtext” in much psychiatry the description of which I will develop in what follows.

III

When I entered these arenas where “justice” for “victims” was decreed in such a way as to assume rather than document the ‘truth’ of their injuries, I encountered a veiled point of view inspiring the contemporary psychiatric debates, but not specifically articulated in the action that ran through them. This view stirred the enterprises while garnering support from those in the public assuming that a power for “unmasking the truth” rests amongst the skills of psychiatrists.

I’m referring to the modernist “school of suspicion” that Paul Ricoeur described. Ricoeur in speaking about the prestige of suspicion in modern thought identified three key intellectual figures who, searching different domains of human life, sought to expose the various kinds of false consciousness sustaining conformity and so illuminate the “reality” behind social appearances – the very kind of skills that some of the public
believe psychiatrists have acquired. “Three masters,” he said, “seemingly mutually exclusive, dominate the school of suspicion: Marx, Nietzsche, and Freud.” And each in their different ways provoke broad-ranging suspicions about the good faith presumptions of trust and hope ordinarily and naturally tied to such cultural structures and institutions as family, nation, and church.

Marx and Nietzsche play subsidiary roles for psychiatrists but do augment the Freudian heritage of suspicion built around his descriptions of the awesome power over the mind of the developing infant. Freud taught that families (particularly fathers) transmit to the next generation the curbs of ‘civilization’ along with such “discontents” as the repression of urges for pleasure and conflict-driven neurotic attitudes.

This interpretation of family life as a pathogenic site of domination had a long run in the mid 20th century. But, in the early 1970s these concepts were converted with little difficulty into the ideas of sexual abuse and the repression of memories.

A simple enough reversal of application of repression permitted psychiatrists to step from believing in a child repressing his or her unacceptable memory of an instinctive wish for sexual relations with the parent of the opposite sex to believing in a child repressing from memory the realization that he or she had been the abusive focus of the uncontrolled sexual actions of an instinctively trusted parent.

The “recovered memory” movement with its attached multiple personality disorder claims was a Freudian heresy in which the signal event related to sexual seduction and drive had a reversal of vector – but all else was unchanged. The traditional Freudian sequence of the child repressing “castration fears” and its later expression as general anxiety moved into believing in the child “repressing memories” of actual sexual trauma abuse and ultimately displaying Multiple Personality Disorder.

In like fashion as political conflicts over the Vietnam War led to a view of the Government and Military Services as the instruments of US capitalist imperialism and aggression, PTSD became an explanation for all psychological problems of veterans. Fighting for this diagnosis and expanding its scope became a way of identifying new victims with refractory emotional wounds and was justified as bringing such victims some compensation.

IV
But one can ask, what explains this susceptibility of psychiatrists to ‘suspicion’? What substrate of assumption led them to promote therapies that amputated from people their natural sources of affection and support – family and country?

Several authors have suggested answers to these questions. I’ve mentioned Paul Ricoeur describing the school of suspicion. Karl Jaspers in his 1913 “General Psychopathology” was first to point out how the Freudian school was extending its presumptions of suspicion beyond the bounds of what psychiatrists actually could know.

Alasdair MacIntyre in his magisterial “After Virtue” identified the ‘therapist’ as one of the stock characters of our age, who along with the ‘manager,’ strove primarily to manipulate situations for power and profit rather than for progress.

But perhaps Phillip Rieff best illuminated the issues in a series of books studying psychotherapy and therapists as they came to command authority in our culture. In “The Triumph of the Therapeutic” Rieff explains how in the “first tradition of our culture,” Judeo-Christian in nature, psychological values and life’s truths were inseparable. The task of psychological healers right through the mid-19th century was to bring personal aims and life’s meaning into a coherent and realistic relationship with one another. A “second tradition” inspired both by progress in the applied sciences and by “death of God” nihilism encouraged psychological healers and patients together to transform reality rather than conform to it and mitigate the irritations of living with whatever techniques available – persuasive talk therapy or calming medications.

Whereas the therapies of the “first tradition” rested on presumptions of faith, hope, and affection, the therapies of the “second tradition” rested upon presumptions of misaligned power and aimed at creating in the patient that sense of “well-being” to which all other duties and responses must defer.

Rieff announced the unconditional surrender of America to this second tradition in The Triumph of the Therapeutic. With such surrender the school of suspicion, now unrestrained, bore down on the time-honored bearers of authority – family, country, and church – and by taking center stage with the public could justify any therapy claiming to enhance “well-being”. Rieff did not specify all the results but the disasters of the “recovered memory” therapy and the exaggerations of PTSD are but recent manifestations of issues he perceived.
What’s the solution? First: psychiatrists need to remember that their prime aim— as with all doctors—is not first to therapeutics but first to diagnostic formulation and assessment.

This is scarcely a remarkable idea given that all human efforts in helping one another build on answers to two questions: 1) how do we tell right from wrong and 2) how do we tell truth from error. For all that the first question (telling right from wrong) has the more practical significance in everyday affairs and especially in clinical matters, its answer depends on how the second ostensibly theoretical question (telling truth from error) is resolved.

History teaches that justice follows the struggle for truth far better than truth follows the blind pursuit of justice. The latter approach has inspired witch-hunts and often generated fanatic modern examples of Captain Ahab—seeking to ferret out and destroy every white whale of untamed, undue strength even if heaven falls.

An important and classical sociological study by Max Weber makes clear just what often goes wrong in these psychiatric conflicts. In his essay “Phenomenology of Sociopolitical Actions: a methodological approach to conflict,” Weber distinguishes an “ethic of responsibility” (Verantwortungsethic) from an “ethic of conviction” (Gesinnungsethic.) In this way he called attention to how one can understand some social conflicts as derived from the fact that some people act with cautious concern for the consequences and implications of their actions whereas others act in ways inspired by personally valued ideals that are expressed, almost in emblematic way, in the action itself.

Weber’s message is that certainly in professional actions, such as those of doctors, responsibility and conviction must go hand in hand if good results are to be expected. Both responsibility and conviction call for a commitment of practitioners to standards of assessment and truth as these justify the privileges and status offered to those practitioners.

Psychiatrists may be more attuned than other doctors to cultural and political notions in those matters represent the contexts in which their patients live and to which
they respond. Occasionally a foregone conclusion is buried in the evaluation and treatment proposals of psychiatrists. The psychiatrists may succumb to their implications when proposing causes and treatments of mental distress before they have carried out an adequate study of the facts of the matters. This is at least my view of these matters and it is this view that promotes my solutions.

I hold that all psychiatrists must return to – and indeed see as an aspect of their commitments to responsibility – the standards of assessment that encourage the pursuit of truth. As it turned out demanding positive evidence of sexual abuse in the family rather than presuming it ultimately put an end to the tyranny of the “recovered memory” therapies and simple skepticism in the face of the numbers claimed put the PTSD figures post-Vietnam in a more accurate light.

But even today, we psychiatrists are not addressing the diagnostic explosion of PTSD. Our veterans are suffering. Conditions of dependency and psychological invalidism are growing in their group. Even their suicide rates are increasing without a coherent understanding of why and what could be done. Social and clinical assumptions about PTSD strive to encompass all these concerns – but fail when put to the test.

Only an insistence on a thorough assessment of the psychological make-ups, on-going behaviors, and social situations of returning veterans will differentiate them from one another and identify the many different and distinct sources of their dismay and disorder. This exercise in coherent and realistic assessment must replace the sentiments wrapped up in so many of the diagnoses of PTSD and simultaneously provide appropriate treatments and expectations to the men and women who devoted themselves to our service and protection. Right now political and social presumptions – about the nature of our wars and the “rights” of its victims – have kept these kinds of clinical understandings from evolving. We surely soon will look back at this with some shame.

VI

What then is my final message? Demand of psychiatrists bringing new “insights” exactly what you would demand of a physician or surgeon bringing a new and potentially dangerous treatment procedure – a full accounting of its risks and benefits. Stay skeptical
about the cultural idioms that come and go. See them mostly for the psychobabble they are.

Psychiatry does much good. But, it is still the most immature of the medical disciplines. Because its domain is the human mind and its motivations, psychiatry can propose and promote erroneous assumptions that attract people looking for simple answers to a daunting world. Ultimately a wholesome justice depends on foundations of truth, foundations with standards for amendment and growth. What applies the world over must eventually come to rule in psychiatry. Divided loyalties in these matters must be resolved as truth will be tardy in a suspicious realm.