Response

Our Debt to Jay Katz

Elyn Saks, M.Litt., J.D.*

Professor Jay Katz is a giant in the field of law and medicine. His particular interest in law and psychoanalysis drew many students to his classes and his office for stimulating conversation. As a person with a longstanding interest in psychoanalysis and law (indeed, I am in training now to become a "research psychoanalyst"), I turned to Jay Katz as someone to learn from and emulate. How might we best bring to bear the insights from a deep inquiry into human nature on our understanding of the law? Law requires a theory of the person, and psychoanalysis provides one of the richest that exists. Still, combining psychoanalysis with the law raises many challenges. Working at the interface of these two disciplines, Professor Katz has been a model for others interested in this endeavor. It is a deep honor to be asked to reflect on and celebrate the work of Jay Katz in this symposium

In this brief response, I focus on three things. First, I address the interesting distinction between the work of Professors Katz and Goldstein that Robert Burt has so carefully laid out. Second, I discuss how I see psychoanalysis informing Katz's work. Third, I discuss how his work has led other investigators, including me, to pursue a research agenda that probably could not even have been formulated without his influence.

I. RECONCILING GOLDSTEIN AND KATZ

Let us turn first to Burt's paper.[1] The distinction that Burt draws between the work of Goldstein and that of Katz is extremely rich and well-taken. Burt suggests that Goldstein uses psychoanalytic principles to pour content and

---

* Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences, University of Southern California Gould School of Law; Adjunct Professor of Psychiatry, University of California, San Diego, School of Medicine; Research Clinical Associate, New Center for Psychoanalysis.

1. Robert Burt, *The Uses of Psychoanalysis in Law: The Force of Jay Katz's Example*, 6 YALE J. HEALTH POL'Y L. & ETHICS 401 (2006).

HeinOnline -- 6 Yale J. Health Pol'y L. & Ethics 415 2006

meaning into indeterminate legal standards, to make them determinate so as to resolve legal disputes. To take Robert Burt's example, Goldstein suggests that the child's best interests in a custody dispute are to be placed with the person who is the child's "psychological parent." By contrast, Katz uses the insights of psychoanalysis to *create* disputes in order to complicate situations where there is seemingly the absence of any dispute. Consider, for example, the myth that doctors' and patients' interests are the same, thus obviating the need for rigorous informed consent.

Burt's distinction captures, and is meant to capture, something aspirational for Goldstein and Katz, even if their aspirations are not always fulfilled in practice. The psychoanalytic principles which Goldstein invokes may, when applied, be no less indeterminate than the general rules they are meant to explicate. For instance, the concept of a "psychological parent" can be extremely hard to apply. How many years do we look back? What if both parents are psychological parents? What if the psychological parent also poses some kind of harm to the child? What if one parent takes care of the daily needs of the child, but is emotionally cold and detached, while the other parent has poor skills in providing daily care, but is warm and connected to the child? One could propose a bright-line rule, for example, that the parent who has spent the most hours with the child in the last two years is deemed to be the "psychological parent." But, while such rules may be relatively easy to apply and certainly bind the decision-maker, they also risk getting things badly wrong.

In contrast, Katz introduces complexity at one stage of the process, but may then invoke determinate principles at another (e.g., that the patient must be willing to converse at the risk of an intervention being imposed on him or her). Conversation may be open-ended, but ultimately, if the parties cannot agree, there must be a decision and hence a rule. Yet if people know this decision rule in advance, the party whom it benefits may have less incentive to talk; conversation may be stopped in its tracks. If the outcome will (eventually) be in my favor, what incentive do I have to keep the conversation going?

What the above suggests is that if we take a temporal perspective, both Katz's and Goldstein's approaches may find their natural homes. We do not have to choose between the two, for they each are appropriate at different points in the course of a conversation. Goldstein looks at the point at which it is obvious that conversation alone cannot resolve the dispute, when the resources of conversation have been exhausted and a decision has to be made. And Katz looks at an earlier point where careful and honest searching may lead, so to speak, to a negotiated truce.

In the end, as much as Goldstein would like to resolve disputes with clear rules and little room to fudge, he cannot avoid the parties negotiating at times when the rules are unclear; and as much as Katz would like conversations to

HeinOnline -- 6 Yale J. Health Pol'y L. & Ethics 416 2006

continue and ultimately yield an agreement, he cannot avoid ending conversation at times by imposing some definitive resolution between the parties.

Finally, the differences between Katz and Goldstein may also have more to do with their normative preferences regarding the exercise of discretion by authorities than with their beliefs concerning psychoanalysis. Goldstein is worried about abuses of power and therefore attempts to articulate determinate rules, based on determinate psychoanalytic positions, which constrain authority. Although Katz is also mindful of abuses of power, he is more hopeful about the power of conversation to lead to optimal solutions.[2] Goldstein fears discretion and Katz embraces it. Ultimately, a decision to take either of these positions may turn on one's tolerance for ambiguity. But how much tolerance is optimal in this context, and for legal actors in particular, is an open question.

II. THE SILENT WORLD OF PSYCHOANALYSIS

Katz's work is thoroughly influenced by psychoanalytic ideas. A central theme throughout his work is that unconscious and irrational influences on decision-making are pervasive. This of course is Freud's central insight.[3] Also important are Katz's psychoanalytic ideas about how those unconscious and irrational processes affect the doctor-patient relationship in particular. For example, the patient may unconsciously and irrationally endow the doctor with omnipotent powers to cure him, and the doctor may have unconscious fantasies about being an all-powerful rescuer or savior. These fantasies emerge most pointedly in the course of a psychoanalytic treatment, and, as an analyst, Katz will have experienced them at close hand. A third and extremely important insight in his work is that we must apply these principles not only to patients, but also to doctors. Psychoanalysts are trained to be mindful of their own fantasies

---

2. Thus, in an especially hopeful passage, Katz writes:

> If doctors could learn, and in turn teach their patients, that it is possible to sit down and reason together about the most important personal anxieties and fears that illness and its treatment engenders, then they could also point the way to living life not by submission but by mutual respect, with careful attentiveness to one's own and the other's rationalities and irrationalities. Living the life of medicine in such new and unaccustomed ways could extend the dominion of reason and thus make doctors true healers to mankind.

JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 226 (Johns Hopkins Univ. Press 2002) (1984) [hereinafter KATZ, SILENT WORLD].

3. *See, e.g.*, SIGMUND FREUD, *The Interpretation of Dreams* (1900), *reprinted in* 4, 5 THE STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 1 (James Strachey ed. & trans., 1964) [hereinafter, FREUD, *Interpretation of Dreams*]; SIGMUND FREUD, *The Psychopathology of Everyday Life* (1911), *reprinted in* 6 THE STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 1 (James Strachey ed. & trans., 1964).

HeinOnline -- 6 Yale J. Health Pol'y L. & Ethics 417 2006

and fears as they treat patients. They must maintain their vigilance lest they fall into unwitting "enactments" with their patients.

All of the above leads Katz to propose a new understanding of psychological autonomy that takes into account the influence of the unconscious and the irrational. He is not satisfied with abstract principles, such as Kant's, that lack a foundation in both the rational *and* the irrational aspects of human nature.[4]

Finally, Katz proposes a means of accommodating the decision-making frailties he describes: a searching conversation about the patient's—and the doctor's—thoughts and fantasies. Psychoanalysis is the "talking cure,"[5] and that, in part, is what Katz wants for all physician-patient interactions. He is, of course, mindful that doctors cannot be expected to conduct a mini-analysis when they are informing patients. Yet for the analyst, as for Katz, insight is key: The truth shall set one free.

One striking thing about Katz's approach is its origins in a discipline that, until relatively recently, involved the most "silent" doctor of all—the analyst. Classical analysts are meant to be anonymous to their patients, sparing in what they will say, and neutral as to the values of their patients. Analyst neutrality is an important part of Katz's perspective. But the traditional anonymity and abstinence—which may lead to virtual silence—seem to conflict with Katz's prescription for conversation. The good analyst will be conversing with herself, so to speak, in order to be mindful of her participation in the phenomena emerging in the consulting room. But she will not reveal her thoughts and fantasies to the patient.

Even among classical analysts, of course, the "blank screen" is currently understood as somewhat mythic.[6] And there are also other psychoanalytic schools that bring the doctor's relationship with the patient into sharper focus as the agent of change.[7] There are also raging debates about how "self-disclosing"

---

4. *See, e.g.*, KATZ, SILENT WORLD, *supra* note 2, at 108.

5. *See* SIGMUND FREUD, *Five Lectures on Psycho-Analysis* (1910), *reprinted in* 11 THE STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 1, 21 (James Strachey ed. & trans., 1964).

6. See, *e.g.*, James L. Fosshage, *Toward Reconceptualizing Transference: Theoretical and Clinical Considerations,* 75 INT'L J. PSYCHOANALYSIS 265 (1994); Jay R. Greenberg, *Prescription or Description: The Therapeutic Action of Psychoanalysis*, 17 CONTEMP. PSYCHOANALYSIS 239 (1981); Irwin Z. Hoffman, *The Patient as Interpreter of the Analyst's Experience*, 19 CONTEMP. PSYCHOANALYSIS 389 (1983).

7. *See, e.g.*, JOSEPH M. NATTERSON & RAYMOND J. FRIEDMAN, A PRIMER OF CLINICAL INTERSUBJECTIVITY (1995); ROBERT D. STOLOROW ET AL., PSYCHOANALYTIC TREATMENT: AN INTERSUBJECTIVE APPROACH (1987); Howard B. Levine & Raymond J. Friedman, *Intersubjectivity and Interaction in the Analytic Relationship*, 69 PSYCHOANALYTIC Q. 63 (2000); Thomas H. Ogden, *The Analytic Third: Implications for Psychoanalytic Theory and Technique*, 73 PSYCHOANALYTIC

HeinOnline -- 6 Yale J. Health Pol'y L. & Ethics 418 2006

analysts should be.[8] It would be interesting to explore whether Katz's ideas would lead him to recommend a different relationship between analysts and patients than classical analysts have prescribed. It would also be interesting to see whether he would think disclosure is desirable in order to respect patients, even when this is not optimal therapeutically (and, to make things harder, when what is optimal therapeutically will have the effect of increasing the patient's overall autonomy).

III. OUR CONTINUING DEBT

This leads me to discuss three directions that Katz's works suggest we take, and that I and others have begun to pursue. The first is to study informed consent in Katz's very domain—that of psychoanalysis. What are psychoanalysts' practices regarding informed consent, and what should those practices be? Should analysts simply assume consent if the patient keeps coming back? Or should analysts inform patients at the beginning of treatment about the nature, risks and benefits of, and alternatives to, the treatment? Are there other or different elements of informed consent, in this context, and if so, what are they?

Perhaps most intriguing is the question whether informed consent is even possible in the psychoanalytic context. Perhaps the patient can understand, for example, transference and regression[9] only after they have already occurred, at which point it might be too late to act on that understanding since the patient can no longer easily extricate himself from the relationship with the analyst. Another important issue is whether informed consent in the psychoanalytic process is likely to be therapeutic or counter-therapeutic. Analysts' norms concerning abstinence, for example, might be such that the informed consent process would be in tension with these norms and might therefore be counter-therapeutic.

I intend to do legal, theoretical, and empirical research on this question.[10] It

---

Q. 167 (2004); Robert D. Stolorow & George E. Atwood, *Deconstructing the Myth of the Neutral Analyst: An Alternative from Intersubjective Systems Theory*, 66 PSYCHOANALYTIC Q. 431 (1997); Robert D. Stolorow, *From Isolated Minds to Experiential Worlds: An Intersubjective Space Odyssey*, 54 AMER. J. PSYCHOTHERAPY 149 (2000).

8. *See, e.g.*, NATTERSON & FRIENDMAN, *supra* note 7.

9. "Transference" refers to the "displacement of patterns of feelings, thoughts, and behavior, originally experienced in relation to significant figures during childhood, onto a person involved in a current interpersonal relationship." PSYCHOANALYTIC TERMS AND CONCEPTS 196-97 (Burness E. Moore & Bernard D. Fine eds., 1990). "Regression" means a "return to a more developmentally immature level of mental functioning." *Id.* at 164-65.

10. My project on informed consent is supported by grants from the International Psychoanalytic Association's Research Advisory Board and the American Psychoanalytic Foundation. *See* Elyn Saks, *Informed Consent and the Therapeutic Alliance* (Feb. 12, 2006)

HeinOnline -- 6 Yale J. Health Pol'y L. & Ethics 419 2006

will be interesting to see what analysts do, what their reasons are, and whether obtaining patients' informed consent has been helpful or harmful. Looking at the informed consent question directly in the psychoanalytic process should lead to insights that will be helpful in other medical contexts. Indeed, Katz has already shown that bringing psychoanalytic ideas to bear on understanding informed consent in the general medical context is a fruitful approach.[11] At a minimum, one would expect analysts to be more sensitive than others to unconscious and irrational forces at work in the informed consent process.

The second direction in which Katz's work leads us concerns our stance toward the seriously mentally ill. Katz writes mostly about non-psychiatrically ill patients (the exception is his *Enchanting Legal Fiction* article[12]). His emphasis on the pervasive influence of the irrational and the unconscious has the effect of breaching a perhaps idealized and distinct boundary between the mentally ill and the mentally healthy. Psychoanalysis teaches that we all have many unconscious and irrational fantasies. Psychiatric patients and other patients (indeed, people generally) are on a continuum. Two paths are then possible: to restrict the freedom of some apparently rational people or to protect the choices of some apparently irrational people.

In my own work on abrogating patient choice[13] I draw on three broad principles, all rooted in Katz's work: protecting the right to be unconventional (our "autonomy interest"); protecting those incapable of caring for themselves (our "paternalism interest"); and not discriminating on the basis of irrational beliefs that are pervasive among the non-ill and ill alike (our "nondiscrimination interest"). Katz has given special emphasis to the idea that all of us are pervasively irrational.[14]

Another principle that comes from Katz's work is to identify culprits that may compromise patients in the doctor/patient relationship, e.g., fantasies about doctor omnipotence. With these pitfalls in mind one can design instruments to assess people's capacity in different contexts. Katz's ideas have certainly

---

(unpublished manuscript, on file with the author). The empirical part of the project has just begun, four hundred surveys having been recently sent to analysts around the country.

11. This is the central endeavor of KATZ, SILENT WORLD, *supra* note 2.

12. Jay Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755 (1969) [hereinafter Katz, *Enchanting*].

13. *See, e.g.*, ELYN R. SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL (2002); ELYN R. SAKS, *Competency To Decide on Treatment and Research: The MacArthur Capacity Instruments*, *in* 2 COMMISSIONED PAPERS BY THE NATIONAL BIOETHICS ADVISORY COMMISSION: RESEARCH INVOLVING PERSONS WITH MENTAL DISORDERS THAT MAY AFFECT DECISION-MAKING CAPACITY 59 (1999); Elyn R. Saks, *Competency To Refuse Treatment*, 69 N.C. L. REV. 945 (1991).

14. KATZ, SILENT WORLD, *supra* note 2, at 118-19.

HeinOnline -- 6 Yale J. Health Pol'y L. & Ethics 420 2006

influenced my colleagues and me in formulating the "California Scale of Appreciation" (CSA), an instrument we have designed to measure one aspect of capacity to consent to research.[15]

The CSA measures deficiencies in a subject's understanding of the factors bearing on a decision to participate in research. An example of a "deficiency" in this regard is a subject's belief that the researcher is omnipotent—an item coming directly from Katz's work. Another example would be a subject's belief that withdrawing from the study would cause some catastrophic event to occur. Katz's underscoring of the pervasive influence of the irrational has also led us to require a gross departure from the norm in how one fails to appreciate the issues in order to be classified as incompetent; to do otherwise would be to risk discriminating against the mentally ill. To that end, we make use of the idea of a "patently false belief" in judging patients' appreciation.

One interesting problem arises, though, when one accepts Katz's account of our compromised decisional abilities: Why *should* we distinguish between the mentally ill and the mentally healthy in a case in which their decisions are motivated by the same fantasy?[16] For example, if a psychotic patient says his reason for agreeing to undergo surgery is that his doctor is God and therefore no harm will befall him, we would say he was incompetent to decide. But what about the non-ill patient who has the same *unconscious* fantasy that leads him to the same decision? What difference does it make whether the fantasy is conscious?

In his *Enchanting Fiction* paper, Katz speaks of the primary process overrunning secondary process ways of thinking in this situation.[17] Although descriptively true, this does not address why consent is invalid, as a normative matter, when this "overrunning" occurs (and not when it does not). Put differently, why does the invasion of the primary process matter if both patients

---

15. Elyn R. Saks et al., *The California Scale of Appreciation: A New Instrument To Measure the Appreciation Component of Capacity To Consent to Research*, 10 AM. J. GERIATRIC PSYCHIATRY 166 (2002).

16. Elyn R. Saks, *Mental Health Law: Three Scholarly Traditions*, 74 S. CAL. L. REV. 295 (2000).

17. *See* Katz, *Enchanting*, *supra* note 12, at 769-70. For the distinction between "primary process" and "secondary process" see FREUD, *Interpretation of Dreams*, *supra* note 3, at ch. 7. According to Moore and Fine, the concept of primary process, on a descriptive level, "embraces such characteristics of unconscious mentation as the disregard of logical connections, the coexistence of contradictions, the absence of a temporal dimension and of negatives, and the use of indirect representation and concretization (imagery)." Secondary process thinking is "[g]overned by the reality principle: it accounts for reality-attuned, logical thought, exemplified by delayed, modulated drive gratification through problem-solving (the internal activity of trial and error)." PSYCHOANALYTIC TERMS AND CONCEPTS, *supra* note 9, at 148.

HeinOnline -- 6 Yale J. Health Pol'y L. & Ethics 421 2006

have the same belief and that belief is the real reason they are making their decision? Why should we care whether the primary process thinking has become conscious?

One response to the notion that unconscious and conscious fantasies should be equally regarded is that unconscious fantasies are not accessible. But psychoanalysts make judgments all the time (fairly reliable judgments, one hopes) about fantasies the patients themselves may be unaware of. The ability to do so is the whole premise of psychoanalysis. Indeed, many patients do not acknowledge these fantasies even after they are brought to their attention, and yet the analyst may be quite certain that they exist and are exerting force toward certain action.

In addition to the "access" issue, more general proof issues may exist. The best way to *establish* that the psychoanalyst got it right is if the patient acknowledges that she did. But this is not the only way. In the end, notwithstanding the issue of practicality, the question of unconscious fantasies underlying choice is one of immense theoretical interest.

This puzzle aside, Katz's work normalizing the pathological and pathologizing the normal is extremely important as we think about how to treat those with serious mental illness. A few points seem to follow from his humane, yet sophisticated, approach. Even severely mentally ill people have pockets of health that can and should be tended. Like healthy people, they deserve respect and respectful conversation. Indeed, psychiatric patients desire to be treated with dignity just as do the mentally healthy. Moreover, given their patent vulnerabilities, these patients perhaps should receive more, rather than less, respectful conversation. As Katz rightly points out, many seriously ill psychiatric patients have the unconscious fantasy that they are not deserving of respect.[18] How much more important, then, to give it to them. The conversation should help empower even psychotic patients to mobilize what strengths they have to make competent decisions.

In fact, empirical research shows that patients with schizophrenia are capable of normal decision-making.[19] For instance, on the California Scale of Appreciation, only between approximately eight and thirteen percent of older outpatients with psychosis were incompetent.[20] This percent of the patients held patently false beliefs—again, the barometer of unacceptable beliefs—bearing on their condition and the research they were participating in. This result should

18. *See* Katz, *Enchanting*, *supra* note 12, at 768, 771.

19. Laura B. Dunn et al., *Assessing Decisional Capacity for Clinical Research or Treatment: A Review of Instruments*, AM. J. PSYCHIATRY (forthcoming 2006) (manuscript at 32-41, on file with author).

20. *Id.* at 170.

HeinOnline -- 6 Yale J. Health Pol'y L. & Ethics 422 2006

perhaps not be surprising given Katz's work. The mentally ill and mentally healthy may be much closer to each other than we might have expected or would wish to believe.

The third and final direction that Katz's work suggests is toward new efforts to enable seriously ill psychiatric patients to make competent choices even when they initially appear incompetent. For example, my colleagues at University of California, San Diego School of Medicine and I are designing and studying "enhanced consent" protocols which allow schizophrenic patients to attain as much understanding as normal controls in a brief period of time.[21] Our notion is that the problem may not be in the patients' capacities but rather in the investigators' way of presenting the material. That is, the problem lies with the means of informing for consent and not with the patients' ability to be informed. Katz's prescription of searching for ways of communicating and obtaining consent has fueled much of this research.

In closing, I would like to say one thing about the idea of "conversation." Some people might say that this idea represents a desire and goal of very verbal people. In the same way, some people might say that psychoanalytic conversations are only attractive to and effective with "sophisticated" people. But I think this criticism misses the point of Katz's call for conversation. This call is about respecting people, wherever they are, and helping them, in their own language, to understand and explore what is happening to them, and some of their deeper feelings about what is happening to them. You do not have to be a college graduate to appreciate the enormous benefits of conversation. Everyone, at some level, wants and can be benefited by such conversation.

Jay Katz has begun a deep and rich—as well as important—conversation with the discipline of psychoanalysis which shows no sign of ending. Our debt to him is enormous.

---

21. Laura B. Dunn et al., *Improving Understanding of Research Consent in Middle-Aged and Elderly Patients with Psychotic Disorders*, 10 AM. J. GERIATRIC PSYCHIATRY 142 (2002); Laura B. Dunn & Dilip V. Jeste, *Enhancing Informed Consent for Research and Treatment*, 24 NEUROPSYCHOPHARMACOLOGY 595 (2001). In addition, my colleagues and I are engaged in an NIMH-funded empirical study of an enhanced consent procedure using DVDs.

HeinOnline -- 6 Yale J. Health Pol'y L. & Ethics 423 2006