

Whores of the Court

*Psychologists as De Facto
Triers of Fact in Our Justice System*

In February 1992, [Eileen Lipsker] came to the Fairmont Hotel ballroom in San Francisco to explain the process of her memory return and her testimony at the trial to the American College of Psychiatrists. Afterward, the psychiatrists, including some of the most distinguished members of the profession in this country, crowded around Eileen. They believed her, they told her. They admired her. They felt intense compassion for her ordeal. At first, Eileen's big light-brown eyes looked doubtful. But along came another psychiatrist, and another, and yet another. With each one of their congratulations, Eileen brightened a bit. And soon she was glowing like the moon.

Lenore Terr, *Unchained Memories*, 1994

THE PSYCHOLOGY-BASED COURT CASE

One afternoon in early 1989, Eileen Franklin Lipsker, a young American mother, gazed deeply into her daughter's dark eyes and fell directly into a nightmare twenty years past. The merest accident of expression in her daughter's eyes brought Eileen face-to-face with another child, long dead, brutally murdered in California in 1969. With the vision of the dead child's face as the key, a whole vault of terrible memories of that long ago death became unlocked in Eileen Franklin's mind and she began to remember, slowly at first, but then

faster and faster, what her mind had fought so hard to keep hidden from view—that as a child herself she had witnessed the murder of her little friend, Susan Nason, at the hands of Eileen's own father, George Franklin. When these long-repressed memories were fully recovered and Eileen knew what she had, she also knew what she had to do. She brought before the legal authorities in California her memory of that terrible trauma from so long ago.

On November 28, 1989, the police arrested George Franklin and charged him with the murder of nine-year-old Susan Nason twenty years before.

There was not much direct evidence in this case. Susan's body had been found eight weeks after the murder in a rather remote wooded area. The material details of the case were widely published in the media—that Susan's head had been crushed by a rock, that she had worn a silver ring on her finger, that she was found lying not far from an old mattress—but at the time of the crime, no circumstantial evidence tied any particular individual to the crime and no eyewitnesses came forward.

Twenty years later there was still not much evidence other than Eileen's recovered memories. She said her father committed the murder; he said he did not. No one else saw anything. Eileen claimed that the trauma of witnessing the horrifying murder of her little friend had been so great that she repressed the memory for all those years and then, quite inexplicably, recovered it twenty years later.

Given the lack of physical evidence and the heavy reliance on psychological claims in this case, it is not surprising that in Franklin's trial for murder the bulk of the "evidence" presented was the opinion of experts—psychiatrists and psychologists—concerning the repression and recovery of memory, and the consequent reliability of Eileen's accusations against her father. Dr. Lenore Terr, a California psychiatrist, was the prosecution's principal witness in explaining to the court the obscure psychological phenomena the jury had to consider in weighing the case against George Franklin.

The prosecution's case rested on certain psychopolitical assumptions that have become popular in some segments of the mental health community. It is assumed that children who experience terrible trauma, like witnessing murder or experiencing sex abuse, often suffer, like some Vietnam vets, from post traumatic stress syndrome. It is also said

that one of the most common features of this stress disorder is the loss of the memory of the precipitating traumatic event—what psychiatrists call "repression" of the traumatic memories—because the mind seeks unconsciously to protect the person from having to reexperience the trauma in memory. Lastly, it is assumed that repressed memories can be recovered in the proper conditions, usually in the context of therapy, but perhaps through an accidental triggering as in Eileen's case.

These psychological assumptions and countless others like them—lacking any scientific basis but embraced unquestionably by their adherents—over the last twenty-five years have crept insidiously into our legal system, into legislative bodies and courtrooms all over the country.

In George Franklin's case, the judge and jury accepted as scientific fact Dr. Terr's testimony regarding trauma theory, repression, and recovered memories; they took as truth the startlingly assured statements of this psychological expert about historical facts and mental mix-ups, and her confident explanations of the way the mind works. On November 30, 1990, based on the word of his estranged daughter and the testimony of this expert psychological witness, George Franklin was convicted of murder and sentenced to life in prison.

Dr. Terr writes that when Elaine Tipton, the prosecutor, asked several jurors after the trial what led to their decision, "She told me that a number of them said my testimony had convinced them. I learned something from that: sometimes hypotheticals are just as compelling as specifics" (Terr 1994, p. 58).

Did George Franklin murder Susan Nason? Was Eileen really so scared by the awful event she witnessed that she immediately lost all memory of it, continuing to pal around happily with her father as before, riding around the state unconcernedly in the same vehicle where she supposedly witnessed the assault on her little friend? Can a memory really be blown out like a candle in an instant, only to be relit by accident twenty years down the line? When Dr. Terr lectured the courtroom in California on the mysterious operations of the mind that would permit just such a sequence of events to transpire, should the court have accepted what she said as reliable truth?

All over America today, psychological professionals like Lenore Terr are climbing confidently into the witness box to lecture judges

and juries on just such matters: how the mind works, how memory works, what a trauma is, what effects trauma has on memory, which memories are trustworthy and which are not.

With nothing else to go on in most of these trials other than the word of the psychoexperts so confidently testifying, it is crucial that we know the answer to these questions: Do all these hundreds of very expensive experts really know what they are talking about? Can the rest of us trust them? Can we rely on what they tell us to be the last word in scientific knowledge about the workings of the mind?

Alas, no. Psychology's takeover of our legal system represents not an advance into new but clearly charted areas of science but a terrifying retreat into mysticism and romanticism, a massive suspension of disbelief propelled by powerful propaganda.

Thanks to the willingness of judges and juries to believe psychobabble with scientific foundations equal to horoscope charts, babble puffed about by psychological professionals with impressive credentials, what we've got now are thousands of self-styled soul doctors run amok in our courts, drunk with power, bedazzled by spectacular fees for the no-heavy-lifting job of shooting off their mouths about any psychological topic that sneaks a toe into a courtroom.

The demand is great, the supply is huge, and the science behind it all is nonexistent. But the reality does not matter.

With the passage of well-intentioned and broad-reaching social welfare and safety net legislation over the last decade buttressing Americans' willingness to buy into any claim made by a certified psychological professional—not just claims about trauma and memory—our legal system today generates a virtually unlimited demand for psychoexpert services while the psychoexperts display an equally unlimited willingness to service those demands.

Lenore Terr sound-alikes are echoing around the country in hundreds of courtrooms in various types of trials both criminal and civil. Thousands of psychological "experts" confidently—and expensively—inform judges and juries, patients, plaintiffs and defendants not only about how memory works—as in the Franklin trial—but how the mind itself works, how the personality is formed, what aspects of character and behavior can be changed and how to go about it, as well as what wrong was done, when and how it was done, who did it, how much responsibility a party bears, and whether and

when said party can be rehabilitated. In the civil realm, psychoexperts determine for the courts the nature and extent of psychic injury, disability, and discrimination; the presence or absence of abuse; and the relative fitness of parents.

The result is what has all too clearly become the rape of the American justice system.

A Mental Devil Made Him Do It

The man who stabbed the daughter of state Sen. Arthur Dorman 16 times in February did not know right from wrong at the time, making him guilty of the crime but not criminally responsible, a Howard County circuit judge ruled yesterday.

Gary C. Moncarz was found guilty of murdering Barbara Susan Dorman, his girlfriend of about a year, but Judge Dennis M. Sweeney ruled that Moncarz suffers from a severe mental illness that prevented him from understanding his actions.

Moncarz, 42, a former accountant, was remanded to the custody of the state Department of Health and Mental Hygiene until he is deemed no longer a danger to society or to himself.

State's Attorney Marna McLendon said psychiatrists will determine when Moncarz can be released but that he likely will spend a long time in an institution. (Francke, Baltimore Sun, August 27, 1996)

In criminal trials, we have competing teams of psychoexperts analyzing the accused, first to tell the judge whether the defendant is competent to assist in his or her own defense; then, if the defendant is found competent, the defense hires another raft of experts to testify that competent or no, the defendant is mentally disordered in some way and so should be found not guilty by reason of insanity, or, if not completely insane, his or her criminal responsibility should be considered less due to some diminished mental capacity or state of mind.

"He cannot understand the charges against him. She couldn't tell right from wrong. He couldn't distinguish fantasy from reality.

She couldn't control her actions. He is the victim of an irresistible impulse. He was traumatized by the war. She was in a flashback. He suffers from an incapacitating mental disorder. She has a psychological disease. It's not his fault because he wasn't taking his medication."

A mental devil made him do it.

Che Rashawn Pope reportedly said five words before he pulled the trigger of the gun he was pointing at 17-year-old Sadrac Barlatier in Mattapan Square.

"This is your time, man."

Pope, 18, has been charged with first-degree murder in the October 11, 1995, shooting. His defense attorney is considering arguing that Pope . . . killed because he is afflicted with "urban psychosis" from living in an environment made "toxic" by exposure to gangs, poverty, fatherless families, drug use, teen-age pregnancy and violence. (Ellement, *Boston Globe*, October 14, 1996)

In old mystery stories, motives were assumed to be simple and the detective always asked first, "Who benefits from this crime?" That was yesterday. Today the psychiatrist asks, "Who traumatized this perpetrator?"

Psychological explanations invoked to get people out of impossible situations are much like the *deus ex machina* solution to irresolvable plots in ancient plays. When all the characters are inextricably knotted up with no hope of resolution in sight, suddenly the god descends from the heavens and takes everything in hand. And, like *deus ex machina* and all other good dramatic devices, psychological resolution tales require considerable suspension of disbelief to operate effectively.

What we want today is not retribution but the understanding that is the heart of a compelling narrative. We want a good story, preferably a classic tale if not an epic drama. We are no longer willing to judge the conduct of others as good or bad, because we no longer believe that the individual is actually responsible for his or her own conduct.

Lately, in Massachusetts, we had the tragic and senseless murder of a brilliant young student at Harvard by her female roommate, who then committed suicide. The press was full of psychological experts

speculating that this appalling action was caused by cultural isolation disorder or school stress disorder or rejected friendship disorder. Not one expert suggested that the fault lay with the murderer herself. Why not? Have we lost all belief in personal responsibility for good and bad?

Modern psychology, permeating our culture and our legal system, has convinced the larger society that responsibility for behavior belongs to the background and context in which it occurs, not to the individual performing the action. We believe that people act—when they act badly—for reasons that are essentially written in their history and outside their control.

Rehabbing Rapist Killers

This is also the reason that so many Americans are so ambivalent about punishment for crime. We vastly prefer the idea of rehabilitation over punishment, especially for criminals who can make even the remotest claim to victim status. Thus we have, despite any evidence of effectiveness, judge after judge sentencing criminals of every dangerous description and degree to so-called treatment programs.

When O. J. Simpson pled "no contest" some years back to the charge of beating his wife, he was sentenced to psychotherapy. Cellular psychotherapy. He did it by telephone.

In 1975, Officer Matthew Quintiliano, a policeman in Connecticut, was sentenced to therapy after he killed his first wife. He was cured by the wonders of modern psychotherapy in three months and was freed. He married again and subsequently killed his second wife.

Why do we, the public, go along with psychotherapy as a sentence? Because it goes right along with the idea that no one is really responsible for his or her own actions. We are all victims of outside malevolent forces. Criminals are not bad; they are damaged. Since society caused the damage or allowed it to happen, society should repair it. Rehabilitation has long been a component of the criminal justice system, so rehabilitative psychotherapy fits well as a natural extension of that idea.

Does it work? Can psychotherapy really rehabilitate wife beaters and murderers and rapists and drunks and druggies? Our current method of measuring effectiveness is to ask psychotherapists if psychotherapy works. Mostly they say yes.

They are wrong. Even for what is probably the most important question — "Will this guy kill or rape again?" — the forensic clinician is correct in his or her predictions no more than one third of the time.

Constructing the Psychological Child

The demonstrated incompetence of forensic clinicians at seeing into the souls even of their own patients has not stopped the legal system from granting them terrifying power, not only in criminal domains but also in any and all cases involving children as defendant, victim, witness, or subject of some adult dispute.

When a fifteen-year-old, 220-pound "child" in Massachusetts is accused of stabbing the neighbor lady ninety-six times, unto death, it is the court-ordered psychological evaluator who counsels the judge whether the young man should be tried as a child who can be rehabilitated or as a man subject to a man's punishment for a man's crime.

When ten- and eleven-year-old boys drop a five-year-old child to his death from the roof of a fourteen-story building, it is child specialists who peer with mental telescopes into their histories and into their futures and tell the judge what caused this terrible behavior and what can be done to fix the boys so it will not happen in the future. The courts accept this counsel from the highly paid professionals because they think they have no choice. Our courts accept at face value the claims of all these entrepreneurial experts that they understand what goes wrong with children and they understand how to **fix** them.

They don't.

Psychological professionals also claim to have special skills that allow them to detect unerringly what is in the best interests of a child. They tell our courts who will be the better parent, who is too crazy to have custody of a child, whether moving from one place to another will disturb the child's mental health, and whether the child was abused by one parent or another.

Are mental health professionals any more knowledgeable than you or I about whether a child has been abused in the home? About whether the child is better off removed from the home? About whether the child will grow up better under Mother's custody or under Father's? Of course not. How could they be? There are no special secret tests for any of the factors that child clinicians claim are so crucial to their so-called professional opinions.

It is essential for the future health of American children and their families that all these professionals be forced to lay their cards on the table so that everyone, parents—prosecutors, and judges alike—can see what an empty deck they are dealing from. The system is a farce and it perpetrates awful injustices.

My Mind Has Fallen and It Can't Get Up

Like family law, the entire arena of civil litigation also has experienced a huge increase in the testimonial activities of the forensic clinician. The modern proliferation of mental disorders has provided a veritable bonanza for entrepreneurial psychologists, not to mention their associated attorneys, not only in traditional injury and liability tort cases but also in disability and discrimination claims.

How does it work? Simple. Hire a psychoexpert to come into court and testify that you are damaged invisibly—mentally, emotionally, psychologically—that you suffer from one of the hundreds of psychological disorders "recognized" today. Then you have two ways to go. In a straight injury claim, your expert can testify that your psychic injury was caused by the trauma you experienced at the hands of your neighbor, your employer, or an unfeeling institution. In a disability claim, the expert must testify that your employer or a public accommodation discriminated against you by refusing to recognize or make reasonable accommodation to your disability. In both cases, you require much money to repair the injustice.

A typical case is that of the employee fired from a radio station in Washington state for offensive on-the-job behavior, who recently was awarded \$900,000 by a jury for a discriminatory firing and for the psychic injury done to her by the discrimination. Her poor job performance, according to professional opinion, was produced by a mental disability and therefore occurred entirely outside the realm of personal responsibility.

Psychological disabilities, not incidentally, can be diagnosed only by trained professionals whose word cannot be credibly disputed by anyone other than another trained professional. No mere layperson can hope to match or, God forbid, criticize the diagnostic skills of the clinical psychological professional.

The cost of the needed treatment, the psychotherapy, is always included in the requested compensation in civil injury trials. Thus

you have therapists testifying that yes, it is absolutely crucial that this plaintiff receive plenty of expensive psychotherapy for her disorder. Having therapists testify about the need for psychotherapy is about as smart as answering an insulation ad that promises Free Analysis of Your Home's Heating Efficiency.

They Say This Is Science

In criminal trials like that of George Franklin, in which the psychoexpert Dr. Terr created a completely novel and entirely hypothetical model of the operations of mind and memory, and sold it to the jury as science—science!—and in the innumerable civil trials over just about everything, we now have countless psychoexperts shamelessly regaling the courts with their personal opinions about the workings of the mind and behavior, which they have wrapped in the trappings of science through nothing more than a liberal sprinkling of jargon and some fancy-sounding titles and credentials.

That the courts accept expertise on the experts' own valuation of it reflects desperation as much as acceptance. Our courts—we, the people—need help to understand past behavior, to control present actions, and to predict who's going to do what kinds of awful things in the future.

Common sense tells us some things. We believe that the older guys get, the less likely they are to rape anyone. We believe that if guys knock around one woman they will knock around another one, and if he hits you once he will hit you again. We believe that most men who beat up on their children in a real nasty way do so much more than once. We know that most killers don't kill more than once in a lifetime—which makes rehabilitation of murderers a kind of funny concept—and we know that the older a guy is, the less likely he is to be violent. (He is also more likely to drive slowly and to wear a hat.)

We also know that all these little factoids gained from our own experience, newspapers, movies, and television are unreliable, the best-we-can-do, unscientific beliefs that don't give us absolute security or predictive accuracy. What's to say that this particular seventy-five-year-old man won't knock your head in with a baseball bat and rape you? Who's to know if this other guy wasn't so horrified by his hitting his wife once that he'd kill himself before doing it again?

We want more certainty than that provided by rules of thumb, and we want more safety than that provided by our own limited experience. Thus modern Americans will embrace almost any psycholegal theory or claim that highly paid and highly arrogant experts spin on the witness stand. We and our judges are blinded by jargon, fancy-sounding credentials, and fancy degrees.

Does it drive all of us crazy to live with the myriad uncertainties that arise because the field of psychology is in its infancy and simply unable to answer—sometimes unable even to address—so many of the questions in our justice system for which definitive answers are desperately needed? Perhaps so. But relying on pseudo-experts who are simply not up to the job the courts demand of them will not further the cause of justice in this country. It will just make the whole system and the whole society sicker.

For all forensic psychologists who work one side of the courtroom or the other, the job is lucrative. However, the idea that much of professional psychology's move into the courtroom has been motivated by simple economic interest is not really all that alarming. Money is a motive we can all understand. As a society, we are used to people willing to do anything to chase a buck, and we understand them.

But we also must wake up to the fact that the present and growing dominance of psychology in the courtroom poses a graver danger to society than simple monetary corruption. Much of the present marriage of psychology and the law has been cemented by a virtually impregnable arrogance and institutionalized in both law and legal practice, and that is a scary thought indeed. Both the public and the practitioners themselves have been seduced into believing the pseudo-experts' bunkum, have managed to get that bunkum written into law, and have effected a wide acceptance of a crucial judicial role for the bunkum artists as well.

TWO ROADS DIVERGED—EXPERIMENTAL AND CLINICAL PSYCHOLOGY

The public and its legal system do not know that the psychology that holds such sway in their legislative chambers and courtrooms lacks any scientific foundation because most of the men and women who make up the scientific and academic discipline of psychology have kept their mouths shut about what's going on. The experimental sci-

entists have clung to the mistaken belief that the practice of psychology in the public domain is the territory of the clinical practitioners. The scientists felt that if they didn't step on the clinicians' territory, the clinicians wouldn't step on theirs.

Who are the scientists and who are the clinicians among the different varieties of psychologists? The scientists, the experimentalists, are researchers who study perception, language, learning, cognition, and memory, mainly. The clinical types are the practitioners who focus on personality as well as on so-called abnormal behavior. Another way of saying this is that the experimentalists don't see patients; the clinicians do. (That's why they are called "clinicians"; they go to clinics to see patients.) Also, the clinicians don't do experiments; the experimentalists do, sometimes in laboratories and sometimes in the real world. Of course, these divisions aren't clean. There are people who study personality for example, who do real experiments; there are learning theorists who see patients; and so on. But in general, the two divisions hold well enough.

The split into clinician/practitioner versus scientist/experimentalist also holds across the various psychological subdivisions of academic clinical psychology, professional psychology, psychiatry, counseling, and psychiatric social work and nursing. In each subdivision, the majority of the practitioners are clinicians untrained and inexperienced in scientific research; the minority were actually trained in or actively engage in science.

For social workers and for psychiatrists and psychiatric nurses in medical educational settings, the situation is even worse than for conventionally trained Ph.D. psychologists. In these fields, there is not even the rhetorical expectation that the future practitioner will be broadly educated in psychological theory and research.

(In this book, I will use common terms for psychological practitioners working within the realm of the justice or legal system—psychiatrists, psychologists, social workers, or other—whatever the particular education and training, unless that background is relevant to understanding or evaluation of some point.)

THE BIG LIE

Experimental psychologists know that the education commonly possessed by licensed mental health care providers, whatever their back-

ground and training, is woefully inadequate to the job demands. They know too that with the present state of psychological knowledge, there are severe limitations on what any education could provide to the most diligent student. No education on earth today can be held to give an adequate account of how the mind works, how personality and character are formed, or what can be changed and how.

Psychology is a science in its infancy. With the best will in the world, it could not today meet the demands and expectations placed on it even by patients in need, much less by the legislative and judicial systems of the country. The entire psychological community knows all of this, at least the scientists do, and most of them ignore it.

The psychology establishment has permitted the tenets and practices of clinical psychology to be incorporated into our laws and our courtrooms, knowing full well that they are untested, untestable, profoundly unscientific, and not even generally held to be factually true. We have allowed the courts and the public to confuse the methodology and findings of scientific, experimental psychologists with the practice and interpretations of clinicians. We have allowed so-called clinical psychological experts we know to be utterly unequal to the task to presume to take over the roles of judge and jury as finders of fact in American courtrooms.

We know forensic psychology's massive infiltration of the judicial system has been wrong. But, because of the takeover, the prestige and the power experienced today by members of the psychological community—experimentalist and clinician alike—are unprecedented in history. Who can blame the ever-reaching branches of psychology for succumbing to temptation?

THEY MUST KNOW WHAT THEY ARE DOING

There has been another critical factor driving what must seem to the public like almost criminal negligence on the part of the profession of psychology: Many experimentalists would argue that because numerous troubled people seem to find in therapy the help they need, it is not just permissible but perhaps even desirable to ignore its complete lack of scientific foundation. This has been a grave error, with wide-ranging consequences for the field of psychology and the public alike.

"Hey, he cured me. He must know what he's doing, so I'm sure he can cure other people." It seems reasonable, doesn't it? I was

better off after my time with a psychiatrist, so I assumed that the psychiatrist must have made me better. It follows that he must have known about what was wrong with me psychologically, what caused it and how to fix it, doesn't it?

No. The effectiveness of a therapeutic approach in treating a disorder is logically unrelated to the validity of the therapist's theory of causation of the disorder.

How can that be? Let us see.

Psychopathological Science

Clinical Research

The most insidious thing about bad science is that it can afflict even some of the more intelligent, methodical, and honest members of the scientific community. The reason is that it appeals to a broad element in human nature, not just to vices but to some virtues as well.

Peter Huber, *Galileo's Revenge*, 1993

LEAPING BEYOND THE DATA

I'm in bed with Ann. We're making love. She teases me, and I get my feelings hurt. I don't know why, but I hate her for teasing me. So we stop making love, and we each turn away from the other and go to sleep. Now I'm sleeping. I began to dream. In the dream I'm in bed with Ann, just like I really am, and we're making love, and she begins to laugh at me, to make fun of me. And suddenly I realize she isn't really Ann, she is my mother, in disguise somehow. And I'm in bed fucking my mother! And she's laughing, saying, "I finally got you. I finally got you!" And I'm so ashamed, so embarrassed, I just start hitting her to make her stop. (Barber 1986, pp. 56–57)

This dream was related by a young man, John, who had been arrested one night for beating up his girlfriend, Ann, although he claimed to have no memory of the event. Even though Ann did not

press charges, John decided to seek help from a psychotherapist.

The therapist, Dr. Barber, chose dream analysis and hypnosis as therapy techniques. His weekly instruction to John was, "Some night this week, and I don't know which night will really be best . . . but some night this week, you will have a dream. This dream will be interesting to you, and will tell you something you need to know about your life right now. As soon as the dream ends you will awaken, and you will remember the dream vividly as you write it down so you don't have to memorize it. And you can bring in your notes about the dream next time." The therapist directed John to have amnesia each week about all of this dream instruction business.

Finally, after numerous sessions in which John would relate his dreams under hypnosis, he came in with that supposedly highly revealing dream about having sex with his mother and his girlfriend that "explained" why he beat up Ann.

In the days that followed that dreamwork, John began to remember bizarre and painfully confusing incidences of sexual seduction by his mother. . . . His view of his own sexuality, and of his terrible need for both control over and distance from women, was also undoubtedly rooted in these early experiences. . . . Memories of the actual torture of being locked in the dark closet [one of his punishments for not satisfying his mother] made clear how John had developed his dissociative capacities. (Barber 1986, p. 57)

"Dissociative capacities" is the phrase John's doctor uses to describe John's ability to beat up women and remember nothing about it afterward.

So, after a short time, John was completely cured, terminated therapy, and became engaged to be married—to a girl we hope is luckier than Ann.

Quite an impressive little story, isn't it? Is it true? Who could possibly know?

WITCH DOCTOR FALLACY

Consider this example: In a mythical tribe, a person who behaves in a way that leads him to be labeled mentally ill is tied to a stake, burned,

and beaten. During this procedure, the witch doctor dances around the stake rattling his gourds until the patient's behavior improves. The witch doctor believes that the patient is possessed by a spirit and the purpose of the treatment is to scare the spirit the hell out of the body. If the symptoms of many people who receive such treatment quickly disappear, and given this kind of treatment one can imagine that it is highly likely that they will, then one could conclude that the witch doctor's treatment is effective in curing mental illness.

If we assume that the positive outcome—disappearing symptoms—supports the witch doctor's theory of psychopathology, then we are in the rather difficult position of having to accept a theory of demonic possession as the cause of mental illness, the common primitive explanation of bizarre behavior. We must conclude that the witch doctor knew what was wrong with his patient, knew what caused it and how to fix it.

Most modern Americans would not accept that conclusion. The witch doctor may believe he has cured his patient; the patient may believe he was cured by the witch doctor. But the rest of us know that there are many possible reasons for the improvement in behavior, despite the beliefs of both doctor and patient, and we are not about to conclude that the witch doctor has any special knowledge of mental illness at all.

We can see that the effectiveness of therapy is logically unrelated to the validity of the therapist's theory of mental illness when we are presented with the witch doctor scenario, but in the case of modern psychotherapy we often forget it.

In the case of cancer, we don't usually make this logical error. Although there are now successful treatments for some cancers, and significant advances in understanding the origins of cancer, very few patients will assert that their oncologist knows all that could be known about cancer.

Why the difference? Why do we go the witch doctor route with psychotherapy but not with cancer therapy? Part of the answer is that in most types of mental illness there is no independent, corroborating measure of mental illness except for what the patient says and does. This is not true of cancer patients. The patient can feel great, go to work, and still have cancerous tumors that can be observed in a number of ways. Whatever he or she may say, the patient has cancer

and the doctor knows it. The harder it is to verify independently the disease process in medicine, the more likely it is that medicine will fall into the same witch doctor trap as psychotherapy.

We have no direct, objective indicator of mental health. We can't measure the mind. And because mental functioning cannot be measured directly and objectively, psychotherapists are boxed into the corner of believing the patient, and the public falls into the trap of believing our witch doctors. The clinician has no way to verify independently what the patient says, and the public has no way to verify independently the clinicians' assertions about mental life.

All of us, patients, clinicians, and public alike, are willing to accept the occasional success in therapy as evidence that therapists are experts in causation of mental disorders and in general psychological functioning. Our belief is quite understandable.

That the general public confuses psychology's hit-or-miss success in making people feel better as evidence of a comprehensive understanding of general psychological functioning is not a new observation, although it is much overlooked these days. And the fundamental inadequacy of psychology as a science is not a new issue.

What is new is the extraordinary depth and extent of the acceptance, as a science, of the principles and practices of clinical psychology by the older institutions of our society—by courts and police, by judges and juries, legislators and policy makers. Our legal system has been told that clinical psychology is a scientific discipline, that its theories and methodology are those of a mature science, and our legal system has believed it. Given the deplorable state of the "science" of clinical psychology, that is truly unbelievable.

THE IDEAL OF SCIENCE

Science is an ideal. Some people would say that it is so much an unreachable ideal that it is a fiction. That is not true. That so many fail so often in so many ways does not change the nature of their endeavor.

What is it that the people engaged in science are trying to do?

They are trying to acquire knowledge about what things exist and how they work. What distinguishes scientists from other seekers after knowledge is their belief in and practice of a specific methodology for seeking truth.

Scientific methodology is essentially controlled observation of

how some aspect of the world changes when some other factor is added or removed, increased or diminished in quantity. Scientists make predictions about what lawful changes will take place under what circumstances. The accumulation of these tested laws of change—of cause and effect—makes up the knowledge base that is the body of scientific theory. Through the testing of predictions—hypotheses, in scientific jargon—under carefully controlled conditions, the theoretical body of scientific knowledge is built step by step.

Control in the experimental testing of predictions is essential because it is impossible to know what you are seeing if too many things are going on at once. The goal of science in the experimental testing of predictions is to reduce the number of things "going on" to a controlled and observable level so that the results obtained can be reliably attributed to a particular cause, not to any of a number of uncontrolled and unknown factors.

But what makes science so powerful is a second trait that it has. Science exists independently of the scientist. While any individual scientist may claim to see something or to think that he or she is seeing a certain pattern, such a finding is not considered valid until anyone—skeptic, friend, or foe—can achieve the same results in an independent experiment of his or her own. The findings discovered through observation in one laboratory must be replicable in another laboratory. Data measured and gathered by one instrument must be the same as data gathered by another similar instrument. And thus the objectivity comes not from an individual practitioner but from a system that demands consistent and repeatable results.

Objectivity and replicability depend too on reliable instrumentation. Data attributed to the scratch on the lens of a lab scope are not the findings of science. Objectivity and replicability depend as well on commonly held assumptions, consistently defined terms, and clearly defined phenomena. When researchers cannot even agree on what they are trying to observe and measure, it is impossible to engage in the systematic testing of hypotheses and the logical buildup of coherent theory.

Science depends on its practitioners to play by the rules and to be absolutely honest about both their successes and their failures.

What distinguishes a scientist from any other seeker after truth is exactly this. The scientist can be and often is wrong. A real scien-

tific theory tells you, in effect, "If the theory is right, then this particular thing ought to happen under these certain conditions. If it doesn't happen, then the theory is wrong." If a theory cannot be proven wrong in its predictions, then it is not science.

This is not to say that every scientist faced with incontrovertible evidence that his or her beloved theory is wrong will trash the old without a qualm and embrace the new. Some philosophers of science even claim that a field changes only when old scientists die off and younger ones come forward to view the evidence with less biased eyes.

In clinical psychology, however, the imperviousness to factual challenge is not just the don't-bother-me-with-facts mulishness of a few stubborn graybeards, it is a legacy handed down from generation to generation.

CLASSICAL CLINICAL JUNK SCIENCE

Clinical psychology is classic junk science.

In his 1993 book *Galileo's Revenge: Junk Science in the Courtroom*, Peter Huber defines the term so:

Junk science is the mirror image of real science, with much of the same form but none of the same substance. . . . It is a hodgepodge of biased data, spurious inference, and logical legerdemain, patched together by researchers whose enthusiasm for discovery and diagnosis far outstrips their skill. It is a catalog of every conceivable kind of error: data dredging, wishful thinking, truculent dogmatism, and, now and again, outright fraud. (pp. 2–3)

There are a great many ways to do science badly, and the junk science that makes up the bulk of the body of "knowledge" of clinical psychology manages to exemplify every one of them. The myriad failures of psychology as a science are not at all surprising, considering the roots of modern clinical practice. It is impossible to understand the essence of clinical junk science without a cursory understanding of clinical "science" as practiced by the principal founding father, the great man himself, Sigmund Freud.

What "scientific instruments" did Freud use to gather the data to build his theory of the healthy and unhealthy development of per-

sonality, with its psychosexual stages, Oedipus complex, castration anxiety, penis envy, Id, Ego, Superego, defense mechanisms, and the unconscious mind? Well, he analyzed his patients' dreams, he listened to their little slips of the tongue, and he asked them to freely associate to various words he gave them. That's it. The patient talked. Freud listened. A theory was born. And it grew, and it grew, and it grew.

The "instrument" for gathering data and building theory used by Freud and his cohorts and followers and by nearly all clinicians today was and is "clinical intuition."

Coitus Interruptus

Freud gives a nice example of using intuition to develop his version of scientific truth when he explains how he discovered in a patient of his the connection between depression, sinus pain, constipation, and coitus interruptus.

This patient had quite a few children. He was troubled intermittently with anxiety, various aches and pains, and, well, constrictions, in his sinuses and bowels and lower back. The pattern of their coming and going was a mystery. Suddenly the symptoms ceased altogether. Finally Freud discovered that when the patient's wife was pregnant, she permitted him to ejaculate in the customary way, but when she was between pregnancies and unenthusiastic about commencing another, she insisted on coitus interruptus. This, according to Freud's brilliant reasoning, caused the patient's system to back up physiologically and psychologically, inducing the various blockages here and there. The prescription for his cure, then, was obvious, if somewhat inconvenient for his wife. (Freud was surprisingly literal in his metaphors, prescribing both cocaine and nose surgery for other blocked customers.)

It is beyond foolish to ask whether "research" of this order can properly be characterized as objective, replicable, or generalizable. The ordinary standards of scientific methodology don't even come into play. Likewise, it is futile to ask whether Freud's intuitions were falsifiable. Freud's intuitions were freely supplanted when new intuitions seemed to him to be more plausible. And there is no reason whatsoever to expect any other "researcher" employing the intuitive interpretive methodology to have the same intuitions as Freud. "Objective intuition" is an oxymoron. Likewise, whatever "generaliz-

ability" and "replicability" there may be for such work resided entirely within Freud's own head.

Freud's collected works, occupying some two linear feet of library shelf space, provide hundreds of examples of his clinical intuition at work building the pseudo-science of clinical psychology. They provide no examples of the objective testing of falsifiable hypotheses under carefully controlled conditions of observation producing replicable, generalizable results. None. In Freud's work, there is not one scintilla of what any respectable scientist would call science.

As the twig is bent, so grows the tree.

CLINICAL JUNK SCIENCE TODAY

Have things changed in clinical psychology? Are the instruments modern clinicians use any better than those of Freud?

No, they are not, and nothing has really changed.

Like Freud before them, in place of data gathered or theory built by any instrument even remotely scientific, today's clinical practitioners offer the courts and legislatures—not to mention their patients and students—their clinical intuitions about how the mind is formed and how it functions, about psychological injury or guilt, about repression and recovery of memory, about trauma and the unconscious, dangerousness, parental fitness, child welfare, competency, rehabilitation, or any psychological thing under the sun.

The Miss Marple Approach

In common parlance intuition means the kind of knowledge gained from experience with people that is very hard to put into explicit words: "I've seen a lot of clients like that, and after a while, you just get kind of a feel for it."

Intuition is real. Of course it is. It's exactly the kind of knowledge a good cop is using when she feels suspicious of the way two guys are standing together on a street corner. It's the knowledge an experienced teacher uses when he "smells" a plagiarized term paper. It's what Agatha Christie's Miss Marple relies on when she says that weedy little fellow reminds her of old Tom's son down at the garage, who always made his repairs just a little weaker than they should be.

We all use intuitions like these in our daily lives. But we do not permit police officers to arrest people for looking vaguely suspicious;

universities do not permit professors to flunk students unless the plagiarism can be proved; and even Agatha Christie supplemented Miss Marple's unfailingly correct intuitions with a bit of material evidence. We should require at least as much restraint in the exercise of clinical intuition by psychological practitioners when they hand the court a professional report, or mount the stand to testify. Perversely, we require less.

How Did Dr. Terr Know How Eileen's Mind Worked? Consider, for example, the source of evidence Dr. Lenore Terr used when she testified about the functioning of Eileen Franklin's mind at her father's trial for murder.

Did Dr. Terr undertake controlled observation of Eileen's mind? Well, be fair, how could she? She did what all clinicians do. Eileen Franklin Lipsker told Dr. Terr a story and Dr. Terr created a wonderful theoretical interpretation of Eileen's account of her claimed experiences.

Did Dr. Terr have any way of judging whether what Eileen told her was true? Of course not. How could she? Dr. Terr got the "information" about what and when Eileen forgot and what and when Eileen remembered from Eileen herself. That's where clinicians always get the evidence for their "theories," except, of course, when they analyze dead people.

What about logical consistency within the story itself? There isn't any. Dr. Terr said that Eileen had repressed the terrible traumatic experiences of her childhood, but in fact Eileen claimed to remember many events in her abusive childhood, including numerous things about her violent drunken father, who beat his wife and children. And yet she forgot the murder.

What about the physical facts of the case? Many people took the apparent eyewitness-type detail as evidence of Eileen's general veracity, while defense attorneys tried to argue that all the details about the crime that Eileen claimed to have recovered with her unrepressed memory had been published in the popular press at the time of the murder and were available to anyone, eyewitness or no. However, the accuracy of the physical details reported by Eileen is irrelevant to establishing the validity of the psychological claims about repression and recovery of memory.

Eileen Franklin Lipsker may have seen her father commit murder or she may have seen someone else commit the murder or

she may simply have heard about it, read about it, dreamed and fantasized about it. I don't know. But neither does Dr. Lenore Terr.

The psychoexpert presenting a creative interpretation of a claimant's story is authenticating that story, corroborating it, vouching for the veracity of the story without a scintilla of data gathered from anywhere but the claimant. What's the point? To tell the court that the claimant is a truthful person? How would any psychological expert know that? Clinicians are not lie detectors. They are no better than any judge or jury at distinguishing truth from falsehood. Besides, lie detection is not supposed to be the function of an expert psychological witness in court. The psychoexpert adds nothing to the claimant's testimony except a fraudulent veneer of authenticity that is utterly misleading and entirely out of place in any courtroom.

Grandmother Riding a Broom Consider the case of Richard and Cheryl Althaus of Pittsburgh, whose sixteen-year-old daughter one day accused them of sexual abuse. Dr. Judith Cohen of the Western Psychiatric Institute and Clinic at the University of Pittsburgh diagnosed the girl with post traumatic stress disorder brought on by sexual abuse. How could Dr. Cohen possibly know that the allegation of past abuse was true with such certainty as to warrant a diagnosis of PTSD? Retrospective clairvoyance?

Miss Althaus also claimed that her grandmother flew about on a broom, that she had been tortured with a medieval thumbscrew device, that she had borne three children who were killed and that she had been raped in view of diners in a crowded restaurant. (Associated Press, *New York Times*, December 16, 1994)

In her defense of her diagnosis, Dr. Cohen "argued that her job had been to treat Miss Althaus, not investigate the patient's accusations" (Associated Press, *New York Times*, December 16, 1994).

No investigation. No corroboration. No physical evidence that any of these highly unlikely events transpired. No questioning, even about the multiple pregnancies and murdered infants? No curiosity, even about granny on the broom or the thumbscrews or maybe which restaurant had the floor show? This is really nuts. The good news is that a jury recognized that it was nuts.

A jury awarded more than \$272,000 today to a couple and their teenage daughter who had joined in a suit charging a psychiatrist with failure to evaluate the girl's accusations of parental sex abuse. The parents, Richard and Cheryl Althaus, had been arrested and charged with sex abuse before their daughter, Nicole, recanted. They won \$213,899 in their malpractice lawsuit against the psychiatrist, Dr. Judith Cohen, and the Western Psychiatric Institute and Clinic at the University of Pittsburgh. . . . When the verdict was read today, Mrs. Althaus closed her eyes, sighed and held her husband's hand across their daughter's lap. Miss Althaus, smiling, said afterward, "I'm going back to college." (Associated Press, *New York Times*, December 16, 1994)

This refusal to seek corroboration of the patient's claims is clinical junk science in its most common form.

You cannot validate a clinician's intuitions with more intuitions, and you cannot validate what a patient says with what a patient says. However consistent or plausible the story is does not touch on the matter of truth, on accuracy and reliability.

Selective Amnesia and the Solar Phallus Man

Peter Huber, writing on the similarity between the layperson's willingness to believe in prophetic dreams and the pseudo-scientist's discovery only of data that confirms his or her theory, says: "Selective amnesia, a pick-and-choose economy with the truth, has a remarkable power to make the dreams that do occasionally come true seem important. In a similar manner, great catalogs of data that don't track the hoped-for results can be explained away before they are ever recorded in the laboratory notebook" (1993, p. 28).

A truly hilarious example of pick-and-choose research occurs in a current dispute over the theoretical work of Carl Jung, who is, along with Freud, one of the founders of psychoanalysis. He developed and popularized the theory of the collective unconscious. According to this theory, we all have buried deep down in the mind common myths and "archetypal" images, a sort of race memory of the human species.

One basis for Jung's theory . . . is a case known as Solar Phallus Man. This man, a patient at the Burgholzli Mental Hospital in Zurich, where Jung was a physician until 1909, claimed to have seen a vision of the sun with a phallus. The image, Jung contended, came from the ancient Hellenic mystery cult of Mithras, a pagan god associated with sun worship.

Over the years, Jung used the case as a proof of the theory, arguing that the man could not have known about Mithras and so must have derived the image from deep within the collective unconscious. (D. Smith, *New York Times*, June 3, 1995)

But a modern Jung scholar, Richard Noll, claims that the patient was simply familiar with popular books of the time on the subject and that Jung knew this and lied to the psychological community when he hid this fact from his followers.

This is a notable dispute because it so closely echoes the controversy over alien abduction fantasies raging around Cambridge, Massachusetts, these days. Abduction proponents argue that the alleged abductees tell remarkably similar stories and have somehow been insulated from the popular sci-fi culture that saturates America. QED, they were all abducted by Martians.

How can anyone, in good faith, take such "data," subject them to the interpretation of clinical intuition, and treat them as "evidence" to support a "theory"?

Flashbacks, Trauma, and Vietnam Veteran Killers The most extraordinary aspect of clinical research when considered from a scientific point of view is its imperviousness to the complete absence of material evidence considered indispensable in any other endeavor that claims to be a science. One such courtroom favorite is the flashback. Vietnam veterans who hear the radio station traffic helicopter overhead suddenly see themselves back in combat, crouch down, and take cover. Seized by a flashback, these suffering vets load up rifles and blow away the wife and kiddies under the misperception that the family is the enemy.

The public likes flashbacks because they have such dramatic power and fit in so well with currently popular theories of memory. However, is there actually any evidence at all that flashbacks exist? No. The existence of authentic flashbacks presupposes that memory

works like a video recorder, storing perfect, unalterable records of life's experiences in the mind. When a flashback occurs, the patient puts the video machine on rewind and then hits the play button. Zoom. Back again to the enemy-infested jungles of 'Nam. Sounds perfectly plausible, doesn't it?

Well, no. In fact, everything we know about memory suggests that flashbacks are impossible. We have no video recorder between our ears. There is no evidence that the "tapes" of life's events, whether traumatic or otherwise, are stored in little vacuum packs in the brain, waiting in pristine condition to be replayed as needed. Memory is selective, destructive, reconstructive, alterable, distortable, dissolvable. No videotape. No film. Not even a handwritten diary. There may indeed be people whose hallucinations, fantasies, or nightmares carry a powerful sense of *déjà vu*, but a sense of familiarity carries no seal of authenticity.

Nevertheless, professional trauma experts can be found who will claim straight out that the nightmares often are exact replicas of the traumatic event. What an extraordinary assertion! Just trying to imagine the evidence necessary to make such an astounding claim quite stuns the mind. My video player must be jammed. How could anyone claim to know that your nightmare is an *exact replica* of your experience of twenty years ago?

Does the lack of evidence for the existence and operation of flashbacks stand in the way of clinicians specializing in trauma hiring themselves out to explain to the courts about the delusionary authenticity of flashbacks? Indeed not.

A Louisiana court, using a M'Naghten modified insanity test, acquitted a former Marine of murder in *State v. Heads*. The accused had experienced extensive combat as a point man in long-range reconnaissance patrols in Vietnam. After returning home he suffered a flashback following a stressful marital breakup and killed his brother-in-law... Heads, reportedly perceiving his brother-in-law as a Viet Cong, pulled a rifle from his car, shot the victim through the eye and then "stalked the ranch house as though it were a straw hooch." The defense convinced the jury that Head's combat flashback had destroyed his ability to distinguish right from wrong. (Davidson 1988, p. 425)

Evidence for such intuitively compelling psychological phenomena is not necessary. All that is needed is for a well-credentialed expert witness to climb onto the stand and present this gobbledygook with sufficient authority and a lot of scientific-sounding jargon, and who is going to demand some petty little thing like scientific proof of what is said? It is distressingly easy to confuse a compelling narrative with self-evident truth.

Great novelists, for example, are wonderful at explaining human behavior, or at helping us seem to understand the underlying motivations and actions of individuals. . . . Although a reading of Hamlet may seem to reveal great insights into human nature, the play by itself does not constitute scientifically validated knowledge. (Ziskin, 1995, p. 85)

Tests, Tests, Tests

Intuition is the most frequently and widely used tool in clinical psychology, but it is not the only weapon in the forensic clinician's armamentarium. Clinicians who work for institutions of various types, like hospitals and universities, and those who testify in court or provide reports to the courts on various matters usually buttress their clinical intuitions with a slew of figures from what are known in the trade as assessment instruments.

The purpose of these tests is to blind judges and juries with science, but a quick look at the standard instruments used to gather data for court-ordered evaluations and in clinical research should give the most credulous pause.

MMPI and the Inkblot test Essentially two types of nonintuitive instruments are used for assessing psychological functioning, so-called objective tests and projective ones.

Objective tests are pencil-and-paper tests in which the person being assessed answers any number of multiple-choice questions about various topics. The most widely used and the most generally respected of the so-called objective tests is the Minnesota Multiphasic Personality Inventory (MMPI), designed in the 1940s by Starke S. Hathaway and John C. McKinley. The test asks 550 true-or-false questions about people's attitudes about religion and sexual practices,

their perceptions of health, and their political ideas, as well as information on family, education, and occupation.

The basic idea underlying both objective and projective tests is that the answers on the tests give away people's most secret psychological pathologies when their answers mirror those of patients with known diagnoses. The logic is simple. Depressed people supposedly give answers A, B, and C to questions 1, 2, and 3. You give answers A, B, and C to questions 1, 2, and 3. Voila! You are a depressive. Perfectly straightforward.

Generally, the questions were specifically designed to lack what is called content validity, so as not to give away the nature of the mental illness being assessed. Hathaway and McKinley thought that a test of depression that asked a bunch of questions like "Do you feel low a lot of the time?" was a dead giveaway both about what was being tested and about what the expected answer was for that question. They wanted a test that could not be scoped out easily by those taking it.

This design was compromised somewhat by the inclusion of questions designed to reveal symptoms supposedly known to be exhibited by certain supposedly well-defined groups of mentally disturbed people, but the balance of the test items were not obviously indicative of some kind of pathology. Answers on the MMPI are said to reveal hypochondriasis, depression, hysteria, masculinity-femininity, paranoia, hypomania (excitability), psychopathic deviancy, psychasthenia (irrational fears and compulsive actions), schizophrenia, and social introversion (withdrawal). There is also a scale that is supposed to detect truly savvy test takers who are just faking it.

Projective tests — the second big category of so-called psychological assessment instruments — are usually pictures (sometimes words or sentences), either meaningful or not, that supposedly stimulate the test taker to tell the tester some sort of revelatory story about what he or she sees in the picture.

The most famous of the projective tests, the inkblot test, was developed in 1938 by Hermann Rorschach, inspired by earlier so-called tests of imagination. As Anne Anastasi explains in her classic *Psychological Testing*, "projective techniques are regarded by their exponents as especially effective in revealing covert, Intent, or unconscious aspects of personality. Moreover, the more unstructured the

test, it is argued, the more sensitive it is to such covert material" (1970, p. 494).

There are ten Rorschach cards, five black-and-white and five colored. The client-patient-plaintiff-defendant is asked to go through the cards and discuss freely what he or she "sees" while the tester asks questions. The Rorschach, "unstructured" as it is, lacks any content validity at all.

What's wrong with using these putatively "scientific instruments" to measure enduring personality traits like paranoia or serious mental illnesses like schizophrenia?

Basically, they do not do the job. They cannot do the job. As instruments to measure the psyche, they are useless.

Just what, exactly, do we suppose that people labeled as suffering from a particular kind of mental illness have in common other than the category label? For the testing approach to work, the people who serve as the definitive representative groups for the making of the test must all truly have the same kind of mental illness, and that illness must manifest itself in uniform ways across all or nearly all of the patients.

Not even the fairly straightforward category of depression can make that claim—what most depressed people have in common is that they say they are depressed—so where does that leave the other hundreds of mental diagnoses used today?

There are no studies showing that, for example, one hundred people with, say, Diagnosis #10 give the same answers to the 550 questions on the MMPI or the same bird-butterfly-blood responses to the inkblot test. Not only would establishing so many consistent patterns of responses across all the mental diagnoses available have been an extraordinary amount of labor, it would never have worked out whatever the effort expended. Why not?

The logic does not hold water.

Even if we were to grant against all the evidence, just for the sake of discussion, that all or most of the persons categorized with a certain diagnostic label do actually show the same symptoms, does it follow logically that they also share views on religion, sexual practices, politics, and health as asked on the so-called objective MMPI? No. Of course not. And what sort of thinking or logic dictates that schizophrenics or depressives or obsessives or whoever all feel the same way

about the color red or the use of detail or "negative" space or whatever as required by Rorschach scoring systems?

Or, vice versa, that a great many people answer religious or political questions in common ways, or see one particular inkblot as looking like a butterfly, says nothing at all about their possible mental illness or lack of it, about their schizophrenia or depression, or their degree of compliance or contrariness or whatever. Why would it?

The logic underlying the use of psychological tests to diagnose people with unknown problems—that everyone with a certain type of mental illness resembles everyone else in the labeled group, right down to their feelings about the pope and the president, the color red, cannibals, and butterflies—is foolish on the face of it and empirically false.

In fact, the authors of the MMPI gave up the original attempt to use the test to diagnose various kinds of mental disorders almost before the ink was dry on the first edition.

Anastasi explains, “[W]e cannot assume that a high score on the Schizophrenia scale indicates the presence of schizophrenia. Other psychotic groups show high elevation on this scale and schizophrenics often score high on other scales. Moreover, such a score may occur in a *normal person*” (1970, pp. 445–46; italics added).

In a nutshell, that means that the most widely used instrument for testing personality in America has a theoretical foundation that is pathetically weak.

Was the MMPI, then, simply abandoned as hopelessly not up to the job? Oh, no. Of course not. Remember, clinicians are the people who think sinus problems are caused by sexual practices. The current routine is to take persons with similar profiles across the nine scales and then try to find something else in their lives that correlates with their MMPI profiles. By the end of 1995, there were over nine thousand such published studies. That means that for just about any profile a person displays in answers to the MMPI, the clinician can probably find some study somewhere that correlates the profile with something—low self-esteem, perhaps, or maybe cigarette smoking or eating disorders.

Are these profiles meaningful? Oh, no. They are not even reliable. In fact, the reliability of MMPI code types falls apart after two weeks. Two weeks! From one-third to one-half of subjects tested didn't

even have code types in the same diagnostic grouping on tests given two weeks apart. This is supposed to be a test of the enduring makeup of the personality? It is not completely unreasonable to suppose that adults might respond in much the same way from time to time on items questioning their religious or political beliefs, for example, but they don't. Numerous studies show that for normal college students, more than half show different profiles even when tested again only one to two weeks later. For psychiatric populations, the percentages who stay the same are even lower. After a year, the stability is laughable.

Undeterred by what others might see as crippling logical and empirical problems for both objective and projective tests, testing advocates slog ahead with revisions, elaborations, and embellishments of both objective and projective tests—especially the MMPI and the Rorschach—blinding the rest of us with a blizzard of code words and scoring systems.

The courtroom doubter—attorney or judge—bold enough to challenge the validity or reliability of these tests will in turn be challenged, "Well, what about the brand-new, state-of-the-art, high-tech, computerized scoring system, eh? Doesn't that answer your objections?"

The answer is "No, it doesn't." It can't and it won't until the tests acquire a theoretical foundation and empirical reliability and the diagnostic categories themselves achieve some degree of solidity to give a firm foundation for their measurement. Until that day arrives, the truly bewildering expenditure of intellectual effort to pump air into a dead horse will remain just that. It is sad and puzzling that so many excellent minds pass their time in just this exercise.

Neither clinical intuition nor any of the countless psychological tests currently in use and endlessly under development can possibly be held to be scientific instruments capable of providing precise and reliable data about the structures and functions of the mind, normal or abnormal, in general or for individual cases. It is laughable and downright fraudulent to pretend otherwise. It is inconceivable that any scientists would tout such "instruments" as the tools of their trade.

I Had a Case Like That So There Must Be Many Like That

Not only does clinical research routinely fail to control for innumerable extraneous factors outside the researcher's agenda, it nearly

always also fails to observe the most basic of conditions for ensuring that results can be generalized—choosing a sample that is truly representative of the people to whom the researchers want to generalize their findings. In the most common kind of clinical "research" the clinician "studies" only one individual, or sometimes a few, and then generalizes the "findings" to an indefinitely large number of other, unknown persons.

What is wrong with that?

Let us say that you had never before encountered the dog breed Bouvier. Let us say that the first Bouvier you encounter has blue eyes. Do you then conclude that Bouviers have blue eyes? Of course not. But in time you see another and another and another Bouvier, until you have seen ten such dogs and each and every one of them had blue eyes. Would you not then conclude that Bouviers generally have blue eyes? Of course you would. Who would not? But, at the same time, you know perfectly well that you might be wrong. It might be the case that 99 percent of Bouviers have brown eyes and you just happened to have encountered ten examples of that minority blue-eyed strain.

Because we are all aware that our personal experience is limited, even when we have seen a number of instances that support our hypothesis, we retain some doubt about our conclusion. In science, the attempt is made to reduce and quantify the doubt by sampling randomly from among all those Bouviers in the expectation that a random sample makes it more likely that the dogs seen will resemble those in the whole population of Bouviers more closely than would a sample based on nonrandom personal experience. In most clinical research, random sampling to reduce uncertainty and increase generalizability is not even an issue. Clinicians often generalize from single instances, from samples of one.

What a Single Instance Means Other than the fact that the accumulation of reliable scientific knowledge cannot proceed based on the ungeneralizable intuitions of individual practitioners about individual cases, what else is wrong with depending on case studies of actual patients?

Let us say that you are an American who has never known anyone Vietnamese. You know a fair amount about the Vietnamese because of our shared history, but you have never known, personally,

an authentic Vietnamese person. It happens that you hire one to do some computer programming for your business. So you get to know the guy a little. And you notice that he has some priorities, or values, that are different from yours. Different religious practices. (He's Catholic.) Different attitudes about sex. (He's chaste.) Different work habits. (He works like a crazy Vietnamese boat person grateful to be in America.) Different sense of family. (He sends most of the pittance you pay him back to Vietnam to support his mother and father.) And different life goals. (He wants to reunite his family and make them proud by succeeding in computer science.) So he's rather different from you.

What do you conclude from your relationship with this guy about Vietnamese people in general? "Nothing" is the conservative, scientifically correct answer, but that is bull. You conclude that it is very likely that most or at least many Vietnamese are like this guy you've hired. Why would you conclude that from just one guy? Well, why not? Why would you conclude that the guy you met is the wild card in the deck? You wouldn't.

We think people will be normally distributed. That if you grabbed a thousand guys off the street and measured their heights, say, most of the guys would fall in the middle and the farther you got away from that middle—like up to seven feet or down to five—then the fewer and fewer guys there are going to be. Most people are average; most people fall in the middle of whatever you are measuring. If I ask you what are the chances that the next man to show up at some party you're at is over seven feet tall, you're going to say it's damned unlikely unless you're hosting a Boston Celtics' party. We expect people to be average. When we meet the first person in our experience from some unknown bunch of people like the Vietnamese, we expect him to be average, to be typical. It's far and away the best guess, is it not?

It is far and away the best guess, but it is by no means a sure bet.

Tigers and Quicksand Is it sensible or foolish to generalize from a single experience? Say you meet your first tiger and it growls at you and charges, and you barely escape with your life by slamming the door of the cage shut just in time. How smart would you be to leave the cage door open and just stand there when you encounter your second tiger? Not smart. Not smart at all. If you survived the mauling

and having your arm bitten off, people would say to you, "Just how many tigers do you have to meet before you get the idea?" Because one should have been enough. You should have learned. How many times do you have to step in quicksand before you get the idea?

The same logic holds for the case study. If I meet one Catholic, chaste, hardworking, and so on Vietnamese fellow, then there are probably lots of Catholic, chaste, hardworking Vietnamese family men out there, right? Sounds good, doesn't it? It certainly works well enough for tigers and quicksand.

What's wrong with applying the same "logic" to people? First off, it doesn't matter if you're wrong about the quicksand or the tiger. A conservative approach to both cannot hurt you. Nor can it hurt anybody else. In fact, it might well protect you. When it comes to people, however, instant generalization has a big downside. Even if your prototypical Vietnamese was a good guy, generalizing from him to all Vietnamese leads only to witless stereotyping of millions of highly individualized people. And you're going to be real disappointed when the next Vietnamese computer programmer you hire steals your software ideas and skips town with a Protestant prostitute. When people ask you why you trusted this guy, are you going to say to them, "Well, I knew another Vietnamese man once and he was a great guy"? You can't say that; you would sound too stupid.

You know, we all know, that you cannot generalize from one individual to all individuals who are members of a group, because there is no way to guarantee that that individual is the most representative—the average—of the group. To make a reliable generalization to the whole group, one would need to study the behavior of many, randomly selected, and, one hopes, representative members of the group.

In every science, the ability to generalize your findings depends on the quality of your instruments, but it also is only as good as your sampling techniques. If we get a good sample, we can trust the generalization. Generalization is still dangerous, even with a good sample, especially when we try to apply it to a single unknown individual, but it is not so completely crazy as generalizing to millions from a *single* example.

For these reasons, no one with any scientific respectability would argue that the case study has any research usefulness at all

except to stimulate thought. Good ideas for research can be found in individual cases; research itself cannot. It is just inexplicable, then, that clinical psychology continues to publish hundreds of such cases each year in professional journals and to use them as teaching materials in class.

Double-Blind and Double-Sighted Even good science has its pitfalls. One of the most pernicious is the unconscious agenda. This is often called the Rosenthal Effect after Robert Rosenthal, who demonstrated its operation in some fairly important social science studies. Because the effect is so well-documented and so destructive of any claim to objectivity, researchers long ago devised a procedure for obviating those effects—a procedure routinely ignored by clinicians engaged in their pseudo-science.

The Rosenthal Effect is simply the effect of expectations of both researchers and subjects on the outcome of experiments. If the researchers who give sick patients little pink pills to make them better believe that the little pink pills *will* make them better, and if the patients believe that as well, better the patients will get. And this is true whether the little pink pills contain penicillin or white sugar. You get the effect you expect to get. Any properly designed experiment uses "placebos," little pink pills that really are sugar for half the patients, and real pills for the other half, and neither researcher nor patient knows who is getting what. That's called a double-blind experiment.

What you get in clinical psychological research is double-sighted experimentation. Both the clinician and the subject—often a patient—expect to see the same thing, and see it they do. Wonder of wonders. Aren't clinicians taught how to do research in graduate school?

Actually, many clinicians in academic departments and their graduate students often do make stabs at doing "research" beyond the case study. They grab a batch of college sophomores and give them three or four questionnaires and then look to see if there is any relationship between answers on one questionnaire and answers on another. For example, they might first ask students to fill out a questionnaire on family history with lots of questions about maltreatment, then ask the same students to fill out one on how they feel about themselves, and then another on how they feel about the relation-

ships in their lives. Researchers expect those students who report having rotten families and childhoods to also report feeling rotten about themselves and rotten about the personal relationships in their lives. Amazing. They do.

Any participant in one of these studies would have to be completely brain-dead to miss what the researchers are getting at with their questionnaires. They are suffering from face validity overload. The hypotheses in the so-called studies are transparent to both the participants and the researchers. This kind of double-sighted research is so common in academic departments, it is almost the prototype for today's clinical doctoral dissertation.

Strange too is the complete lack of any effort to make sure that all these questionnaires—there are thousands of them, with new ones being created every day—actually have anything to do with reality. They only ask people to "report" things as they see them. There is no cross-check to see if, for example, families reported to be abusive were truly abusive. The only subject matter for such "studies" is the question of whether students—or patients—are consistently negative or positive when asked about a number of related issues. This activity gets people Ph.D.s in clinical psychology but it sure as heck isn't science.

Shape Shifting in Clinical Junk Science

If we look at the most basic of issues in the definition of a science—common terms used in a consistent way—we find that even that most trivial of requirements is not met by clinical psychology. Definitions of concepts are so fluid, ever-changing with the whim of the speaker, and so utterly without any substantial basis that it is impossible to prove any claim, no matter how inconsistent with any other claim, to be wrong. As soon as any reasonable logical or evidentiary challenge is launched, the psychofact shape-shifts, assumes a new form, and heads off into unknown territory.

I Can Explain, It's a *Different* Kind of Gravity Dr. Lenore Terr, the psychological expert who was crucial to the conviction of George Franklin for the twenty-year-old murder of nine-year-old Susan Nason, gave us an illuminating example of definitional shape shifting as she prepared for the Franklin murder trial and provided a perfect illustration of why clinical methodology, theory, and claims should not be welcome in our courts.

Long before she ever met Eileen Franklin Lipsker, Dr. Terr had become famous through her interviews with the children who were kidnapped, school bus and all, in Chowchilla, California. These kidnapped children showed no evidence of repression following what seemed to have been a very traumatic situation—the children were kidnapped in their bus, driven into a pit, and buried underground with an air vent to keep them alive. As reported in Terr's book *Too Scared to Cry* (1990), the children had *not* been traumatized out of their wits during the misadventure, had *not* repressed their memories of the events, and even years after, they were quite capable of fairly clear and complete recall.

Now, this is not a great surprise. In fact, many people—even far too many young, vulnerable, defenseless children—remember their traumatic experiences all too well. Many of these people would welcome the opportunity to put out of their minds forever horrible memories of months or years of war, torture, or imprisonment, but cannot do so.

Yet here we have Eileen Franklin claiming that the death of her friend Susan was a memory so horrible that it remained hidden from her mind's eye for twenty years. How could that be? What made Eileen's trauma so special that it wiped out her memory?

Dr. Terr explains, "There were great differences in the wholeness of retained memory between the Chowchilla kidnap victims and Eileen Franklin Lipsker. The Chowchilla group consistently remembered everything. Yet Eileen started to repress on the very night of the day she witnessed her best friend's murder" (1994, p. 11).

How is Dr. Terr going to explain away this huge discrepancy? It would be like explaining why dropped apples sometimes rise up into the air instead of falling down to the ground. How could that happen?

Easy. It is a different kind of gravity.

After I met her, I realized that Eileen was what I had defined as a Type II trauma victim—a repeatedly traumatized child. She had always remembered, for instance, that her father was an unpredictably violent alcoholic—this she had not forgotten. . . . Moreover, Mrs. Franklin was hospitalized a couple of times for mental illness. The illness memories too might have been frightening. All this would have added up to make

Eileen a child well rehearsed in terror—a child prone to losing the memory of an ordeal.

These experiences were probably frequent enough and awful enough, in fact, to have allowed Eileen to develop the knack for automatic repression. By the time she was eight years old, she had no doubt practiced "forgetting" so often she could repress when she really needed to. Children who go through a number of terrors protect themselves this way. They are able to muster massive defenses against remembering, because this is the only way they can get through a frightening childhood. (Terr 1994, pp. 11–12)

You might think that Dr. Terr is saying that it will be easier for you to remember a single instance of rape if you have experienced only one than it will be if that instance is just one among dozens. She is not. Dr. Terr means that somehow an automatic mechanism of unconscious forgetting is triggered when you are the victim of multiple instances of abuse and not when you are the victim of only one or a few episodes. She is saying too that the traumatic amnesia is highly selective, applying in Eileen's case not to episodes of violent and unpredictable paternal violence, or to displays of maternal mental illness, but only to Susan Nason's death and some other unspecified but no doubt repeated traumas more horrible than drunken assaults but less horrible than murder.

This creative view of the mind is interesting, but it does leave all people who have survived the Holocaust, or other long-term hideous experiences like war, slavery, torture, and imprisonment, and who remember it, in a rather odd position. Dr. Terr is suggesting either that such experiences were not horrible enough to be traumatic and thus cause amnesia through repression, or that somehow most of the millions of people who find themselves in such situations are just generally pretty resilient.

Whether George Franklin killed Susan Nason is not as important as the misleading psychobabble poured out to make sense of Eileen's story. To account for Eileen's denial of memory of her traumatic event, Dr. Terr had to create a convoluted story that turned her previously held views on memory and trauma inside out. Fluid definitions like that are clever but they do make cross-examination of psy-

choexperts impossible. Changing definitions case by case and expert by expert makes any claim about the effects of trauma consistent with every other claim. And if we ever encounter a case that doesn't quite fit, we can create Type III traumas, and Type IV, and so on. There is no logical, theoretical, or empirical impediment.

Dr. Terr took this nonsense into court. Dr. Terr got a man convicted of murder on the basis of her clinical intuition, buttressed and complemented by her selective perception of the interesting story her client told to her. It was no problem at all with a theory so insubstantial and research that is no more than the intuitive biases of its expositors.

An old chestnut of a graduate school joke says that the B.S. degree stands not for bachelor of science but for "bull shit," the M.S. for "more of the same," and the Ph.D. for "pile it higher and deeper." The endlessly metamorphosing concept of traumatic repression is an excellent example of this process.

What kind of a theory could possibly be assembled on such a quicksand foundation?

Diagnosing the Foundations of Clinical Psychology Describing clinical psychology as "soft science" is flattering the field; it is as soft as a grape. Consider just the shocking but indisputable fact that it is rare to find agreement across clinicians or clinics on the results of psychiatric evaluations, on the basic mental diagnosis itself so central to countless criminal defenses and claims of psychological injury.

In the United States, diagnoses are usually based on the Diagnostic and Statistical Manual of the American Psychiatric Association (APA). Generally, everyone—every psychiatrist, psychologist, clinical social worker, psychiatric nurse, psychotherapist, and counselor—is supposed to use this diagnostic manual.

The first Diagnostic and Statistical Manual came out in 1952, followed by a revision in 1968; the DSM-III appeared in 1980, and was followed by its own mini-revision, the DSM-III-R in 1988. In 1994, we got the DSM-IV, some nine hundred pages long, covering 374 mental disorders.

The authors of the new DSM-IV claim that the sets of symptoms—what they call "criteria sets"—that are supposed to be used to determine a particular diagnosis were arrived at by consensus. That sounds like an impressive, almost scientific, level of agreement among

clinical practitioners until you see what these psychiatrists mean by consensus.

By consensus, they mean that the members of work groups assembled sets of symptoms for the various diagnoses by simply including all the symptoms championed by numerous different practitioners, turning the combined list into a Chinese menu multiple-choice test. Consequently, the manual directs that a particular disorder should be diagnosed if the patient shows one symptom from column A, two from column B, and one from column C. This inclusive approach certainly took care of any little niggling disagreements about which symptoms belong to which disorder, but it represents a pretty distorted view of the word "consensus." It's like saying that one hundred people agreed on what to have for dinner by the simple expedient of ordering everything on the menu. Consensus, my foot!

A new National Institute of Mental Health analysis of some 34,000 patients diagnosed with depression revealed that the majority do *not* suffer most of the "classic" physical symptoms of depression: unexplained fatigue, insomnia, poor appetite, restlessness, unusually fast heartbeat, constipation, or weight loss. Where patients do claim to experience a symptom such as "eat less than I used to," the only indication that that is true is the patient's say-so; there is no accompanying weight loss. Even among the most severely depressed patients, some 10 percent show no physical symptoms at all.

What this study shows is that clinicians reach their diagnoses for reasons of their own, just as they did before the publication of the new nine-hundred-page manual. Perhaps each diagnostician has his or her own favorite symptom of depression or schizophrenia or whatever—the tidy little symptom checklist is nothing more than a sham. The sham gives both the patient and the public alike the illusion that the mental disorder diagnosed is on another reality plane than the telltale behavior when indeed the disorder is often nothing more than a single "symptom" itself.

It is undeniably true that in the diagnosis of a medical condition such as cancer physicians will certainly disagree over which symptom has the strongest association with a particular diagnosis or which is most indicative of a certain prognosis, but that a test for breast cancer, for example, would be no more than a cobbling

together of a bunch of oncologists' varying opinions is unthinkable.

How did the authors of the diagnostic manual arrive at all those 374 different categories of mental disorders in the 1994 manual?

Consensus again. Disorders and symptoms went into the book if the various co-authors for the different sections of the manual agreed that they should. Sometimes that meant as many as sixteen people agreed, sometimes as few as five. The APA calls this "consensus." Whatever it is called, it has nothing to do with agreement among the tens of thousands of psychological practitioners out there in the field.

(That politics and passionate lobbying have since the first edition played a not insignificant role in determining which "mental disorder" gets into the book and which stays out is undeniable and has been the subject of several books, including Kirk and Kutchins's *The Selling of DSM*, 1992, and Paula Caplan's *They Say You're Crazy*, 1995.)

Given their farcical "empirical" procedures for arriving at new disorders with their associated symptom lists, where does the American Psychiatric Association get off claiming a scientific, research-based foundation for its diagnostic manual? This is nothing more than science by decree. They say it is science, so it is.

Clinical psychological practitioners simply do not mean by "science" what real scientists mean. And they never will without a drastic change in the foundations of their discipline.

We Can Explain Everything Science is evaluated as science not solely by its definitions and methodology — where clinical psychology fails spectacularly — but also by its explanatory adequacy — where it truly excels. Clinical psychologists, from Freud to the present, provide us with wonderfully plausible and comprehensive explanations of any and all aspects of human behavior. Of course, so do novelists.

We must be wary of any theory that explains too much. If virtually anything that could possibly occur can be "explained" by the theory as well as any other, even opposite, occurrence, then that explanation is not scientific because it is unchallengeable and irrefutable.

Pretend you are a male patient of mine. Assume that I assert that your classic seductive relationship with your mother, your alienation from your weak and distant father, and the symbolic structure of your dreams, along with the strongly feminine character of the literary career you have chosen, clearly tell me that you are homo-

sexual. You say, "I am not! I have a happy wife and seven children!" I reply, "So what? You are just defensively overcompensating for your homosexuality."

Anything a patient says, anything at all, can be found to have a coherent psychological interpretation despite an apparent surface contradiction between what is said and the interpretation. You cannot prove clinical psychological theory wrong in any respect. If you deny my clinical explanation, or if aspects of what you tell me are inconsistent with the explanation, then I have only to invoke mysterious psychological mechanisms to ride right over you.

How are you going to prove that I, your therapist, am wrong? You can't. Anything you say about your life and how you feel is perfectly consistent with my interpretation. Since, by definition, you have no access to your unconscious mind, who are you to dispute my claims about your unconscious? Good luck trying it.

Neither the patient nor anyone else, in or out of a courtroom, can falsify the claims a clinical professional makes about the working of the mind. Without observation of the phenomena of interest or their reliable indicia, testability is impossible. If testability is impossible, then falsifiability is moot.

THE STATE OF THE ART

The Unicorn Argument

Court cases, by their very nature, involve agendas. The goal of testimony—scientific and otherwise—is always to make some point for one side or another. That objectivity of all testimony—scientific and otherwise—takes a serious beating in court is not really very surprising.

What is truly astonishing, however, is when the absence of scientific evidence that harm did *not* occur is taken as evidence that harm did occur. For example, some of the attorneys for the silicone breast implant plaintiffs claimed injury by arguing that research has *not* proved there is *not* a connection. That's beautiful. Although not all that common in medical argument, it is an extremely popular tack in the claims made by clinical psychologists.

It is what I call the Unicorn Argument.

For example, I might say, "There's no such thing as unicorns." You say, "Of course there are unicorns. They are always kissing vir-

gins." "No," I say. "I have looked everywhere and cannot find a single unicorn." "You have not looked everywhere, and even if you did, the unicorns were one step ahead of you." Stymied, aren't I? You must be right. There are unicorns all over the place just beyond the edge of my vision.

The silicone lawsuits aside, it is very hard to find any reputable scientist who would make the Unicorn Argument even in the silent recesses of the heart. It is fundamentally counter to scientific reasoning. The scientist believes nothing unless it is proven to be true. "I will *not* believe in unicorns unless you can prove to me that unicorns exist." The unicornist believes everything unless it can be proven absolutely to be false. "I *will* believe in unicorns until you prove to me that there are none."

Clinical psychologists regularly lay claim to beliefs on the grounds that they have not been disproved. But it is not possible to prove that something does *not* exist simply because you failed to find it. There are many possible reasons for your failure, only one of which is the nonexistence of whatever it is you are looking for. There are many possible reasons that people in a study do not behave as expected other than the one the researchers hold to be true.

But true believers will die believing in unicorns. Actually, true believers will continue to believe even in the face of incontrovertible evidence against the belief. Everything, after all, is subject to interpretation and reinterpretation. With the right frame of mind, there is no such thing as incontrovertible evidence.

This outlook on life makes perfect sense in what are properly considered "matters of faith." It doesn't make sense in the training or practice of scientific professionals, psychological or otherwise, and it does not make sense in our courtrooms. You cannot allow Miss Marple on the witness stand to argue for the existence of unicorns. It does violence to logic and terrible damage to real people's lives.

Astronomy and Astrology

Almost since its inception, clinical psychology has been subjected to the same criticism: It's not a testable science; it's a secular religion disguised as a science. And, since the first utterance of this presumably crippling criticism, the defensive reply has been, "Oh, you academics are always saying that." It is time to drop the charge that clinical psy-

chology is nothing more than a secular religion. It has always fallen on deaf ears and it will continue to do so.

A more telling comparison likens clinical psychology to astrology and experimental psychology to astronomy. The names of the two fields are similar, but they have nothing more in common than an interest in the stars. They do not have common aims and their methodologies could not be more dissimilar. Moreover, astrological practitioners do not usually claim that either their general "theories" or the interpretations of an individual's astrological portrait are scientifically based.

Nevertheless, astrology, like clinical psychology, is a comprehensive and coherent system for the interpretation and prediction of human behavior. Also, like clinical psychology, astrology is taken very seriously by a large number of people—whose identities are often quite surprising—who claim that it illuminates and guides their lives.

Astrology is widely accepted as true by believers in astrology, just as much of clinical psychology can be said to be generally accepted by believers in clinical psychology.

It is entertaining but absurd to imagine our courtrooms filled with astrologers testifying that Leos would never commit murder when the sun is in Jupiter or that Capricorns make better parents for Virgos than do Geminis. Very few adherents of astrology would attempt to get astrological interpretations, in general terms or for specific individuals, accepted in court as expert testimony. (Or would they?)

Moreover, despite the millions of horoscope readers and customers of psychics, society will not let astrologers bring their articles of faith into our courtrooms as expert testimony. Society as a whole maintains that there is some important difference in the quality of beliefs of astrologers and astronomers and in the credibility of true believers and scientists, a distinction that is crucial for our justice system to maintain.

Yet we not only tolerate but welcome testimony from clinical psychologists that, like astrological interpretation, is built on nothing more than faith.

It is profoundly disturbing that clinical psychologists are themselves unable to maintain this critical distinction between fact and belief, between astronomy and astrology, as their testimony on the wit-

ness stands in courtroom after courtroom shows. How can educated people so blind themselves to the reality of their own belief system?

The Problem of Psychology

All professionals who identify themselves as psychologists share a common problem: They cannot study what they so desperately want to study, the structures and functions of the mind. They don't want to be philosophers who create elegant logical arguments about the nature of the mind, the nature of reality, and relations between the two. Oh, no. Philosophers get no respect these days. If you go to a party and say that you are interested in whether there will be a sound if a tree falls in the forest and there is no one around to hear it, your fellow party guests will walk away mumbling under their breath, "Get a job."

In today's America, psychologists must be *scientists*. But, alas, they are scientists with no direct access to their subject matter and not a hope in hell of ever getting one. What *experimental* psychologists do, most of them, is compromise. If they wish to study an inaccessible mental process like what little babies pay attention to out in the world, for example, they define "attention" in terms of something that they can actually measure, like the amount of time the babies spend looking at one thing or another.

That makes every research psychologist vulnerable to the same criticism: You aren't measuring what you say you are measuring. You can't measure what you want to measure and you are making great inferential leaps from what you are actually measuring—like babies' looking behavior—to what you wish to measure—like babies' attention. You want to make a description of some mental activity using the building blocks of physical activity; from these shabby clay bricks you are attempting to build a cathedral of glass.

It's a point well taken.

I think it is the general impossibility of arriving at a verifiable account of mental activity that leads so many clinical psychologists into cutting the tie to physical observation altogether. If we are always stuck making these great inferential leaps from the carefully controlled studies of physical behavior to the mental processes underlying those behaviors, if we have no way of guaranteeing that the leaps are in any way producing an approximate model of the mental activity of interest, then to hell with it.

HOW CLINICIANS DEFEND JUNK SCIENCE IN COURT

It is bewildering but true that despite the incessant claims that clinical psychology is a science with its findings soundly based on scientific methodology, clinicians challenged in court often revert to a flat-out denial of the status. Often, when challenged in court about the lack of scientific evidence for their claims, clinicians will reply that they are not scientists, they are artists, and that they are not interested in numbers or groups because they deal with individuals. They claim that science is irrelevant and unnecessary to their conclusions.

In addition, they launch ad hominem attacks on the scientific experts themselves. Dr. Lenore Terr in the Franklin case referred to experts on the scientific study of memory as "outsiders."

The ultimate courtroom put-down of the scientific researcher by a cross-examining attorney is, "You have never seen a patient, have you? So how would you know?"

Lenore Terr describes the use of this tactic in the Franklin murder trial:

As Elaine [Tipton, the prosecutor] had anticipated, Elizabeth Loftus [an experimental psychologist from the University of Washington] eventually also appeared for the defense. She testified that her misinformation experiments served as proof that repressed memory can be changed in the process of intake, storage, or retrieval. But Elaine was ready for Dr. Loftus, and on cross-examination quickly received an acknowledgment from her that she was not a clinician and did not ordinarily use children in her research. (1994, p. 57)

That seeing patients almost constitutes prima facie evidence of the inability to give scientifically accurate and reliable testimony doesn't enter the minds of anyone in court. But it should. It must.

Miss Marple is testifying in our courts. Miss Marple is writing "psychological" reports for our judges. Miss Marple is telling our legislators how to write law to match up with Miss Marple's intuitions about how the mind works. This farcical state of affairs cannot continue. The larger society has already begun to believe the courts mad, and a society that does not believe in its system of justice is a doomed society.