The Goldwater Rule and the Constitutional Conundrum: How to Define Crazy
by Whitney McKnight
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If one in five persons in the U.S. experiences mental illness at any given time, as federal data show, then more than 100 members of our federally elected governing body, including whomever is in the White House, are also suffering from a clinical mental condition at any given time. Does this impact their ability to lead? And why aren't the ones in society among the best equipped to help us navigate and explore these questions – namely, psychiatrists – leaving mostly non-mental health professionals to speculate widely on the mental stability of President Donald Trump in the media?

The answer, according to a psychiatrist thought to be the last surviving co-author of what is colloquially known to mental health professionals as "the Goldwater Rule", is a misapprehension of psychiatry's code of ethics.

"The first thing to appreciate about the so-called 'Goldwater Rule' is that it is not a rule, but rather a principle," Allen Dyer, MD, a professor of psychiatry at George Washington University, wrote to The Washington Diplomat in an email. "Much of the current discussion applies rule-based legalistic thinking to a matter of professional judgement based on principle."

More formally, the "rule" is known as section 7.3 of The American Medical Association's Principals of Medical Ethics with Annotations Especially Applicable to Psychiatry. Because psychiatrists are medical doctors who specialize in mental health, the AMA's code of ethics form the basis of the American Psychiatric Association's own ethical code. Section 7.3 specifies "it is unethical for a psychiatrist to offer a professional opinion [of any public figure] unless he or she has conducted an examination and has been granted proper authorization for such a statement."

Some psychiatrists view this ethical stipulation for membership in their professional association as a gag order. Others see it as an essential tool for protecting the gild. Either way, while none of the APA's roughly 37,000 members has actually been cited for violating this section of the code during the recent campaign cycle, nor since President Trump took office, fear of transgression has largely prevented psychiatrists from entering the public debate over whether President Trump, and possibly others, are too mentally ill to lead.

The fear is misplaced, according to Dr. Dyer, who as a member of the APA's inaugural ethics committee formed in 1973, helped write the code. The author of several books, including, "Ethics and Psychiatry: Toward Professional Definition" Dr. Dyer said in an interview that "the intention … was not so much to punish members of the APA but to educate members to be sensitive to the ethical norms and principals."

Dr. Dyer recalled that the committee believed section 7.3 was the best way to prevent "another Goldwater fiasco", a reference to the APA having been on the losing side of a libel suit filed by

1964 Republican presidential candidate, Arizona senator Barry Goldwater who sued the association after nearly 1,200 of its members were reported in Fact magazine to believe he was not "psychologically fit" to be president.

Thus section 7.3 indeed was crafted in part to protect the gild, something Dr. Dyer pointed out is rooted in the second paragraph of the Hippocratic oath that professes a commitment to medical law above all else. "There are two sides to that coin, one of which is that the interests of patients will be served by a principal of beneficence and the profession banding together to articulate principals of ethics that hold the members to common standards," he said. "The subtler aspect to that is there may be interests in society that are at odds with the interests of the profession."

The guidance is not meant to silence members, however, according to Dr. Dyer. "Section 7 says 'a physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.' That's an affirmative obligation of the profession," Dr. Dyer said. He suggested there has been too much focus on the section's "don't", and not enough on its "do" that states, "a psychiatrist may share with the public his or her expertise about psychiatric issues in general."

For example, if a psychiatrist who had not examined the president were to say the president is a narcissist, that would be unethical because it would be what Dr. Dyer, who is not currently a member of the APA's ethics committee, called "diagnosis from afar." What would be ethical would be to explain in general terms how the profession understands pathological narcissism. "Then it isn't the psychiatrist making the judgement the president is a pathological narcissist, it's an elaboration on the term and the technical meaning of it," Dr. Dyer said.

In March of this year, the APA's ethics committee reiterated and even strengthened its stance that members have the right to make public, general statements about psychiatric diagnoses, but that is where the line is drawn. "When a psychiatrist renders an opinion about the affect, behavior, speech, or other presentation of an individual that draws on the skills, training, expertise, and/or knowledge inherent in the practice of psychiatry, the opinion is a professional one. Thus, saying that a person does not have an illness is also a professional opinion."

The opinion also advises members that they are not precluded from profiling historical figures "aimed at enhancing public and governmental understanding of these individuals."

So far, however, public discussion by APA members has been less about how best to impart current general insights into clinical diagnoses and their psycho-historical implications, and more on whether the rule-that-isn't-a-rule should be scrapped, modified, or adhered to impeccably.

In May, during the association's annual meeting, a standing-room only gathering of psychiatrists from across the nation listened as an expert panel debated the Goldwater Rule. The panelists in favor of the rule included two past APA presidents, one of whom is also a law

professor; the dissenters were a former head of psychiatry for the Central Intelligence Agency, and a psychiatrist-philosopher. Their collective arguments, as detailed in an account written by one of the symposium's organizers, Nassir Ghaemi, MD, MPH, a professor of psychiatry at Tufts University Medical Center in Boston, Mass., reveal that concerns over the Rule extend beyond protecting patients and the profession, but also touch upon the long-standing struggle in psychiatry to overcome suspicions that it is not a real science.

Congressman Tim Murphy (R.-Penn.), himself a clinical psychologist, often cited a pervasive "anti-psychiatry" sentiment in federal mental health policy that drove him to push for more federal support of evidence-based treatments – including medication – which are derived from clinically controlled trials, not simply clinical observation, a DSM mainstay. He also called for the creation of the nation's first-ever cabinet position of a clinically trained professional to oversee mental healthcare delivery. His efforts were based in part on a 2014 House Energy and Commerce subcommittee report that he said in a statement showed "those most in need of treatment – patients with serious mental illnesses such as persistent schizophrenia, bipolar disorder, and major depression – are the least likely to get the acute medical help they desperately need." These provisions he authored ultimately were incorporated into the bipartisan 21st Century Cures Act of 2016.

A furor erupted when President Trump ultimately chose psychiatrist Elinor McCance-Katz, MD, as the new for mental health czar, by-passing Rep. Murphy's own pick, widely reported to be Michael Welner, MD, a forensic psychiatrist.

Rep. Murphy expressed his outrage in a statement accusing Dr. McCance-Katz of having a history of defending what in his view are pseudo-scientific psycho-social approaches to care, over evidence-based treatments for serious mental illnesses like schizophrenia. Although the APA did not actively oppose Dr. Welner, inventor of a controversial, evidence-based scale that seeks to quantify depravity, it did endorse Dr. McCance-Katz, citing her training as an addictions specialist as welcome during a time when the opioid crisis rages in the U.S.

The acrimony points to how historically, the way psychiatrists define, diagnose, and treat mental illness has, at times, lead some in medicine to hold psychiatry at arm's length. In 2013, just prior to the release of the APA's fifth edition of its Diagnostic and Statistical Manual of Mental Diagnosis (DSM-5), Thomas Insel, MD, himself a psychiatrist and then director of the National Institute of Mental Health, wrote a scathing rebuke of the field manual, calling it simply a "dictionary" and deriding its over-reliance on unvalidated symptom clusters that have no basis in biology. He went on to announce that from then on, NIMH grants would be awarded primarily according to a new schema of biology-based research criteria intended to change how mental illnesses are defined and diagnosed, a system that has so far yielded mixed results.

Other critics of the field often touch upon psychiatry's extensive relationship with the pharmaceutical industry, which some believe has led to pathologizing the human condition in order to swell the ranks of those who take pills. Gary Greenberg, a Connecticut-based

psychotherapist and prominent author of The Book of Woe: The DSM and the Unmaking of Psychiatry, criticizes the association for claiming "the naming rights to psychological pain" for the sake of profit.

During the debate at the annual meeting, panelist Paul Appelbaum, MD, who is also the Elizabeth K. Dollard Professor of Psychiatry, Medicine and Law at Columbia University in New York where he also directs the university's Division of Law, Ethics and Psychiatry, is reported by Dr. Ghaemi to have said that, after 40 years in the field, he'd consistently observed that how a psychiatrist views a presidential candidate "without exception" mirrors that psychiatrist's personal political leanings.

Dr. Ghaemi's response was that, "If we accept the perspective that we should say nothing in public because psychiatrists have different views (e.g., bipolar vs. attention-deficit disorder vs. sociopathy vs. narcissism), all of which could be wrong, in this case we must admit that psychiatrists just don't know what they're talking about and thus should say nothing." Doing so, he wrote, would mean "accepting the basic critique of anti-psychiatry groups – namely, that there is no truth to psychiatric diagnoses."

Rejecting this as "nihilistic", Dr. Ghaemi argued in his report that this was antithetical to science, which he said relies upon the free exchange of ideas until the truth, which he called "corrected error" emerges. "Science involves refutation of false hypotheses, not censorship of them," he concluded.

According to panelist Claire Pouncey, MD, PhD, a Philadelphia-area psychiatrist and philosopher, in an attempt to prevent psychiatry's public image, the APA disrespects individual members' rights to exert their moral agency for finding nuance between categorical should and should nots. Last year, as co-author of an article in the Journal of the American Academy of Psychiatry and the Law Online, Dr. Pouncey wrote, "The court of public opinion will adjudicate professionalism and propriety, and the APA may opine in this setting, but embarrassing the profession violates etiquette rather than ethics."

The panelists concluded perhaps the language of the rule should be revised, but a blog post written by the APA's immediate past president Maria A. Oquendo, MD, PhD, stating that "the Goldwater Rule is more important than ever," seems to cement the APA's position. Dr. Dyer himself is skeptical the APA will budge.

Non-psychiatrist mental health clinicians meanwhile are unfettered by the Goldwater Rule. Clinical psychologist John Gartner, PhD publicly and persistently decries the mental state of President Trump. He is the founder of an online petition calling for invocation of the 25th Amendment to remove President Trump from office based on his mental instability.

"When people were saying Trump would pivot and become more presidential, I said, that would be true if he weren't so mentally ill. But people don't stop being mentally ill when it's convenient for them or in their best interests to do so. Because this is a genuine illness and not

an act, even when it's in his best interests to start behaving more normally, he can't do it," Dr. Gartner said in an interview.

Adopted in 1967 after President John F. Kennedy was assassinated, the 25th Amendment clarifies that if the president is incapable of carrying out the duties of the office, then the vice president legally can. The amendment does not spell out what constitutes incapacitation, but mental illness is conceivably a reason, and would likely be addressed by section 4 which speaks to removing a president against his or her will. Doing so would require a majority of executive departments, such as secretaries of the collective Cabinet or another group designated by Congress, as well as the vice president, informing the speaker of the House and the Senate pro tem that they find the president unfit to govern. If the president disagrees, a two-thirds majority bicameral vote in Congress is needed to depose the president permanently.

Dr. Gartner, who divides his practice between Baltimore, Md. and New York, said his petition observes a code of ethics adhered to by psychologists, psychiatrists, and many state legislatures alike, namely the "duty to warn". Generally viewed as the obligation of all mental health professionals to notify law enforcement if a patient is thought to be in danger of self-harm or poses an imminent threat to others, Dr. Dyer emphasized the closest psychiatry comes to this is a California Supreme Court ruling specifically calling for therapists to warn about patients who pose a threat, not any member of the public. "There is no duty to warn in the actual code of ethics. It is a subjective sense that many people feel in view of the alarm of Trumpism," Dr. Dyer wrote in an email.

Dr. Gartner's own approach is to apply the code in any situation. "If we see something, we must say something," he said in the interview. "[President Trump] enjoys inflicting pain on people, which is a very dangerous characteristic in a leader."

Although he does not have a therapeutic relationship with President Trump, Dr. Gartner believes the president has malignant narcissism, a diagnosis originated by the late German psychoanalyst, Erich Fromm, who applied it retrospectively to Adolf Hitler. According to Dr. Gartner, the four main parts are: narcissistic personality disorder, paranoia, anti-social personality disorder, and sadism.

A sizeable portion of the nation's professional mental health contingent agree with Dr. Gartner's position, if not necessarily his exact diagnosis: the petition has well over 50,000 signatures, even if not all can be confirmed as belonging to clinical personnel.

There already is a Democratic-sponsored bill in the House calling for a commission to oversee a medical examination of the president if section 4 is triggered. In that case, Dr. Gartner believes his petition helps give Congress cover. "If we can say 56,000 mental health professionals are warning you that [the president] is dangerously mentally ill, and you are thinking of removing him, we offer the professional observation for what you are seeing with your own eyes," he said in the interview, hypothetically addressing members of Congress.

That argument assumes agreement over which diagnostic criteria to use, however. Malignant narcissism does not appear in the DSM, and so technically is not a clinical psychiatric diagnosis. Narcissist personality disorder does appear in the DSM, but does not accurately describe the president, according to Allen Frances, MD, the psychiatrist who defined the diagnostic criteria of the diagnosis. In an op-ed to the New York Times, Dr. Frances wrote, "He may be a world-class narcissist, but this doesn't make him mentally ill, because he does not suffer from the distress and impairment required to diagnose mental disorder."

Rather than experience distress, the president inflicts it, typically to his benefit, wrote Dr. Frances. "Bad behavior is rarely a sign of mental illness, and the mentally ill behave badly only rarely," Dr. Frances concluded.

Dr. Dyer said he agreed "generally" with Dr. Frances and suggested that whether or not the president has a mental illness is beside the point, wondering if "the real objections are moral and political."

His question once again raises the reliability of the DSM.

"I do think there is a loophole in the understanding of personality disorder that needs further elucidation," Dr. Dyer wrote in an email.

In their attempts to correct inconsistencies created by psycho-analytic theory, the authors of the third edition of the DSM, published in 1980, established what Dr. Dyer called "tick box" criteria. Diagnoses became less ambiguous as a result, but the lack of nuance also has proven problematic. The authors also decided that what had been called "character disorders" sounded pejorative, and implied a judgment against the patient and so the nomenclature changed to "personality disorders." To further remove any connation of stigma, the successive manuals now include that the disorder causes distress to the patient, implying they desire not to exhibit the presenting characteristics.

What would be useful to clarify, Dr. Dyer believes, would be when strategies that people devise as a way to cope with the world – which he referred to as a person's characteristics – from when those strategies develop into something pathological. "This is where we come to the question of what does it mean to have a disorder? There is also a metaphorical aspect of madness, where a person … is not accounting for all the facts of a situation. Then we hear not in a psychiatric sense, but in a popular sense, 'this is utter insanity', but it is not reducible to a psychiatric disorder."

Whether President Trump is distressed by his behavior or bothered by the distress it causes others "merits further consideration," according to Dr. Dyer. "Not just in terms of trying to understand [him], but in terms of the nomenclature that is used," he said.

It also brings into question how to evaluate whether there are times when mental disorder is desirable in a leader, and why. In his book, A First Rate Madness: Uncovering the Link Between Leadership and Mental Illness, Dr. Ghaemi uses psycho-historical contexts to prove his theory

that, “The best crisis leaders are either mentally ill or mentally abnormal; the worst crisis leaders are mentally healthy.” This begs the question: Even if the president is determined to have a diagnosis upon which all the mental health professionals consulted agree, might that be a good thing?

Can psychiatrists help the nation navigate the Goldwater Rule? Dr. Dyer thinks they can and should. “Psychiatrists have to act responsibly. That doesn’t mean you can’t answer questions and address concerns … that can become part of the debate, even as the media focuses on the legal considerations [of] obstruction of justice and corrupt financial dealings,” he said. “Psychiatrists are … looking for ways that their contribution can be constructive rather than further burden the divide.”

This could be tested in an unexpected way, however, since the very legislation intended to clarify how mental illness is defined and treated in this country, now has the potential to create confusion. By empowering the vice president and an executive body to decide a president’s capacity to lead, the 25th amendment was designed to make a coup unlikely, since presumably all will be if not members of the same party, then will have similar sensibilities. However, were there to be an evaluation of the current president’s mental fitness by members of his cabinet in a bid to depose him, there is now a psychiatrist serving as an assistant secretary of mental health.

Whether Dr. McCance-Katz would be called upon to offer her own diagnosis of the president, and what diagnosis she might give if so, is uncharted territory for a nation that has never been faced with a Constitutional need to clarify just what the difference is between a character and a personality disorder.

Dr. Dyer suggested that rather than focus on the mental status of our elected leaders, we should turn to whether they reflect who we are as a common people. “I think as a country the task we need to address ourselves to is [asking] what are the values we hold in common in this country. How are they applied in a particular situation, and if one politician and a group of politicians are flouting those values. I think that is the debate we need to have,” he said.

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