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The Problem of Assessment of Volition
(In Medicolegal Psychiatry)

By now, if we dare enough to revise what are the actual connotations of words used in psychiatry, without being handicapped by the current philosophobia the modern psychiatrists are suffering from, we are to start with revision of what volition could mean. This is particularly relevant in medicolegal psychiatry .

Arieti (l975) has stated that mature volition requires:

(1) the ability to evaluate several alternatives.

(2) the choice of one alternative .

(3) the planning of the chosen alternative .

(4) the will (or determination) to carry out the chosen alternative

(5) inhibition, since in order to will, the individual must be able to inhibit the non willed form of behavior.

In a previous orientation (Rakhawy 1979) the difficulty to delineate the nature and dimensions of volition has been demonstrated to stem possibly from :

l-The concept of volition is extremely related to the vague concept of freedom .

2-Volition is also related to different grades (and levels) of consciousness .

3-It is part and parcel of the general cognitive abilities that are responsible for what we choose and what we leave.

4-The influence of what is called mental mechanisms has a definite indirect relation on what we believe we choose and will.

5- Lastly, volition, to be actualized in a concrete performance, is controlled by the external realistic factors that interfere with the chances for fulfillment of whatever decision has been taken as volitional.

For any act to be called volitional (in the absolute sense, supposing that the choice is between two alternatives to start with, it was also stressed that certain conditions are to be fulfilled (Rakhawy 1979):

(1) To be aware of the other aspect of the self and of both aspects of the objective topic.

(2) To have enough information about the two (or more) aspects.

(3) To have actual adequate ability to take a decision that one aspect (or alternative) is more (or less) favorable.

(4) To be sure that there has been a real possibility to choose the other (unchosen) aspect (alternative). This should be guaranteed as a real possibility that can last for a long comprehensive testable duration .

(5)To guarantee that the left (inhibited) alternative is still occupying some superficial mechanical opposite. If implies, at a certain depth that the left alternative is included in the chosen one some way or another .

(6)A choice is to be a real choice if it has a definite chance to be actualized into a clear cut concrete testable performance.

(7)To bear the responsibility that follows this choice whether it has fulfilled its aim or failed to do so.

(8) A choice is a volitional decision if it is temporary by definition, and then, it should have the ability to branch into new choices and so on

This absolute situation is the extreme for a choice to be volitional. It only demonstrates how much it is difficult to judge a decision or an act as volitional. Practically, in particular moment, there is but one pace setter at a particular level of maturity organizations. The volition is measured by the proportion between the area and depth of the level of consciousness involved and the cognitive orientation, along with the decision taken, ready to be actualized in a practical performance.

The symptom labelled abolia (lack of volition) is least agreed upon in our psychiatric practice. In our practice in Egypt it is usually said that a patient has lost his volition (lack of volition) once he stops going to work . This could be, and is usually, far away from the actual state of affairs . Not infrequently, many patients have decided, cold blooded, not to work. He is actually performing the will not to work. If we are to demonstrate the actual loss of volition, we can trace this back to basic concomitant and underlying factors. We can easily,then detect certain definite underlying factors that could be partly responsible for a decision not to be fully volitional (in normal life).

Certain performances could no be judged as volitional in the proper sense if they are predominantly actualized through:

(a) deeply seated reflex response (favourable or unfavorable)

(b) complete identification .

(c) hypertrophy of other defensive mechanisms .

(d) absolute negativism .

(e) repetition of the same script .

At large, one can,then, identify certain different forms of the so called volition . Some examples are provided :

l- Peripheral volition, where the individual can take decisions related to some peripheral areas of his existence, usually as regards details but not the least approaching some central or basic choice .

2-Aborted temporary or situational volition, which stops short of fulfilling its ultimate goal.

3-Genuine central volition, which is related to increasing awareness and cultivating abilities. This fulfills more and more the necessary conditions for what have been called absolute volition (if this ever occurs).

The relation of volition to the essence of being is the profoundest aspect of volition. It is rather related to the so called genuine (or absolute) volition.(Related to and not identical with) . To be is to will. This is the only explanation that justifies including symptoms of loss of self limits and passivity phenomenon as disturbance of volition. If the patients fails to be, to have his very own self boundaries, he is but unable to will.

Medicolegal aspects of volition in psychiatry:

We have just noticed how much it is difficult to assess an act as volitional in normal life. This has been known since long time. Roger Smith, as translated by Ghoz (l982) has discussed the relation of mental disorders to social history and theories of volition in the early decades of the nineteenth century. Now-a-days we stopped discussing what is volition and escaped in more and more reductionistic solutions If it is becoming really difficult to define what is volition in psychiatric practice for practical assessment or therapeutic goals, it is much more so in legal setting.

When the distinction between neurosis and psychosis had been established and accepted, it was the tradition to say that neurotics have intact volition while psychotics have different grades of impaired volition. In recent nosology, there is no such clear cut demarcation. The legal responsibility is to be judged by the degree of impairment of basic functions needed for an act to be considered as volitional. Consequently a person is responsible in as much as his action is volitional .This did not solve the problem, since there is no real common standards that can help in grading the degree of impairment of volition .

In medicolegal practice, one can meet a schizophrenic in remission, or even a chronic established case of schizophrenia who can take decisions of volitional quality more adequate than certain cases of severe obsessive compulsive neurosis. Also cases of kleptomania or pyromania are sometimes indulged in certain illegal offenses out of the irresistible

pathological impulse.Thirdly, in cases of somnambulism, when the dissociation is really profound the individual can perform a crime while he is in a state of altered consciousness.

The situation of explosive or stormy personality needs special judgement for the efficiency of their volition at the explosive outbursts. In epilepsy the time of actual clearance of the state of altered consciousness is hardly to define. Hence, when the volition has regained its efficiency is always a matter of debate. In paranoid states the volition, in general, is intact, i.e. the patient chooses and acts in the direction he wills and decides. This is perfectly all right and apparently healthy in the area away of his delusional system. While in the area of delusional system, the impaired volition is the will to inhibit the consequences of abnormal beliefs that could be responsible for criminal act.

All the above mentioned problems refer to the well known fact that it is not the diagnosis that essentially counts in judging the degree of impairment of volition in medicolegal psychiatry.

We can reach a logical conclusion that is not the least new saying that: each case should be considered on its own merits and the degree of volitional handicap should be judged regardless the diagnosis or the severity of the illness. All that should count is the assessment of the degree of impairment of a particular function in a particular situation at a particular moment . Although this would seem to be logic, in its depth, it is some sort of escape .

We have to take in consideration certain ethical issues and personal factors not excluding religious or ideological beliefs of the judging psychiatrist himself. Moreover certain basic considerations related to the function and philosophy of law in the light of criminological and penological standards are acting as an essential variable influencing the judgement of the psychiatrist whether conscious or unconscious. The claimed abuse of psychiatry in the Soviet Union is not only directed to political authorities but to practicing psychiatrists. If there is any possibility that psychiatrist in the Soviet Union are brain washed, the condition is not less serious in western practice where pharmaceutical agencies brain wash psychiatrists' minds at their own request .This has its reflections in every field of psychiatric practice including medicolegal practice.

A more profound issue is worth considering in this respect. This is related to the claim that psychosis, including schizophrenia, is not only a reaction, but also, and more basically, an action (Shulman, 1968). Insanity is a point of view . This means that the psychotic existence and action are more or less willed . This is more true when we speak about awareness of the psychotic that he has chosen this situation without knowing before being psychotic. After the psychotic break, this awareness, in retrospect, makes him more and more responsible for

being ill. This is usually utilized for the sake of the patient in intensive therapy and, under optimal circumstances, the consequent improvement of the patient's condition may help to prove this hypothesis as valid. In general, one can argue that if psychosis is volitional, then what is based on volitional is volitional. I am not for such generalization in all cases, but this is to be considered, even in medicolegal practice, some way or another .

The current attitude about the structural organization of the human psyche as formed of multiple alternative hierarchical, or cross sectional organizations under normal healthy conditions can add more to our difficulties. If so, one can argue that if one ego (the child ego state for instance) has committed the crime why the other ego (the adult for example who has not been active at that particular moment) be responsible for such crime? However, such argument should be theoretical since, at a fixed moment, under normal conditions, some hypothetical axial core, or integrated whole, is responsible for the act of all organizations of the psyche in general.

To conclude, the problem of assessment of volition in psychiatry in medicolegal psychiatry is directly related to the general philosophy and ideology of a particular stage of development of each society as well as to the personal and scientific frame of reference of the practicing psychiatrist. A goal-oriented attitude about the penalty as a therapeutic tool and about the psychiatric label as social stigma penalty may make the duty of the judging psychiatrist much more human, scientific as well as logical.

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