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### Introduction

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## INTRODUCTION

Thomas L. Shaffer\*

This symposium abounds with learning and insight, but one should not overlook the fact that its purposes and its effect are revolution. Institutional confinement of the "mentally ill" in America is a massive social failure and a festering evil. These authors—lawyers, social scientists, scholars, psychiatrists, and students—have a target in their sights, and they are not out primarily to analyze the target; they are out to destroy it.<sup>1</sup>

The organization here is forthright and consistent with its benevolent tractarian objective. In the first and shorter part, on the "medical" decision to institutionalize, Professor Rosenhan, Mr. Roth, Mr. Dayley and Ms. Lerner assert a familiar thesis—that the commitment decision is a process of social definition, of rejection, by society, of deviance from norms of behavior; there is nothing honestly scientific, let alone medical, about it. Mr. Ferleger, a professional counsel for mental patients, concludes this section by examining the impact of the medical decision within the institutional environment and the concomitant threat to the civil liberties of mental patients.

The second and larger half of the symposium is addressed to legal rights. Professor Friedman and Dr. Daly relate the confinement of deviants to traditional constitutional principles of interest balancing; Dean Morris and Dr. Luby compare raw official data on commitment with social and economic variables which document the logical (but neglected) insight that mental-deviance processes are used to contain other forms of deviance; Dean Alexander and Dr. Szasz document a sharp distinction between penal (or as they call it, institutional) psychiatry and the contracted-for ministry of psychotherapy (only the former, needless to say, is under attack here). This legal section is completed by Ms. Tanenbaum's analysis of criminal sexual psychopath devices, which are used against sexual deviants with a familiar medical

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1. I have been invited to this present task because of a talk I gave to the American Hospital Congress in August, 1972, predicting such an attack. The National Observer, Dec. 9, 1972, at 26. That talk was interpreted, almost universally, as a piece of revolutionary fervor rather than, as I intended, a cool lawyer's prediction of what psychiatry could expect from law-reform lawyers. So polar are the times that one cannot even manage an insincerely friendly warning.

excuse, and Ms. Kennedy Pollack's analysis of *Jackson v. Indiana*, a recent Supreme Court decision which complicates a state's ability to use the competence-to-stand-trial rubric rather than create adequate procedures for trial of the mentally ill.

One way to analyze all of this is in terms of the objectives of the revolution, rather than in medical categories.

The universal, and most pressing, objective of the movement is to eliminate torture, mutilation, and homicide in institutions. Dean Morris and Dr. Luby, on admittedly thin data, are encouraging on institutional progress in this respect, but Mr. Ferleger, whose perspective is perhaps better, and other recent indicators,<sup>2</sup> are not encouraging at all. Mental hospitals are malign, global places. Mental patients are still beaten, shocked, drugged, or mutilated into submission. Even where these abuses are controlled, as they are probably controlled today in many places (the hospital in which Mr. Ferleger researched, for instance, or the hospitals Dean Morris and Dr. Luby looked at), the environment and the haze of drug-induced docility appear to create and confirm illness and deviance rather than "cure" it. Under Thorazine, "the patient . . . remains generally unconcerned, unquestioning and much easier to manage"—he exhibits, in other words, all of the classical benefits of lobotomy.

Mr. Ferleger's clients and subjects, if not mutilated, are nonetheless bored, rejected, depersonalized, unheard, sexless, and ultimately either isolated or brought to docile conformity. They are not seen by anyone in the external, "sane" society as significant, interesting, or even humanly hurt and needful. To be in a mental hospital, as Professor Friedman and Dr. Daly demonstrate, is to be a non-person. Mental patients are, as a matter of law, less than human.

The second objective of the revolution is to obtain for people in institutions—and one should include here the retarded<sup>3</sup>—the best care, and the promptest care, available. It is hard to avoid,

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2. *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971); 334 F. Supp. 1341 (M.D. Ala. 1971); 344 F. Supp. 373 (M.D. Ala. 1972), which documented every wild word used in this paragraph of text; see Bergin, *The Return of Lobotomy and Psychosurgery*, 118 CONG. REC., No. 26, E1602-12 (Feb. 24, 1972); B. ENNIS, *PRISONERS OF PSYCHIATRY* (1972). One cannot account for these atrocities by finding hospital personnel universally sadistic. Mr. Ferleger, Dean Morris and Dr. Luby find sadism to be rare. What seems to be operating are neglect and the fact that the institutional objective is, always and primarily, docility. Atrocity could therefore be put on a docility spectrum, ranging from the surest and least likely method of control (murder) through drug-induced docility, electro-shock, mutilation of the brain in lobotomy, beating, seclusion, and deprivation of "privileges," and on to the subtle forms of behavioral conditioning which Mr. Ferleger describes.

3. See *Wyatt v. Stickney*, *supra* note 2.

from Mr. Ferleger's research, the conclusion that most inmates receive little attention and much abuse, and that those who are given any ministration at all are given whatever can be devised to keep them quiet. The honest rubric for this, per Dean Alexander and Dr. Szasz, is protection *from* the deviant, *for* society and *for* the family (but not from the family for the deviant), and, as Dean Morris and Dr. Luby demonstrate, four-fifths of mental patients are locked up by their families.

Habilitation (or *rehabilitation*) is at best a promise to condition the "patient" into conformity ("We can't just let them sit by and be sick"), and at worst a benign, hypocritical excuse for containment ("problems of agitation are really management problems"). The second objective of the revolution hopes, without much reason for hope, for the day when courts will allow, as Ms. Kennedy Pollack prescribes, only that involuntary treatment which is truly temporary and demonstrably effective.

Both of these first two goals imply a fundamental replacement of authority in the system. No one seems as willing to say it as Dr. Szasz has been, but the political implication of our awareness of the mental institution mess is that the medical profession has failed to discharge its stewardship. ("I've found," one of Mr. Ferleger's psychiatrists says, "that most transfers [to maximum security] are for one reason—the medication is too low.") Above all else, control of institutions and of the processes for entering and leaving them, has to be taken away from the doctors. Confinement of the "mentally ill" is one of the rare instances—and, with a million citizens confined in mental institutions, the most flagrant—in which persons can be forced to undergo medical treatment.

There never was any reasonable hope that doctors could, for instance, predict violent behavior better than the rest of us can; it should not be surprising (as Mr. Roth, Mr. Dayley and Ms. Lerner and Professor Friedman and Dr. Daly note), that in fact they are worse at it. The right-to-treatment rubric, Professor Friedman and Dr. Daly argue, begs the question. The right to refuse treatment is, perhaps, the issue. As matters stand: "The law presumes that the person who is partially incapacitated is best assisted by depriving him of all liberty."

The third objective of the movement—the ultimate objective, really—is to abolish institutional psychiatry (and, I think, involuntary clinical and behaviorist psychology) altogether. One either opens the doors of the institution or erects such imposing legal protections against involuntary commitment as to make it impossible to lock the doors. Institutional psychiatry is part of a broad, old, but ever new movement to solve problems by eliminating

people who create or carry problems; the "mentally ill," like the aged ill, the retarded, and the unborn, are social nuisances—which tells you nothing about them, but everything about the rest of us.<sup>4</sup> Ms. Tanenbaum's discussion of the appeals of grade "B" criminal sexual psychopaths in California symbolizes the anomaly of it all; these people are, with unusual candor, certified by psychiatry to be (a) sick, (b) untreatable, (c) not necessarily guilty of crime, but (d) deserving of confinement.

One happy feature of these papers as tracts in the revolution is that they are realistic about the fact that the mental-health process is sociological, not medical. Mr. Roth, Mr. Dayley, and Ms. Lerner argue, and Dean Morris and Dr. Luby demonstrate, that the poor, the black, women, and the unrepresented are at least twice as likely to be involuntarily committed as the rest of us. The issue of bizarre people has become heavily medical only because psychiatry has allowed itself to be converted from the appealing image of Freud bidding Dora good-bye (because she *wanted* to go and he, a mere doctor, did not even want to stop her),<sup>5</sup> to the keepers of jails and houses of torture, retribution, and silly experimentation. Or, to vary the apocalyptic metaphor, the process of labelling and excluding deviants has become medical because it is comforting for us to find the unacceptable sick rather than bad. We have lost the rigor of our Puritan tradition, but not its fearful insecurity.

Psychiatry (see Mr. Roth, Mr. Dayley, and Ms. Lerner) appears to be massively frustrated at the poor results of shock, chemistry, "rage reduction," "aversive therapy" and confinement, although it seems usually to want to keep on trying. It is finally, though, too easy to blame all of this on the doctors. (One reason we keep doing it I think is that so many of the doctors are incredibly defensive and unscientific in their reaction to law-reform lawyers and renegade psychiatrists.) In the last analysis we revolutionaries had best realize, as we begin, that America has mental hospitals because it wants them. The evil is not really hidden. It has for a long time not been hidden. Our fellow citizens know what they are doing. The danger is our own myopic, conspiratorial view of public policy.

It is sufficient for a prisoner to identify the holder of the key to his cell—psychiatry in this case—but the community keeps the prison and hires psychiatry to guard it. A dismal and partial theory of medicine oppresses a tenth of America, but it is clear

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4. A good theoretical source here is K. ERIKSON, *WAYWARD PURITANS* (1966).

5. S. FREUD, *DORA: ANALYSIS OF A CASE OF HYSTERIA* (Collier ed. 1963); see T. SHAPFER, *DEATH, PROPERTY, AND LAWYERS* 230-32 (1970).

enough that the other nine tenths of us give psychiatry its dubious license to practice. We are so ungenerous in defining ourselves that we label as dangerous people who are merely odd. We are so nervous about our identity that we fear people who don't fit our ideas of what people—Americans, citizens—ought to be. We give over our oddballs to the jailers. We console our guilt away by calling the prisoners “patients” and their jailers “doctors.”

As Mr. Roth, Mr. Dayley, and Ms. Lerner demonstrate, it is not surprising that psychiatrists tend to define social problems in their own professional terms; the surprise—the scandal—is that we exalt an expectable professionalism into principles of public policy. The issue, as they demonstrate, is deeper than “due process of law”; it is illustrated by the way a popular lovelorn columnist reacts to personal problems which, in a modern liberal's view, will not respond to conventional admonition. The other day, for example, Ann Landers referred to a man who took too few baths as having “a deep-seated and complicated illness.” But she said, “It can be cured.”

If psychiatry is replaced, who will bear the issues of deviance which to date psychiatry has helped us to hide? One possibility, given the trend in handling other forms of deviance—crime, delinquency, retardation—is a larger responsibility for lawyers.

There are two serious interpersonal—if not ethical—issues in the lawyer's place as an advocate and a revolutionary in behalf of mental patients. The first, a mystery, appears in the fact that other professionals who have labored in this vineyard have grown calluses. The second, endemic in the emergence of the lawyer as a champion of the public interest, is an issue of decisionmaking in the infra-structure. Both issues might benefit from an example, a tough case.

Lawyers are attracted to what psychiatry calls the paranoid schizophrenic (and paranoids to lawyers). Suppose the 22-year-old college student next door exhibits the behavior that stimulates this label. He, John, is convinced that his father wants to kill him, that the father has prevailed upon John's mother to poison John's food, that his brothers and sisters talk about him all the time, and that the neighbors, in league with the police, want to put him out of the way.

The last delusion comes to be true, of course. John tyrannizes his family, runs down the street in the middle of the night, takes his clothes off on the sidewalk at noon, accuses virtually everyone of crime and conspiracy against him, and has even physically attacked one of his brothers and a teacher at his high school. These “attacks,” if typical, did not hurt either victim, but they were understandably scary.

John's parents finally propose to commit him to a mental institution. One of John's few friends, in his behalf, seeks my help, and I agree to appear for John, either in a commitment hearing or on a petition for habeas corpus when he is hospitalized without court order.

These facts—facts, not clinical guesses—seem clear to me:

1. The behavior in question is threatening to strangers, terrorizing to John's family, and disturbing to almost anyone.

2. This behavior is obviously wildly out of contact with reality; it is so clearly out of contact that it impairs John's ability to do anything expected of him by others—and it, and reactions to it, have *in fact* made John miserable.

3. Every generalized source of prediction indicates that John is probably not dangerous. He is no more likely to kill himself than anyone else is; he is *less* likely to kill, or hurt, others than most of us are. He does, of course, cause massive inconvenience, but much of that can be traced more to our reaction to John than to John himself. If we *could* relax—but we can't—John wouldn't be so bad.

4. John will not accept voluntarily the ministration of psychotherapy. The only way to control his conduct is to overpower him, with physical force, imprisonment, or chemicals. Institutional psychiatry will probably make him worse, but it may be able to contain him until time, the course of the "disease," or the grace of God, make him better.

5. Outright criminal confinement (prison) will contain John's behavior, but, at best, it will result in the same psychotherapeutic "treatment" available in a hospital and at worst it will turn John into a "psychopathic" criminal. On the other hand, John's conduct is probably not egregious enough—yet—to earn outright imprisonment unless, as is likely, the police and the court use the criminal process as a means of commitment for "mental care." As Dean Morris and Dr. Luby predict, a good lawyer can probably keep John on the outside looking in.

Now, the first issue for me as John's lawyer: If I deal with him long enough, or with repeated cases of "paranoia" (whether on the commitment issue or on the issues of treatment in an institution), he or his successors will begin to get under my skin. People like John—and I have known a few—are hard to get along with. They are demanding; their delusions—which they love to pour into the ears of lawyers—are endless and tiresome, even if the lawyer is facile enough to avoid being afraid of them. As a legal counselor, one tends to become wary because one fears that any resistance will destroy rapport. It is everyone's experience with John that anyone who argues with him ends up an enemy,

a member, in the argot of social psychiatry, of his paranoid pseudo-community.

Lawyers can live in that ambiguous interpersonal climate; we do it all of the time. But survival takes its toll. And there is no blinding evidence that we lawyers won't end up as neglectful and hardened as psychiatrists, psychologists, and nurses have become. I suspect that empathy for John is the emotional fuel that will keep me working for him; if that is so, this mystery of the calluses may destroy me as an effective advocate.

The classical answer to the dilemma has been the adversary ethic.<sup>6</sup> I don't have to sympathize with John in order to protect his interests. The adversary ethic is glib, fatally so in this case. It is finally glib because I cannot assume here that what John wants—to stay out—is best for John. Dean Alexander and Dr. Szasz touch on that dilemma, in the contractual context, but do not resolve it. If I pursue this dilemma one way I become, as Dean Morris and Dr. Luby predicted, as condescending and tyrannical as the institutional psychiatrists have become. (John is sick and I am, in greasing his way into "treatment," doing what is best for him and what he, if he were only "himself," would choose for himself.) If I pursue the dilemma in the other direction I at best leave John miserable and at worst invite the criminal process, or self-help from family and neighbors, to do to John what institutional psychiatry proposes to do—to render him docile, to neutralize him as a nuisance.

The answer to dilemmas of this sort in other legal contexts—environment, consumerism, representation of the poor, mental retardation—has been the emergence of the "public interest lawyer." The answer to the mystery of client well-being, and the new substitute for the adversary ethic, is a broadened concept of professional responsibility:<sup>7</sup>

. . . the individual lawyer . . . not only has to deal with levels of responsibility as defined and accepted by the profession, he also has to define himself in relation to society and deal with the questions of what he would like to do and what he should do. He must resolve or ignore the possible conflict between his view of the lawyer's role and the rewards which presently reflect the way law in fact is practiced. He must ask the ultimate question: Am I a professional in the true sense of the word if I do not accept public responsibilities which I perceive to be part of my role?

The public interest ethic may lead me to decide that John is

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6. AMERICAN BAR ASSOCIATION SPECIAL COMMITTEE ON EVALUATION OF ETHICAL STANDARDS, CODE OF PROFESSIONAL RESPONSIBILITY, CANON 5 (1969).

7. F.R. RAYMOND, *THE LAWYER, THE PUBLIC, AND PROFESSIONAL RESPONSIBILITY* 4 (1972).



best off in a mental "hospital." I can then, if still pulled by my adversary tradition, simply tell John and his friend to seek help elsewhere. Or I can, on the plausible, defensible theory that John is incompetent, proceed to "represent" him into the "hospital." If I make the latter choice, I can console myself by obtaining as much consent and cooperation from John as is consistent with my view of his competence, and I can do my best to see that he is not abused in the "hospital."

The trouble comes from the fact that I cannot avoid becoming a decisionmaker. I am athwart a Sartrean dilemma, and it is somehow not consoling for me to say that I am merely carrying out for John what poor John wants. John doesn't even know what he wants. Or, if he knows, he cannot tell me. In most cases, I suspect, the railroad will be more visible than it is in John's case, and the "pathology" less drastic; but once in a while I am going to be confronted by the ghost of responsibility, and neither the *enfants terribles* of psychiatry nor the benign aspirations of my own profession will deliver me from fearful choice.



## PART I: THE MEDICAL DECISION

*In contemporary social usage, the finding of mental illness is made by establishing a deviance in behavior from certain psychosocial, ethical, or legal norms. The judgment may be made, as in medicine, by the patient, the physician (psychiatrist), or others. Remedial action, finally, tends to be sought in a therapeutic—or covertly medical—framework. This creates a situation in which it is claimed that psychosocial, ethical, and legal deviations can be corrected by medical action. Since medical interventions are designed to remedy only medical problems, it is logically absurd to expect that they will help solve problems whose very existence have been defined and established on non-medical grounds.*

—T. SZASZ,  
*Ideology and Insanity* 17 (1970)

*If ever it be proven that psychiatry is not reliable, there will be created a doctrinal abyss into which will sink the whole structure of commitment law, not just those portions that deal with the harmlessly insane.*

—*Projects: Civil Commitment  
of the Mentally Ill*,  
14 U.C.L.A. L. REV. 822, 829 (1967)