Civil Liberties and the Mentally Ill

Thomas S. Szasz
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"The history of liberty has largely been the history of observance of procedural safeguards."

Justice Felix Frankfurter1

There are two basic ways in which a person may assume the social role of "mental patient." First, it may be assumed voluntarily, meaning that the role is self-defined. Second, it may be foisted upon a person against his will. This means that a person may be defined as "mentally ill" by someone other than himself. This definition, then, if properly implemented, may become generally accepted or socially verified. Since I have commented on some aspects of this problem elsewhere,2 I shall limit myself here to calling attention to certain ethical and legal aspects of the psychiatrist's involvement with the second class of "mentally ill" patients.

Differences Between the Voluntary and the Involuntary Patient

Our present-day conception of the physician-patient relationship presupposes a patient who considers himself sick and who therefore voluntarily seeks the physician's help.3 The attorney-client relationship is also of this kind. The relationship of a person who consults a psychiatrist or non-medical psychotherapist is similar to the two preceding contracts in that a "sufferer" considers himself to be in "trouble" for which he seeks "help" from an "expert." All this is self-evident and would require no explicit formulation were it not for the fact that much of general psychiatric practice violates these principles.

What is the relationship between the involuntary psychiatric patient and the psychiatrist? It would seem that since the patient

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occupies the sick role involuntarily, the person or persons who assigned him this role must appear, at least from his point of view, as his adversaries. We do not have far to look for a serviceable analogy of this relationship. A person accused of a wrong-doing or crime occupies a similar position with respect to those who accuse and prosecute him. For example, in a criminal litigation, the defendant and the grand jury occupy a relationship to each other similar to that of a so-called psychotic patient and the psychiatrist who recommends his commitment. (More will be said about this presently.) Yet, psychiatrists who function in this way usually consider themselves to be acting for, not against, the patient. If they do so, it is because they claim to have "therapeutic" motives or goals. In this discussion, however, we ought not lapse into the modern psychiatric error of always focusing on motives, and should strive to keep our eyes fixed on social phenomena.4

Illustrative Examples

In order to sharply etch the issues on which I wish to focus, let us consider two paradigmatic situations.

First, the case of the voluntary psychiatric patient. A typical instance might be a man unhappy and troubled about his marriage. Given the proper educational and social circumstances, such a person might decide to seek the help of a psychotherapist. In so doing, he would be willing to undergo the humiliation (should he feel that way about it) and the expenditure of time, effort, and money involved in securing this type of help, on the assumption that the expert whom he has hired might be of some assistance to him. This man has thus defined himself as "mentally ill," but he is free to begin, continue, or terminate "treat-

4 I think it is essential that we not get bogged down in this discussion with considerations of the psychiatrists' motives. Thus, on the one hand, we shall expressly disallow claims of "therapeutic" intent as explanations of commitment; and on the other hand, we wish to defend ourselves in advance against the claim that we are accusing psychiatrists of acting with malicious intent, as if they were siding with the relatives against the patient. It seems likely that, as a rule, psychiatrists recommending commitment do so because they think this advice is reasonable and "right"—in other words, because they believe that this is what is "expected" of them. Whenever this is the case, they act, of course, out of neither good nor bad intentions, but rather fulfill a standardized kind of social expectation. In other areas of work, where the objects of one's actions are inanimate rather than human, this would be called "doing a good, workman-like job." In this connection, see Szasz, T. S., Commitment of the Mentally Ill: 'Treatment' or Social Restraint? 125 Journal of Nervous and Mental Disease, 233 (April–June, 1957).
ment” as he sees fit. The social contract between patient and therapist is similar to that which prevails in cases of, say, pneumonia or peptic ulcer.

The situation concerning the involuntary psychiatric patient is totally different. A typical example might be a case of so-called postpartum depression. Shortly after the birth of a baby, the mother begins to feel and act despondent and fails to discharge her usual housewifely duties. The husband, faced with the dilemma of a disintegrating household and an increasingly incoherent wife, may then call in a physician (who may or may not be a psychiatrist) to remedy the situation. Officially, the help-seeking situation is defined as serving the needs of the wife. But, in fact, it is the husband who calls for help, and since he too is obviously distressed by his wife’s “illness,” a good case could be made out for arguing that he himself hopes to benefit from the physician’s intervention. When the physician arrives, he represents himself as wanting to help the patient (wife). After examining her, he recommends that she be hospitalized. If she refuses to comply with this recommendation, the chances are that he will sign commitment papers. This is a momentous step, for it means that a chain-reaction is being set in motion, the final effect of which usually is involuntary hospitalization and at least temporary loss of civil liberties for the patient.

This chain-reaction will run its usual course, ending with the commitment of the patient, unless she (a) knows how to protect herself from the forces that have been set in motion, and (b) has the necessary vitality, at this point, to avail herself of her potential resources. Commonly, patients lack one or both of these requisites for effective self-protection. Hence, they are not well able to discriminate in regard to the merits of offers promising protection.

A Bill of Rights for the Mentally Ill

It is clear that the social role of the involuntary mental patient can come into being only when someone is accused of suffering from a “mental illness.” To be accused of “mental illness” is analogous to being accused of a wrong-doing or crime, such as, say, theft, assault, or murder. If the legitimacy of this interpretation is granted—and usually it is not, for it is persistently argued that the patient is not being accused of anything but is merely being “protected” and “treated”—a number of inferences logically follow. First, it is essential that the accused be
clearly informed of the nature of the charges against him; second, of who his accuser is; third, that whatever he will reveal about himself might be held against him; and fourth, he must have certain clearly defined methods for rebutting his accusers (for example, he must have counsel to defend him). It is evident that a person accused of "mental illness" and threatened with the possibility of incarceration in a mental hospital—and its attendant calamitous consequences for his employment and other opportunities—does not possess these elementary legal safeguards. In these respects, therefore, he lacks the guarantees of personal freedom which all democratic societies have considered essential for insuring the dignity of man.5

What, then, would a Bill of Rights for the "mentally ill" involve? Without entering into all of the ramifications of this problem, I would submit—as a first approximation to our goal, as it were—that the individual threatened with involuntary psychiatric hospitalization should be accorded the same sort of protection as would be his if he were accused of a wrong-doing (in a civil litigation) or of a crime. This would entail, briefly, the following provisions:

1. The physician (psychiatrist) summoned to examine the patient by a so-called responsible relative, or by someone else, should be officially designated as the caller's agent. His role would be analogous to that of a grand jury whose job it is to decide, not whether a person is guilty of a given act, but rather, whether to put him in the predicament of having to defend himself against certain formally preferred charges. Physicians confronted by "mentally ill" patients frequently act as one-man grand juries. If their decision is to recommend commitment, the person is shifted from the role of citizen to that of "potentially commitable patient" (this corresponds to the role-change from citizen to accused in the criminal analogy). If the patient is to defend himself against the consequences of such an "indictment," he must know that he has been charged with certain "mentally disordered acts." Hence the patient would have to be informed as to the examining psychiatrist's role and the "charges" against him.6

2. The patient accused of "mental illness" should have the right to enlist the aid of an expert on his behalf. Clearly understood, this would, of course, be more than just a right; it would be an expectation. For instance, a man accused of income-tax evasion would naturally rush to his attorney, for he would know that he can reasonably expect help from him. If he were in conflict with the Internal Revenue Service, he would not expect that this agency's legal department could be entrusted with the task of furthering his interests. Responsive to the significance of this provision, society has provided that indigent persons can avail themselves of court-appointed defense counsel, or of other free legal aid, to assist them in their defense. No such opportunities are provided for the "mentally ill." In fact, they are now placed in the impossible situation of having to expect help from those who had first "accused" (i.e., diagnosed) and then "punished" (i.e., involuntarily hospitalized) them.7

3. The conflict of interests having been clearly exposed, the judge entrusted with settling the dispute should be as impartial as possible. This is best achieved by making certain that he does not personally benefit from deciding in favor of either party. In a civil suit, for example, he must not have any economic (or other) interest in the affairs of the litigants.

(a) At present the judge's position in the commitment procedure is anomalous, because the problem is a priori so defined that even when he decides in favor of the plaintiff, he is "helping" the defendant! In other words, in approving the physician's certificate recommending commitment, he clearly rules in favor of the plaintiff. Yet, by sentencing the patient to a "hospital," for "treatment," the whole thing is made to appear as if it were not at all a contest of opposing interests.8

(b) What would the judge's task be if the procedure were changed so that "mental patients" would have the same rights as criminals (and everyone else) in our society? Faced with a more sharply etched conflict of interests—as for example between depressed, ineffective wife and neglected husband, or between alcoholic-abusive husband and all-suffering wife—and not with

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7 Szasz, T. S., Malingering: "Diagnosis" or Social Condemnation? 76 A. M. A. Archives of Neurology & Psychiatry 432 (October 1956).
8 Szasz, T. S., Commitment of the Mentally Ill: "Treatment" or Social Restraint? 125 Journal of Nervous & Mental Disease 293 (April-June 1957); Politics and Mental Health: Some Remarks Apropos of the Case of Mr. Ezra Pound. 115 American Journal of Psychiatry 508 (December 1958).
the pseudo-problem of "mental illness,"—the judge could not take refuge in the easy way out, namely commitment, believing that he is doing the "right thing." Being more truly impartial toward the needs and actions of both parties, he might more readily dispose of these problems by assigning lesser penalties than those entailed in commitment and involuntary hospitalization. In general, he might be more disposed to resolve conflicts of interests between "responsible relatives" and "irresponsible patients" by pointing out that if A does not like what B is doing, he can either ask B to leave and cease annoying him, or should that fail, he can leave. This shows us immediately what sort of new problems would arise if there were a Bill of Rights for the "mentally ill." To consider this further would carry us too far afield, and we must remain content with reiterating the all too familiar observation that it is far easier, at least for those in power, to run a society by oppressing certain groups or segments of the population than it is by granting equal rights to all.10

Commitment as an Extra-Legal System of Social Control

I do not see how it is possible to deny that persons who fall into the second class of "mentally ill patients"—that is, the involuntarily hospitalized or committed patients—are deprived of their civil liberties. How can this occur and how is it accomplished?

The main reason for its occurrence is simple: Those judged to require hospitalization for "mental illness," but who refuse to acknowledge their need for it, are regarded and treated as if they were children. This is why we hear of such things as "responsible relatives," "guardians," and other similar social statuses. In no society, no matter how democratic or egalitarian, do children have the same civil rights and liberties as adults. It is manifestly absurd to expect that such an arrangement could work. Children thus constitute a ready-made reservoir of humanoids: they have all the attributes and potentialities of persons, but are not quite persons themselves. Moreover, since there are certain significant


10 In an excellent discussion of the privilege against self-incrimination and its relation to confidential communication privileges, Louisell quoted the following utterance which, I assume, is something of a classic among legal scholars: "It is far pleasanter to sit comfortably in the shade (in India) rubbing red pepper in a poor devil's eyes than to go about in the sun hunting evidence." (Louisell, D. W., The Psychologist in Today's Legal World: Part II. 41 Minnesota Law Review 731 (1957), at 749).
empirical connections between childishness (or psycho-social immaturity) on the one hand, and what is often called "mental illness" on the other, the temptation is great legally to demote, as it were, adult mental patients to the judicial rank of children.

The ways and means whereby the disenfranchisement of the mentally ill is brought about are numerous and complex. I shall omit discussing specific social and legal procedures and shall focus instead on certain basic principles. The crux of the matter, perhaps, is this: Physicians (especially psychiatrists), the police, judges, and mental hospitals and their staffs constitute a set of social agencies (structures), possessing social power. Although these persons and institutions are, so to speak, properly legalized, nonetheless they operate in what is, in a larger sense, an extra-legal atmosphere. What is meant by this is that although the activities of each of these persons, as presently exercised, are legally sanctioned, and hence—as common sense would have it—entirely proper, the totality of the arrangement is, I submit, against the letter and spirit of the constitution. Instead of trying to document this assertion, which would require a separate essay in itself, let me merely cite some pertinent examples which will highlight the major issues involved in the ethics and legality of commitment.

Consider a man or a woman who is a Christian Scientist and who is suffering from an illness. Can the law compel him to seek medical treatment against his will? No. Or, take the case of a man who belongs to the religious sect known as Jehovah's Witnesses and who needs an operation requiring the use of blood-transfusions. The latter procedure is specifically prohibited by the beliefs of these people. The law permits them to forego the benefits of this medical procedure. Significantly, should the child of such parents require a blood transfusion, legal steps can be taken to remove the child from the parents' custody and make him a ward of the state. Permission for the procedure can then be obtained in spite of the parents' wishes. Here we have a close analogy to commitment: as the jurisdiction concerning the child's welfare is taken from the parents, so the mental patient's jurisdiction over his own body and personality may be wrested from him and placed in the hands of others (relatives, the state, etc.). Finally, consider the way conscientious objectors were treated during the last war. Their human dignity was respected and they were allowed an alternative to regular soldiering.
Faced with induction into the armed forces, they had the option of electing to serve in a non-combatant capacity.

Faced with the possibility of psychiatric hospitalization, what options do mental patients have? If the patient is wealthy and not too disabled, he may be fortunate enough to have a number of choices. He is, thus, relatively well-protected. But is it not precisely the most downtrodden, the most "disabled"—whether because of poverty, lack of education, color or creed, or what not—who need the legal safeguards of a democratic society the most? Hence, we should consider the options that the poorest and most "psychotic" persons have when faced with the dilemma of involuntary mental hospitalization. They have, in fact, no option but one, namely, "voluntary commitment." This is like pleading guilty when accused of a crime. The offender confesses all and throws himself on the mercy of his accusers and judges. The status of "voluntary commitment," which still exists in many states, would really have to be considered a farce, were it not for its tragic implications. Why should someone be committed voluntarily? If the patient is in the hospital really of his free will (this does not imply that certain kinds or degrees of pressure might not have been used to get him there), why should he be put in the jeopardy inherent in a committed status? Thus, voluntary commitment is not at all the humanistic compromise between fully voluntary hospitalization on the one hand and imprisonment on the other, which it is often claimed to be, but, on the contrary, is merely another sign of the fact that the committed patient is legally much like a slave. He may be a "voluntary" slave as against an "involuntary" one, but what is the difference? In either case, while he is in the hospital he has few of the basic human rights which he would have outside of it.

I have tried to show, by means of these examples, that a considerable part of contemporary psychiatric practice—namely, that dealing with involuntary patients—deals with a set of extra-legal offenses, rules, and penalties. In other words, there are

11 It is pertinent to point out in this connection that the values of equality and justice do not play the same role in medicine as they do in law, ethics or philosophy. In their thoughtful study of the similarities and differences between the sick and the criminal (roles), Aubert and Messinger clearly stated that: "Equality before medicine is not an ideal of the same kind as equality before the law. It is the duty of the health authorities, not of medical science nor of the doctor, to think of justice." (Aubert, V. and Messinger, S. L., The Criminal and the Sick. 1 Inquiry 137 (1958), at 155.)

two basic ways in which a person may be penalized in our present society. One is by running afoul of the law. The other by running afoul of psychiatrists. Let me specify. The first set of rules and penalties, made up of the laws of a country or state, are familiar to everyone. They are set out in advance and usually people try to keep within them. Nothing more need be said about laws as a system of social controls, except that they should serve as the standard against which the second set of rules may be measured. These consist, on the whole, of social customs or mores. By their very nature, they are not as clearly set forth nor as well specified as laws. If they are violated, the usual penalties are, as they should be, extra-legal: That is, social ostracism, loss of employment or friends, personal enmities, and so forth. At some point in these extra-legal penalties, however, there is a bridge with the legal system of law-enforcement. This bridge is the medical profession. Physicians are licensed by the state and thus owe a measure of responsibility to it. When physicians are involved in adjudicating certain interpersonal and social conflicts, they can, and often do, implement the powers inherent in their expert status with the power of the police.

Summing up, it is important to note that the two systems of social controls overlap to some extent. Offenders officially defined as criminals may plead insanity. Psychiatrists then join jurists in interpreting rules and affixing penalties. All this, however, takes place in the framework of traditional legal safeguards. A man accused of a crime is innocent until proven guilty. The psychiatrist is bound by this ground-rule as much as everyone else associated with the trial.

In the alternate system, that is, where a person is accused of "mental illness" and the psychiatrist wishes to involve the legal system by recommending commitment, the ground-rules are different. Once the psychiatrist has made a "diagnosis," the patient is considered "sick." The psychiatrist does not have to prove his allegation (in court or outside of it). But the patient must now prove, as it were, that he is "not sick." And how can he do this, especially when he is ignorant of the criteria used to establish

that he was "sick" in the first place? Thus, in sum, the patient has no counter-diagnostician (comparable to the defense attorney), the judge is not impartial, and the patient finds himself in legal jeopardy without having broken a law or being accused of a crime, and without having been tried and convicted.

**Due Process of Law Versus Psychiatric Treatment**

My thesis may require clarification on two specific points, both pertaining to the precise means for safeguarding the involuntary mental patient's civil liberties. I shall try to deal with these issues in the hope of anticipating and answering certain objections that might be raised against my views.

The first problem concerns the matter of informing the patient that the psychiatrist who had been summoned by, say, the relatives (or the employer, etc.) is not his agent, but is an agent of the caller. The question may be asked: How do you explain such a thing to a so-called "catatonic patient" or to a "homicidal paranoid"? Implicit in this is the assumption that the patient's condition is not unlike that of a man struck by a car bleeding to death. You do not try to explain about a transfusion to such a man; rather, you take steps to treat him.

There can be no doubt that if we regard "psychiatric emergencies" (of the type mentioned above) as essentially similar to acute medical and surgical emergencies, then instituting treatment without consulting the patient may be well justified. But we have only shifted ground, for the question now becomes whether or not "catatonia" or "homicidal threats" constitute occurrences that are significantly similar to acute injuries or comatose conditions. Clearly, there are many differences between them, which we cannot consider here.\(^\text{15}\) But even on the basis of the similarities, the alleged acute "illness" would justify only the briefest therapeutic endeavors without the patient's consent. For example, the patient brought to the hospital in a diabetic coma (involuntarily, since he was unconscious), is given the necessary treatment for his disturbed physiological state. As soon as he has regained consciousness, his consent for further treatment must be obtained. Thus, even though his treatment may be incomplete, he has the right to leave the hospital. Indeed,

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patients often avail themselves of this right—however self-injurious (in a physiological sense) their acts might be. We then speak of their “signing out (of the hospital) against medical advice.” It is clear, therefore, that only the briefest retention (and psychiatric treatment) of so-called unmanageable patients could be justified on this basis. But commitment is for an indefinite period of time. It is anything but a brief, transitory episode lasting only until the patient regains consciousness and self-determination. On the contrary, his self-determination is, by means of this act, taken away from him. Hence he cannot hope to regain it in the course of a naturalistic sequence of events, such as would be a recovery from a physiological imbalance. He can regain it only by fulfilling certain normative behavioral criteria. 16

What kind of alternatives to our present practices can we contemplate? One possibility would be, perhaps, to involuntarily “hospitalize” some persons who fall into the category of the “unmanageable patient” and thus separate the “combatants” (i.e., patient and his socially significant objects). When this is done humanely, it is quite common for the disturbed behavior to subside. In the hospital, the patient may appear to be more or less “normal,” only to exhibit “psychotic” behavior again when his relatives visit him or when he leaves the hospital. Clearly, then, such a patient could be informed about who is whose agent. This, however, would necessitate that the hospital psychiatrist dissociate himself from his customary role of “helping the patient” or, more accurately, that he redefine what “helping the patient” involves. I submit that helping the patient under such circumstances requires, first, that the psychiatrist deal frankly with his own split roles and loyalties. Thus, however paradoxical it may seem, only after identifying himself as (partly) the relatives’ agent can the psychiatrist be of help to the patient! This derives from the fact that to most people the word “doctor” suggests that the person so designated will try to help them, irrespective of who they (the help-seekers) might be. Often, however, this is not true. 17 For example, the physician already may be committed to other patients, or his social role may specifically prohibit him from treating certain patients (e.g., physicians who are full-time, salaried employees of institutions).

17 Szasz, T. S., Recent Books on the Relation of Psychiatry to Criminology, loc. cit.
In view of this, the psychiatrist's failure clearly to identify himself to the patient (including his social obligations to and contract with others) leaves the latter helplessly impaled, so to speak, on the semantic horns that the word "doctor" represents for him. Only after clarifying the question of "Who is whose agent?" can the patient proceed rationally in his attempts to master his problem. This situation is wholly analogous to the arresting detective's warning that he must issue to the accused, namely, that anything the latter shall say might be used against him. Is this not a genuinely "therapeutic" explanation of the situation? Informing the involuntary mental patient that the psychiatrist hired by someone other than himself is not (primarily) his agent should be viewed in the light of this legal model.

I wish to comment now on another possible objection to my thesis, namely, that many psychiatric patients are "too disturbed" to understand the explanation mentioned in the first paragraph of the proposed Bill of Rights for the mentally ill. The belief that psychotic patients are "too far gone," or "too crazy," or "too sick" to understand what goes on about them, is of course, time-honored. It is similar to the adults' belief that children do not understand what goes on in the world of grown-ups, especially insofar as sexual matters are concerned. This is one of those cases in which a large falsehood or error is based on a small kernel of truth. More often than not, children and "mentally ill" persons are, if anything, hypersensitive to their human environment, especially in regard to communications (verbal as well as of other kinds) that vitally affect them. The commonsense argument that many mental patients could not be correctly informed as to the proceedings against them is belied, lastly, by the fact that relatives, policemen, physicians, and others commonly resort to fancifully embellished untruths in attempts to cajole recalcitrant patients (and children) more willingly to take steps of which they are afraid. The implication of this is that any method (of persuasion) is justified, because the goal to be achieved ("treatment") warrants it. There is a head-on collision here between the medical value of "treatment" (or alleged treatment) on the one hand, and the ethical and legal value of "due process" on the other. It is evident that in some cases we cannot have both, and hence must choose one or the other. Until now, in psychiatric matters, this dilemma has been resolved—perhaps somewhat unthinkingly—in favor of "treat-
ment” and against the human dignities and protections inherent in the “due process of law.”

It is important to note that in similar dilemmas, occurring in more purely judicial contexts, legal scholars have consistently emphasized that in a democracy the value of the “due process” should supersede most other values. Consider, for example, the conflict between the Sixth Amendment, which guarantees the right of the accused to be confronted with the witnesses against him, and, say, the needs of national security which may require keeping secret the names and activities of undercover agents or of confidential informers. Commenting on this dilemma, Pfeffer stated: “The government must choose between prosecuting the accused or keeping its secrets; it cannot constitutionally do both.”

As has often been observed, a democratic social organization puts the government in the position of having to take chances with respect to what its citizens might do. Such a government cannot strive for the maximum safety or security that might be attainable, but instead must sacrifice some of its safety in order to maintain the values of liberty and dignity. As the procedural safeguards of a democracy might make it difficult to apprehend and convict some “criminals” (e.g., so-called professional gangsters), so it might—indeed, it inevitably must—make it similarly difficult to hospitalize certain “mental patients” (e.g., those who are reluctant to seek treatment voluntarily and have committed no social offense).

The essence of my proposal is that we re-examine our psychiatric practices, keeping in mind considerations of value. I submit that the values inherent in the due process of law are generally more important than those of psychiatric treatment, involuntarily administered, or those of safeguarding the public from the annoyance or danger of “mentally ill” persons. This, of course, is a personal opinion concerning values which others need not share. In advocating that whenever procedural safeguards and psychiatric practices conflict, preferential valuation be accorded to the former, I follow in the footsteps of those students of law, men, and society who have taken a similar stand in regard to conflicts of this type. This position, as I see it, is a sort of social pragmatism or empiricism. According to it, it is the nature of social procedures (e.g., laws and their administration,

18 Pfeffer, L., op. cit., p. 182.
19 Szasz, T. S., Moral Conflict and Psychiatry, Yale Review, in press.
social contracts, etc.)—rather than avowed ethical aims—that determine to what extent any given society may be considered "open," and to what extent "closed." 20

Procedural safeguards imply, among other things, that the law, if it be democratic, may not employ methods of crime-detection that would degrade the human dignity of those who use them. It follows that as a democratic law must eschew "criminal" methods of crime-detection and prosecution (irrespective of how well "justified" these might allegedly be by the baseness of the criminal deeds)—so a democratic or humanistic psychiatry must likewise eschew misrepresentation or deceit of any kind (no matter how well justified by alleged "therapeutic" considerations). This means that both law and psychiatry—and, of course, their individual practitioners or representatives—must play their respective "games" with the utmost honesty. Cheating, no matter how well-intended, is not permissible.

One of the cardinal features of democratic laws is that they be clear or unambiguous and well-publicized. The maxim, "Ignorance of the law is no excuse," can be meaningful only in a social context in which ex post facto laws are odious and illegal. Yet, the criteria on the basis of which "mental illness" is diagnosed and involuntary hospitalization instituted, are at once unclear and ex post facto. In other words, patients often do not know that if they act in such and such ways, then they might be committed. Informing them of this kind of social sequenti-

ality is one of the practices I have advocated. It is evident that when one is charged with an unclearly defined offense, defense is virtually impossible. 21 Hence, clarity in regard to social roles, duties, expectations, etc.—defined not only in sentimental-mo-
tivational but rather in social science-factual terms—should be the first task of psychiatry in its relation to the involuntary mental patient. This alone, I believe, would go a long way toward liquidating some of our so-called psychiatric problems. This would come about by the transformation of some of these prob-
ems (now defined as psychiatric) into civil and criminal litigations, and of others into interpersonal and social (group) conflicts. Without such clarification, however, our psychiatric practices may themselves be responsible, at least in some part,

20 Popper, K. R., op. cit.

21 In this connection, see Kafka, F., The Trial. A. A. Knopf, New York, 1948.
for the very psychiatric disabilities that they allegedly set out to cure.

**Mental Illness as Performance Failure in the Family**

Another issue concerning which objections might be anticipated pertains to the problem of the family-member who, on account of his or her "mental illness," presents a serious threat to the remaining members of the family unit. Consider, for instance, the seriously depressed wife, the alcoholic-paranoid husband, or the senile, regressed, and deteriorated grand-parent. Each of these, in his own way, constitutes a threat to the life and well-being of the rest of the family. Since people usually interact most significantly with members of their families, "mental illness"—in one sense—is principally a problem for those "close" to the "patient." This, of course, is the reason why it is mainly family members who "accuse" the "patient" of "mental illness" and summon the aid of the psychiatrist. The objection against this line of reasoning could be stated as follows: "Is it not true that the depressed wife (or the threatening-abusive husband) is 'sick' (or disabled) and that this causes grief for her and for everyone around her? Something must be done and forced hospitalization surely seems like the best and most humane course of action available to us, at this time." On the face of it, this argument is so convincing that it might seem incontestable. Let me make clear, once more, that I am not implying that people nowadays involuntarily hospitalized are not disabled or ill-behaving in some senses. I am very much aware both of their own patterns of behavior as well as of the misery that is in the hearts of those around them. Let us not lose sight of human rights and dignities, however, just because we are plunged into situations of intense human suffering and distress.22

Without going into details, the crux of the matter, as I see it, is that most of the situations that eventuate in a person's involuntary mental hospitalization have one thing in common: the "patient" has failed to perform certain necessary social functions in the family. The emphasis is on the family as the locus of the performance-failure. For should a person fail to perform his job, the chances are that he will be fired; or, if he fails to pay his taxes, he will be prosecuted. What, one might ask, can family members do with respect to each other, when

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one of them feels that another is falling down on his job? When
the family member who fails is a child, he can be disciplined or
punished. But what can be done when it is an adult member of
the family who fails? Three basic alternatives seem to be avail-
able. One is to request altered behavior, by asking, begging,
pleading, self-sacrificing, coercing, threatening, and so forth. The
other is to leave, that is, to sever relationship with the failing
partner. (This may be made conditional upon his or her refusal to
seek the sort of help that we, in our own conscience, consider
beneficial and necessary. Yet, how many people, who consent to
the commitment of others, would regard this as an acceptable
measure for themselves?) The third procedure is to enlist medi-
cal or psychiatric aid and secure the unwilling family-member's
enforced hospitalization. Involuntary psychiatric hospitalization,
and the whole complex machinery underlying it and making it
possible, thus fulfills some immensely important social and
psychological functions.

To begin with, this measure provides an outlet for the
tensions generated by failures in family relationships. These
tensions are resolved, or ameliorated, moreover, in such a man-
er that the moral (religious) integrity of the family is pre-
served intact. This is achieved by a de facto separation of family
members—and often by a total socio-psychological break-up (and
break-down) of the family—while at the same time maintaining
the legal intactness of the family unit. In other words, since
"mental illness" (of this kind) involves failures in adequately
fulfilling family obligations, considerations of its "treatment"—
and especially commitment—involve us in adjudicating what
is in part (or largely) a moral conflict. Ostensibly, then, the ques-
tion is one of "treatment" or "care," but covertly it is a ques-
tion of which value should have preference: the integrity of the
family unit or the autonomy of the individual? Commitment

23 There is a fourth method for solving this problem of the failing (and
hence unwanted) family member—namely, murder. This solution for cer-
tain problems in living is a favorite theme in novels and plays. Moreover,
it is a well known sociological observation that in our culture there are two
main types of homicide. In the one group falls murders committed by pro-
fessional criminals whose victims are either other (competing) criminals or
otherwise professionally chosen victims. In the second group fall the ama-
teurishly committed homicides consisting of the killing of one member of
a family by another (or some variation on this theme). It would seem that
for some people it is easier to kill someone to whom they had been closely
attached than it is to leave him. Likewise, for some people it might be easier
to commit their "loved ones" than to leave them, whereas others might
rank-order their values in an inverse order.
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(and commitment laws) tacitly favor the former. I submit that we should explicitly favor the latter. An analogy may be drawn here to the subject of marriage and divorce. Laws can be made, as we know, that either prohibit divorce altogether, or else allow it and make it more or less difficult or easy to obtain. The point is that for those who consider the family an indissoluble unit, this value takes precedence over other competing values. Yet, since they too must have safety valves that will allow them to escape from an intolerable marriage, they avail themselves of certain alternatives, such as avoidance of marriage, annulment, and separation without divorce. Involuntary hospitalization, I submit, must be viewed as another outlet from intolerable family situations (involving not only spouses but all members living together under one roof).

It is a corollary of the foregoing that while for the individual involuntary hospitalization (of himself or of others) insures maintenance of the family as a “good” (reliable) object, for society as a whole it insures maintenance of family relationships, “loyalties” and “responsibilities” as unchallenged positive values. Thus, our whole social system has a stake in the safety valve that commitment laws provide. Without it, re-examination, explicit re-assessment, and appropriate changes in our traditional ideas concerning the roles (i.e., duties, obligations, rights, etc.) of family members would be necessary. Yet, on the other hand, numerous individuals and society as a whole have a stake also in altering some of our present practices, and especially in increasing the rights—as well as the obligations—of the so-called mentally ill. This holds promise of reducing the burden of caring for them. Finally, there are a variety of social forces in contemporary western culture which in their own rights necessitates steady and rather drastic revisions in our traditional ideas concerning family relations. The familiar roles of father, mother, and child are rapidly disappearing and giving way to new, more functionally (even if more diffusely) defined roles. A new role-definition of the “mentally ill” would, therefore, seem to be in keeping with certain basic trends in contemporary social life. According to this definition, a “mentally ill” person would have more sense, so to speak, than he has been given credit for in the past; hence, he would also have more rights as well as more responsibilities than did his nineteenth century counterpart. All in all, such a person would be, in Harry Stack Sullivan’s felicitous words, “more human than otherwise.”
Summary

It was suggested that a sharp distinction be made between two types of “mental illness” and two corresponding types of psychiatric practice. In the one, the patient defines himself as “mentally ill” in the hope of securing psychiatric assistance for himself; the psychiatrist is his agent. In the other, the patient considers himself to be more or less well, but behaves in such a fashion that certain persons find him seriously annoying. With the aid of a psychiatrist, he is defined as “mentally ill” and involuntarily hospitalized. This psychiatrist is an agent, partly at least, of whoever enlisted his aid (usually a relative of the patient).

The differences between these two classes of “mental illness” were briefly discussed. It was shown that the “mentally ill” of the second type constitute a group of persons deprived of certain of their civil liberties. A parallel was drawn between a person accused of wrong-doing in a legal system, and another accused of deviation in a psychiatric system. By means of this analogy, it was shown that the former can avail himself of certain protections denied to the latter, mainly because the psychiatric-accusatory process itself is defined as being partly for the “patient’s” benefit. A proposed Bill of Rights for the (involuntarily defined and hospitalized) “mentally ill” was presented. It was offered not merely as a practical suggestion but also as a reminder of the deficiencies of our present methods for dealing with this problem.

In conclusion, restraint and confinement by means of psychiatric interventions was described as an extra-legal system of rules and penalties. Some connections between it and legal channels proper were noted. The undignified and unconstitutional character of the social status of the involuntarily hospitalized (committed) mental patient was emphasized.