

Schizophrenia, Civil Liberties, and the Law

by Roberta Rose

At Issue



The At Issue section of the Schizophrenia Bulletin contains viewpoints and arguments on controversial issues. Articles published in this section may not meet the strict editorial and scientific standards that are applied to major articles in the Bulletin. In addition, the viewpoints expressed in the following articles do not necessarily represent those of the staff or the Editorial Advisory Board of the Bulletin.—The Editors.

Abstract

During the past 10 years, extensive studies have shown that schizophrenia is a true biological illness. Like diabetes and hypertension, it cannot be cured as yet, but it often can be controlled by medication. Schizophrenia, therefore, is not a hopeless condition, and many sufferers who receive proper treatment can lead productive lives. The stigma attached to schizophrenia will disappear, and the resistance to the proper use of drugs will also cease when a change comes about in the way schizophrenia is perceived in the United States. Meanwhile, the unique tragedy of schizophrenia lies in the fact that victims often cannot recognize their illness, refuse treatment, and throw away their lives. The question becomes: Is court-mandated treatment indicated when persons are severely disabled, lack the capacity to make informed decisions, and will suffer mental and physical deterioration if treatment is not given?

In an impasse between doctors and civil liberties lawyers over the treatment of 2¼ million Americans who suffer from schizophrenia, biological and clinical psychiatrists favor amendment of State laws, so that disabled persons diagnosed

as mentally ill can be brought into treatment.

The sad irony of schizophrenia lies in the brain's inability to understand its own disease. Schizophrenia is now believed to be a true biological illness that often transforms its victims into human beings too impaired to seek medical help.

But lawyers oppose involuntary treatment as subversive to due process rights, as a form of stigma, and as a political threat. The latter issue arises because totalitarian societies use accusations of insanity for purposes of forced detention. In further argument, in a dated tract whose influence on public opinion remains decisive, the American Civil Liberties Union (ACLU) doubts the existence of mental illness, and declares that it uses the term "without endorsement" (Ennis and Siegal 1973).

The conflict has grown within a context of three circumstances: victims often reach legal age before schizophrenia strikes; State laws virtually prevent involuntary treatment of adults; and the disease takes away the power of choice. Young men and women with schizophrenia seldom can choose the greater of two goods or the lesser of two evils. For example, they may be unable to choose medication that will free them from delusions of persecution but leave them with minor, unwanted side effects. The Socratic premise of the rational citizen, "skilled in the art of measuring," cannot operate, and the Judeo-Christian tradition of free will cannot serve. Indeed,

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untreated victims of schizophrenia, deprived of free will by their illness, seem doomed, like protagonists of Greek tragedy, to suffer a predetermined fate.

While lawyers believe that Americans should not surrender liberty to pursue happiness and life, doctors reply that some Americans choose madness unknowingly. While the ACLU alleges that everyone in a democracy has the right to waste his life, doctors respond that victims of schizophrenia throw their lives away unknowingly and choose pain unknowingly, although it is not in human nature to choose pain. A person with mental illness may not be able to recognize the illness and seek help.

Doctors agree that laws cannot force sick persons to take drugs, the principal treatment for schizophrenia, but they believe that laws can sanction the efforts of grieving and traumatized families to help their sick sons and daughters, and add leverage to social policies in the fight against the illness.

Controversy among segments of the medical and legal professions has taken shape in the dark. A recent documentary on public television, purporting to expose misconceptions about mental illness, substituted one false idea for another. Avoiding the image of the schizophrenic killer, the director followed half-a-dozen young, nonviolent mental patients through several sad years of their lives and reported that none of the patients recovered from their illness. In spite of proper medication and good psychiatric care, each patient deteriorated into ever-worsening forms of madness. Viewers became inadvertent voyeurs, and they received the impression that mental illness is a

hopeless condition.

Mental illness is not hopeless. Studies of 2,000 patients with schizophrenia over the long period of first breakdown to old age show that 25 percent recover, 50 percent recover at least partially, and only 25 percent require lifelong care (Torrey 1983; Shore 1986). If schizophrenia had been portrayed accurately on television, one or two out of six victims would have recovered, two or three would have improved, and only one or two would have gotten worse.

False images of hopelessness and violence, as well as social policies amounting to denial, have influenced public consciousness and, indirectly, State laws. Although the modes of chronic schizophrenia include homelessness, destitution, and inability to work, most States require evidence of suicidal or homicidal tendencies before the courts can intervene.

Although schizophrenia is a group of diseases of a physical organ, the brain, and although "the psychiatric literature confirms the tremendous morbidity and mortality of this disease" (Munetz and Schulz 1986, pp. 170-171), most Americans attribute the illness to bad parents, childhood trauma, and social stress.

Schizophrenia has been properly called a mental illness, because it affects thoughts and feelings. However, some mental health professionals, lawyers, doctors, government officials, lawmakers, judges, and others who influence American policy and practice think of "mental" as the opposite of physical or palpable, and, therefore, as occult or mystic. Refusing to "label" victims, they deny the illness, thus preventing the diagnosis.

And who would wish to suffer

from undiagnosed diabetes, for example, and not receive the benefit of insulin? Like diabetes, hypertension, and other illnesses that as yet have no cure, schizophrenia can be treated by drugs capable of reducing or eliminating symptoms, and allowing some sufferers to lead normal lives. In the case of schizophrenia, however, the law in effect prevents sick people from getting the help they need. Consequently, schizophrenia remains a national disaster—the most chronic, disabling, and tragic disease of our time.

If the law has not recognized the facts about schizophrenia, it is true, also, that doctors reached consensus on symptoms and published diagnostic criteria less than a decade ago (American Psychiatric Association 1980). Typically, a young adult, aged 18-25, suffers from one or more of the following disorders: hallucinations, delusions, inability to speak coherently or logically, unusual emotional responses, and movement disorders ranging from immobility to lack of coordination to involuntary poses (George and Neufeld 1985).

The positive symptoms of schizophrenia are hallucinations (seeing, hearing, feeling, tasting, and smelling things that are not present) and delusions (false, irrational beliefs persisting in spite of contradictory evidence, such as paranoid delusions of being harassed, cheated, poisoned, conspired against, or controlled by outside forces).

Negative symptoms, including flat affect, point to the presence of chronic disease. Victims lack facial and vocal expression, and they seem to lack feeling. Usually, they avoid looking at others, and they may have slow speech, slow movements, and low, monotonous

voices. Some of the other symptoms include indifferent behavior, confusion, inability to keep clean, and inappropriate affect (Goldberg 1985; Lewine 1985).

Among those who suffer from chronic schizophrenia, violence is very uncommon; apathy and withdrawal are more characteristic and, contrary to popular belief, symptoms of illness may not be evident.

In time, however, bizarre symptoms begin to appear. The chronic schizophrenic population includes the homeless, "bag-people," passengers laughing and talking to themselves on subways, vagabonds dressed in many layers of clothing, and specters hiding behind curtains in suburban bedrooms. Many schizophrenic patients have experienced what sociologists call downward social mobility, the loss of their former place in society. For example, a middle-class college graduate, deprived of the skills and judgment necessary to a middle-class lifestyle, may be living on welfare in a slum.

Unable to accomplish the normal tasks of life, schizophrenic patients ignore these tasks, and suffer "the consequent loss of consensual frame of reference and the need to replace it with a private logic [and] the distrust of others and their logic, and the assignation of private and secret meanings to ordinary events" (Shulman 1984, p. 33).

But State laws ignore the modes of chronic schizophrenia—the marginal life, the existential crises, and the slow death. Young victims are likely to be persons who cannot make decisions, go to school, find jobs, or find homes, and who lose everything of value to human beings.

If each life is "strange," and if we seldom feel prepared for or know how to act in unexpected circumstances, the anxiety or despair commonly experienced is magnified a thousand times in schizophrenia.

A breakdown in the limbic system at the base of the brain, the processor of all incoming stimuli, may account for symptoms (Torrey 1983). Links between schizophrenia and genetic factors, between schizophrenia and brain chemistry, and between schizophrenia and structural abnormalities (enlargement of cavities inside the brain) have been established (Shore 1986).

Focusing on the organic nature of many schizophrenic diseases, clinical and biological psychiatrists have tried to bring the illness into the mainstream of American medicine, where it can be treated. Antipsychotic drugs effectively dispel hallucinations and delusions; five large placebo-controlled studies show that negative symptoms also respond to drugs (Goldberg 1985); and the present consensus on symptoms (American Psychiatric Association 1980) has helped psychiatrists to prescribe the proper drugs.

Neither victims of schizophrenia nor victims of any disease can be forced to take drugs, except in emergencies and in certain other limited situations; but many psychiatrists believe that a change in the way that schizophrenia is perceived in America will help to make antipsychotic medicine more acceptable.

Because tardive dyskinesia (involuntary movements), mild in most cases, occurs in 10–20 percent of patients who have taken drugs for many years (Shore 1986), hospitals and patients resist antipsychotic drugs.

Calling for intensive research to find improved medication, doctors balance tardive dyskinesia, which is not irreversible, against insanity.

The American Psychiatric Association (APA) has sponsored a model law, proposing that a person should be hospitalized against his will if he or she has been evaluated by a psychiatrist as severely disabled (Stromberg and Stone 1983). The APA bill argues that a schizophrenic patient lacks the capacity to make informed decisions about treatment, and the bill sets forth the likelihood of mental and physical deterioration if treatment is not given.

Dr. Daniel Luchins, Associate Professor of Psychiatry, University of Chicago, has suggested principles for laws governing involuntary treatment in the community. He sees the need for court-mandated outpatient treatment when delusions, hallucinations, and dementia disrupt normal activities. Emphasizing the need for followup care for once-hospitalized, once-dangerous patients who relapse without medicine, he calls for a legal mechanism to help keep such patients in treatment if they deteriorate without drugs (Luchins, personal communication). But civil liberties lawyers object to involuntary treatment, both in clear-cut cases of danger to oneself or others (the minority of cases), and in anomalous situations where the mentally ill, like the comatose, cannot decide what is best for themselves.

Behind the ACLU position lie the facts that, until the mid-1950's, the mentally ill often were confined to hospitals for life, inadequately treated, and sometimes physically abused. Guarantees of free legal services and periodic

reviews were not given, and civil rights such as the right to uncensored mail, confidentiality of records, payment for work, and control of personal property were violated.

In 1973 the ACLU categorized abuses and outlined needed reforms. In a related but less beneficial development, standards for involuntary treatment usually were reduced to one: physical danger. More importantly, the use of drugs reduced hospital stays to about 2 weeks, often not long enough, in the opinion of some psychiatrists. In time, untreated mentally ill patients began to walk the streets in large numbers. Consequently, an inadvertent lack of compassion, as great or greater than former abuses, set in.

In the new situation, some doctors began to see civil liberties lawyers as self-appointed judges who condemned sick persons to hopeless lives. Dr. Bernard Shulman, Clinical Professor of Psychiatry, Northwestern University, and Chairman, Department of Psychiatry, St. Joseph Hospital, Chicago, has been moved to say, "lawyers last practiced medicine in America at the Salem Witchcraft Trials in 1692" (personal communication).

In fact, the argument against involuntary treatment based on the specter of lifelong confinement and deprivation of civil rights is no longer valid, and the ACLU's principal argument (that mental illness may not exist) is obsolete.

During the past 10 years, researchers have been able to visualize the brain by using computed tomography, follow radioactive elements as they go through the brain's nerve cells and blood vessels, and measure the brain's electrical impulses and chemicals in ways much more

sophisticated than in the past. New technology also includes positron emission tomography, magnetic resonance imaging, regional cerebral blood flow, and computer-analyzed brain electrical activity mapping.

As research expands, it is apparent that the brains of schizophrenic persons often are structurally or functionally different from the brains of normal persons. Thus, the ACLU is incorrect in doubting the existence of mental illness, which is not a myth, a case of split personality (a much less common disorder), or a rational reaction to an irrational world. Nor is the disorder linked to poetic or artistic talent.

But the ACLU also presents a series of arguments that value due process rights over sanity and life. Rejecting suicide and homicide threats as a cause for treatment, they challenge even the danger standard used by most States (Ennis and Siegal 1973).

A sane person cannot be jailed because of what he *might* do, no matter how dangerous or criminal we suspect him to be. Therefore, the ACLU claims that no good reason exists for discriminating against the "so-called" insane. But this false analogy assumes that schizophrenic persons, like others, can change their destructive behavior without medication and therapy. In rejecting threats of violence as a cause for court-mandated treatment, the ACLU also fails to consider the small minority of the mentally ill (about 1 percent) who act on the basis of delusions or hallucinations, whose victims may be friends, strangers, the President of the United States, or themselves. Although suicide and homicide cannot be predicted with great accuracy, doctors know that persons who threaten violent

acts should be helped, not ignored.

Civil liberties lawyers also point out that totalitarian countries use allegations of insanity against political dissidents. However, precedent cannot suggest cases where political dissidents in the United States have been jailed in mental institutions.

With most States accepting the threat of physical danger as cause for court-mandated treatment, the ACLU position on this issue is less important than its rejection of *parens patriae*, a doctrine from old English law that refers to the right of the state to protect a disabled person. Objections to *parens patriae* (the need for treatment) leave no legal method for protecting schizophrenic persons who are not violent (the majority). But the ACLU claims that rationality tests administered by doctors are suspect:

The main trouble with the rationality test is that, in practice, it is not a test at all. It is inconceivable that a doctor, who believes that hospitalization is the only "rational" choice will view as "rational" the prospective patient's decision to reject hospitalization. The rationality test is also subject to abuse because no one knows what rational means. [Ennis and Siegal 1973, p. 24]

Thus, the ACLU rejects *parens patriae* with two fallacies in logic: first, an *ad hominem* argument, implying that all doctors who give rationality tests are self-serving and eager to spread their nets; second, a hasty generalization: *no one knows what rational means*. But the meaning of *rational* remains available. For example, most Americans would see as irrational the following not uncommon story of a schizophrenic boy's wasted life:

Believing that his parents have mysterious, long-distance powers over persons they have never met, and that they have influenced these persons (a professor, an employer, a girlfriend) against him, a young man of 21 leaves school. Unable to hold a job, he finds street people who befriend him at first. His parents try to place him in psychiatric treatment, but he is of age, he has not threatened suicide or homicide, and the misdemeanors he commits escape the attention of the police.

Many years pass. He wanders. His clothes turn to rags. He seldom bathes. He sleeps in railroad stations. He cadges food. Unable to handle bureaucratic procedures, he fails to apply for welfare. Haunted by his delusion, he seldom sees his family. They send him money from time to time, whenever they know his whereabouts. At 40, weakened by years of exposure in the streets, he dies.

Civil liberties lawyers declare, however, that no court can force a physically ill person into treatment, and the same law should apply to the mentally ill. This idea is inaccurate in two ways. First, it assumes, gratuitously, that schizophrenia is not a physical illness; second, it ignores occasions when life-saving surgery, blood transfusions, and intravenous feedings have, indeed, been ordered by courts. But these examples are somewhat beside the point. In schizophrenia, uniquely, the sufferer often cannot recognize his illness, and someone must intervene to give him a chance in life.

Finally, the ACLU argues that stigma in mental illness is just as damaging as stigma in conviction for a crime, and that no person should be treated against his will unless proof of his illness, like proof of a crime, is beyond a

reasonable doubt (Ennis and Siegal 1973).

Dr. Luchins, for one, answers that schizophrenic persons are more apt to worry about where their next meal will come from. Others remind us that cancer victims were stigmatized 50 years ago because cancer, like schizophrenia, was and still is mysterious in origin. And in the 19th century, before the discovery of the tuberculosis bacillus, tuberculosis also was thought of as a mysterious disease, an illness peculiar to poets like Keats, and fragile beauties like Mimi and Camille. In spite of the stigmatization of cancer, however, and the allegedly romantic and psychic nature of tuberculosis, patients were not denied treatment because the law required proof of their illness beyond a reasonable doubt.

Unfortunately, the problem of stigma in mental illness has helped to obscure the answer to a larger and more important problem: Can treated schizophrenic persons turn into responsible, self-supporting citizens? Perhaps the answer lies in the figure cited by the National Institute of Mental Health: If one-fourth of treated victims recover, and one-half improve, three-fourths can become at least partially productive and self-supporting, and lead better lives.

A recovered patient (Bockes 1985) has written, "Unfortunately, the disease affects one's ability to make the proper decision" (p. 487). The writer, now a graduate student, became ill in 1978. After several hospitalizations, she accepted medicine. Although she tends to hallucinate at times, she knows when attacks are coming, and she uses medication "before things get out of hand" (p. 489).

Attributing her success to drugs, psychotherapy, and financial and emotional support, she has regained control over her thoughts and feelings.

She has the same chance for life, liberty, and the pursuit of happiness as other Americans, but if she had not accepted treatment, and if the law, in effect, had denied it to her, she would have chosen insanity unknowingly.

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Erratum

In my article entitled "The Inpatient Care of the Chronically Mentally Ill" (*Schizophrenia Bulletin*, 12:129-140, 1986), an error appears on page 138. The sentence "Consensus, then, among the estimates is in the 15-40 per

100,000 range (1.5-4 percent)" should read (.015-.04 percent).

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An Invitation to Readers

Providing a forum for a lively exchange of ideas ranks high among the *Schizophrenia Bulletin's* objectives. In the section **At Issue**, readers are asked to comment on specific controversial subjects that merit wide discussion. But remarks need not be confined to the issues we have identified. **At Issue** is open to any schizophrenia-related topic that needs airing. It is a place for readers to discuss articles that appear in the *Bulletin* or elsewhere in the professional literature, to report informally on experiences in the clinic, labo-

ratory, or community, and to share ideas—including those that might seem to be radical notions. We welcome all comments.—*The Editors*

Send your remarks to:

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