2008

Autonomy and Acute Psychosis: When Choices Collide

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THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS. *Elyn R. Saks*. New York: Hyperion Press. 2007.

INTRODUCTION

Professor Elyn Saks[1] is a well-recognized expert in mental health law, having published articles, books, and book chapters on such topics as outpatient commitment,[2] competency to refuse treatment,[3] and the criminal responsibility of people with multiple personality disorder.[4] Saks is also training to become a psychoanalyst.[5] Her latest book reflects her continued interest in mental health issues, but this book

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[2] Elyn R. Saks, *Involuntary Outpatient Commitment*, 9 PSYCHOL. PUB. POL'Y & L. 94 (2003).

[3] Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945 (1991).

[4] Elyn R. Saks, *Multiple Personality Disorders and Criminal Responsibility*, 25 U.C. DAVIS L. REV. 383 (1992).

[5] *See* http://law.usc.edu/contact/contactInfo.cfm?detailID=300.

differs from her previous works because it is written in the voice not of a dispassionate observer but rather of someone who has a personal stake in the topic.

In *The Center Cannot Hold: My Journey Through Madness*, Saks recounts her own experience of schizophrenia, the most serious of all mental illnesses.[6] Beginning with some "little quirks" in childhood[7] and progressing to full-fledged psychosis by her first year at Yale Law School, Saks's illness caused her doctors to predict early on that she would be unable to complete law school and that over the course of her life she would require extended hospitalizations. But not only did Saks finish law school, she has fashioned both a successful academic career and a fulfilling personal life.

Saks explains in the book's final chapter her motives for writing about her illness, motives that include changing public perceptions about people with schizophrenia and providing a hopeful example to others diagnosed with this disease.[8] As Part I of this Review explains, Saks's book is certain to serve these ends. People whose only knowledge of schizophrenia comes from movies and newspaper headlines (or casebooks and law review articles) cannot help but recognize from Saks's story that there is more to this illness than they previously understood. But as Saks herself cautions, she is in many ways not typical of people with schizophrenia. Appreciating some of the ways her experiences differ from the experiences of many others diagnosed with this illness might temper the optimism her story inspires with a bit of realism. Part II presents such a discussion.

That Saks does not undertake a detailed comparison of her own experiences to the experiences of others with schizophrenia does not mar her book; the book is a memoir, not a psychology text. If the book does have a fault, that fault is, as Part III proposes, the wholly (or very nearly wholly) condemnatory way that it presents involuntary medication. Saks herself was administered forced medication during one hospitalization, and she consistently refers to that experience in uncompromisingly disapproving terms. Without this forced medication, however, it seems

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[6] *See* Michael F. Hogan, *Updated Schizophrenia PORT Treatment Recommendations*, 30 SCHIZOPHRENIA BULL. 623, 624 (2004) (referring to schizophrenia as "the most serious mental illness"); Steven M. Paul, *The New Pharmacotherapy of Schizophrenia, in* CURRENT ISSUES IN THE PHARMACOTHERAPY OF SCHIZOPHRENIA xvii (Alan Breier et al. eds., 2001) ("arguably the most severe and disabling of the major psychiatric disorders").

[7] ELYN R. SAKS, THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS 11 (2007).

[8] *Id.* at 330-31.

quite possible that Saks's life might have turned out much the way her doctors predicted it would.[9] And Saks not only criticizes her own forced medication but questions involuntary medication generally, raising the possibility that her book might help deny others the treatment they need if they are to have any chance of achieving the kind of life that Saks's book celebrates.

I. CONTRIBUTION

Schizophrenia is frightening, both to those who experience it and to those who only witness its manifestations. The word "schizophrenia" does not mean "split personality," despite a seemingly endless supply of misuses that would suggest that it does.[10] Instead, it means "split mind"[11]—not a mind that has been sliced into two functional pieces but a mind that has shattered;[12] a mind in which thoughts and feelings are disconnected; a mind that produces meaningless speech, that sees and

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[9] Or worse. Schizophrenia is associated with "an alarmingly high" risk of suicide. Alan Breier, *Introduction: A New Era in the Pharmacotherapy of Psychotic Disorders*, 62 J. CLINICAL PSYCHIATRY 3, 3 (2001); *see also* ROBERT M. JULIEN, A PRIMER OF DRUG ACTION: A COMPREHENSIVE GUIDE TO THE ACTIONS, USES, AND SIDE EFFECTS OF PSYCHOACTIVE DRUGS 377 (10th ed. 2005) (reporting that "approximately 10 to 15 percent of individuals with schizophrenia take their own lives, usually within the first 10 years of developing the disorder").

[10] "Schizophrenia is probably the most misused psychological term in existence." NEIL R. CARLSON, FOUNDATIONS OF PHYSIOLOGICAL PSYCHOLOGY 452 (3d ed. 1995). A recent survey of newspaper articles found that "[t]he range of metaphorical references to schizophrenia was striking." Kenneth Duckworth et al., *Use of Schizophrenia as a Metaphor in U.S. Newspapers*, 54 PSYCHIATRIC SERVICES 1402, 1404 (2003) (listing as "typical examples" such references as "the weather turns schizophrenic—81 degrees one weekend, sleet the next (*Houston Chronicle*)" and "the schizophrenia of a public that wants less government spending, more government services and lower taxes (*Washington Post*)"). It is not just writers of newspaper articles who make this mistake. *See, e.g.*, Ronald Benton Brown, *The Cure for Scholarship Schizophrenia: A Manifesto for Sane Productivity and Productive Sanity,* 13 NOVA L. REV. 39 (1988); Courtland H. Peterson, *Restating Conflicts Again: A Cure for Schizophrenia?*, 75 IND. L.J. 549 (2000).

[11] *See* Duckworth et al., *supra* note 10, at 1402 ("The use of schizophrenia as a metaphor for split personality began with Bleuler's conception of the disease as a mismatch between mood and thought, given its Greek roots 'schizo' (split, schism, or separated) and 'phrenos' (mind).") (citation omitted).

[12] SAKS, *supra* note 7, at 328.

hears things that do not exist, that believes things that cannot possibly be true.[13]

The experience of schizophrenia is legitimately frightening. The hallucinations and delusions, the distorted thinking and disorganized behavior, combined with treatment options that even at their best rarely alleviate these symptoms completely and never actually cure the disorder,[14] all explain why *Nature* magazine once called schizophrenia "arguably the worst disease affecting mankind."[15] In her book, Saks not only describes the facts of her psychotic symptoms—the faceless creatures who wanted to kill her;[16] the voices whispering her name;[17] the belief that other people had inserted thoughts into her head[18]—but she also explains the terror that these symptoms cause: "My psychosis is a waking nightmare, in which my demons are so terrifying that all my angels have already fled."[19]

Schizophrenia also involves an additional kind of fear, an illegitimate fear—the fear that anyone with this illness might at any moment perform some random act of violence.[20] At least two sources

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[13] According to the American Psychiatric Association, "The characteristic symptoms of schizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 299 (4th ed. text rev. 2000) [hereinafter DSM-IV-TR].

[14] *See infra* notes 67-71 and accompanying text.

[15] *Where Next with Psychiatric Illness?*, NATURE, Nov. 10, 1988, at 95.

[16] SAKS, *supra* note 7, at 129.

[17] *Id.* at 99.

[18] *Id.* at 132.

[19] *Id.* at 336. Saks offers this statement in the context of discussing why she would welcome a pill that would magically cure her of schizophrenia, in contrast to Rainer Maria Rilke's refusal of treatment for his bipolar disorder. "The poet Rainer Maria Rilke was offered psychoanalysis. He declined, saying, 'Don't take my devils away because my angels may flee too.'" *Id.* at 335-36.

[20] The great majority of people with schizophrenia are, if anything, less prone to violent behavior than are people in general. Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1284 (2000) ("Recent research demonstrates that most individuals with mental illness are slightly less dangerous than the general public."). Some research does support the argument, however, that people with schizophrenia who are experiencing acute psychotic symptoms and not taking antipsychotic medication are statistically more likely to commit violent acts. *Id.* (noting that

fuel this stereotypical belief: news reports of violent acts committed by people with schizophrenia (nonviolence, in contrast, is apparently not believed to be newsworthy, as it is not reported)[21] and popular media that portray people with schizophrenia as violent.[22] This illegitimate fear adds to the already immense burden that most people with schizophrenia bear,[23] contributing to stigma and ostracization, to a lack of social supports and of job opportunities, and to stresses of all kinds[24]—stresses that can trigger or intensify schizophrenia's symptoms.[25]

"a very small percentage of individuals with mental illness who are symptomatic, who are psychotic and perceive some threat to their well-being, or who have at least partly lost control of their actions are substantially more dangerous than the general public"); *see also* E. Fuller Torrey, *Violent Behavior by Individuals with Serious Mental Illness*, 45 HOSP. & COMMUNITY PSYCHIATRY 653, 659 (1994) ("The data, then, suggest that individuals with serious mental illnesses are not more dangerous than the general population when they are taking their antipsychotic medication. When they are not taking their medication, the existing data suggest that some of them are more dangerous.").

[21] Michael Winerip, *Bedlam on the Streets*, N.Y. TIMES MAG., May 23, 1999, at 42 ("It is the most sensational cases of the untreated-turned-violent that make headlines.").

[22] "[M]ental illness in general and schizophrenia in particular have not fared well in the American cinema. . . . [F]ilms have portrayed persons with schizophrenia as homicidal maniacs or as hapless figures staring blankly at a wall in a primitive version of a mental hospital." Glen O. Gabbard, *Schizophrenia on Filmmaker's Canvas*, PSYCHIATRIC NEWS, Oct. 5, 2006, at 6; *see also* JOHN MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR 77 (1981) (noting the "systematic exaggeration by the media of the crime rates of the mentally ill").

[23] A recent report by the Surgeon General's Office concludes that "active psychosis seen in schizophrenia is equal in disability burden to quadriplegia." U.S. DEP'T OF HEALTH & HUM. SERV., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 4 (1999).

[24] *See* Patrick Corrigan, *How Stigma Interferes with Mental Health Care*, 59 AM. PSYCHOL. 614, 616 (2004) ("People with mental illness are frequently unable to obtain good jobs or find suitable housing because of the prejudice of key members of their communities: employers and landlords."); Bruce G. Link & Jo C. Phelan, *Stigma and Its Public Health Implications*, 367 THE LANCET 528, 528 (2006) ("The extent to which a stigmatised person is denied the good things in life and suffers more of the bad things has been posited as a source of chronic stress, with consequent negative effects on mental and physical health."); David L. Penn & James Martin, *The Stigma of Severe Mental Illness: Some Potential Solutions for a Recalcitrant Problem*, 69 PSYCHIATRIC Q. 235, 236 (1998) ("[S]tigmatization is generally associated with decreased employment and housing opportunities, increased family stress, and conflictual

Saks's book is an antidote to both kinds of fear. Her successes provide hope to others diagnosed with this disorder, and to their families and friends, that schizophrenia does not make living a full, rewarding life impossible. Hard, certainly, but not impossible. More concretely, Saks makes clear that even at her most impaired, the actions of other people still mattered. Doctors and other mental health professionals who treated her with disrespect caused her to feel the way anyone would feel—angry, resentful, hurt.[26] Friends and family who came to visit when she was in the hospital were important evidence that the voices telling her she was worthless were wrong: "It was so easy to feel isolated and alone here; each one of these people who cared enough about me to come and visit gave me reason to hope that I was worth saving."[27] And more broadly, her book adds another person to the very short list of public examples of sympathetic people with schizophrenia.[28] That the

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feelings (from the public) regarding acceptance into the community.") (references omitted).

[25] *See* George Bartzokis, *Schizophrenia: Breakdown in the Well-regulated Lifelong Process of Brain Development and Maturation*, 27 NEUROPSYCHOPHARMACOLOGY 672, 676 (2002) (writing that "schizophrenia is an acutely 'stress reactive' disease meaning that both the onset and the course of the disease are often associated with environmentally produced psychological stress"); William P. Horan et al., *Stressful Life Events in Recent-Onset Schizophrenia: Reduced Frequencies and Altered Subjective Appraisals*, 75 SCHIZOPHRENIA RES. 363, 363 (2005) (noting that "research strongly supports the notion that stressful life events may trigger the exacerbation of psychotic symptoms in schizophrenia"); Julian Leff, *Over the Edge: Stress and Schizophrenia*, NEW SCIENTIST, Jan. 4, 1992, at 31 (discussing the view that schizophrenia is "a manifestation of an underlying brain fault which renders the individual very sensitive to environmental stress"); Joseph Ventura et al., *A Prospective Study of Stressful Life Events and Schizophrenic Relapse*, 98 J. ABNORMAL PSYCHOL. 407, 407 (1989) ("Stressful life events have been implicated in both the onset of initial symptomatology and the return of psychotic episodes.").

[26] SAKS, *supra* note 7, at 145.

[27] *Id.* at 163.

[28] John Nash is perhaps the only widely known public figure to have been diagnosed with schizophrenia. A Princeton mathematician, Nash won the Nobel Prize in Economics in 1994. His life is the subject of the 2001 movie, *A Beautiful Mind* (Universal Studios/Dreamworks Pictures 2001). *See also* SYLVIA NASAR, A BEAUTIFUL MIND (1998) (book on which movie is based). Other people have publicly discussed their experiences with schizophrenia, although they have reached a relatively limited audience. For example, twin sisters (one of whom has schizophrenia) co-authored a book, *see* PAMELA SPIRO WAGNER & CAROLYN S. SPIRO, DIVIDED MINDS: TWIN SISTERS AND THEIR JOURNEY THROUGH SCHIZOPHRENIA (2005), and several psychologists have

public can now know her, a happily married law school professor, cannot help but contribute to creating a more complete, less stigmatizing image of what someone with schizophrenia is like.[29] And that Saks coming forth with her story might inspire others to do the same only amplifies her contribution.

II. CAUTION

Several aspects of Saks's story are not typical of people with schizophrenia. As Saks herself notes, many people do not have access to the same level of resources as she has had; she also counts as unusual the analysts she has worked with as well as her own stubborn streak.[30] But there is more that is unusual about Saks's experience of schizophrenia. First, she has been able to avoid most of the secondary, collateral problems that often compound the terrible experience of psychosis, problems such as substance abuse, incarceration, and homelessness. And second, she has chosen—and responded well to, by her account—a specific type of talk therapy, psychoanalysis, that has long been considered ineffective if not counterproductive for people with schizophrenia.

A. COLLATERAL DAMAGE AVOIDED

As horrible as Saks's experience of schizophrenia has been, for the most part it has not led to additional horrors. For example, people with schizophrenia often are also diagnosed with a substance use disorder.[31] Saks did smoke cigarettes,[32] as do as many as 90 percent of people

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written about their own schizophrenia, *see, e.g.*, Frederick J. Frese, *Mental Illness, Treatment and Recovery: My Experience and Insight as a Consumer*, 11 GEO. MASON U. CIV. RTS. L.J. 83 (2000).

[29] A more balanced view of people with schizophrenia will contribute to reducing the stigma of this illness. "Stigma is further diminished when members of the general public have contact with people with mental illness who are able to hold down jobs or live as good neighbors in the community." Corrigan, *supra* note 24, at 620.

[30] SAKS, *supra* note 7, at 334.

[31] The reasons why people with schizophrenia are especially likely to abuse alcohol and other drugs are uncertain. Two currently popular theories are that people with schizophrenia use these drugs to self-medicate and that people with schizophrenia are unusually prone to addiction. *See* Geraldine Scheller-Gilkey et al., *Relationship of Clinical Symptoms and Substance Use in Schizophrenia Patients on Conventional versus Atypical Antipsychotics*, 29 AM. J. DRUG & ALCOHOL ABUSE 553, 554-55 (2003) (discussing the self-medication and the primary addiction hypotheses).

[32] SAKS, *supra* note 7, at 31.

diagnosed with schizophrenia.[33] Saks has, though, unlike about half of all people with schizophrenia,[34] avoided using alcohol and other drugs excessively. She thereby also has avoided further compounding the difficulties she has faced. As one textbook notes, "Substance use is to schizophrenia as lighter fluid is to fire."[35] More particularly, substance use "is a powerful risk factor" for a long list of bad consequences, including relapse of psychotic symptoms, hospitalization, violent behavior, victimization, HIV infection, and illnesses such as hepatitis C.[36]

Two other compounding problems that people with schizophrenia often face are homelessness and incarceration.[37] Homelessness is ten times more common among people with a psychotic disorder as compared to the general population.[38] And jails have come to be "the

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[33] JEFFREY A. LIEBERMAN ET AL., TEXTBOOK OF SCHIZOPHRENIA 384 (2006) ("An estimated 70%-90% of persons with schizophrenia smoke, whereas the estimated prevalence in the United States general population is 25%.") (citation omitted).

[34] LIEBERMAN ET AL., *supra* note 33, at 385 ("As many as half of patients with schizophrenia are affected by alcohol or drug use disorders."); Marvin S. Swartz et al., *Substance Use and Psychosocial Functioning in Schizophrenia Among New Enrollees in the NIMH CATIE Study*, 57 PSYCHIATRIC SERVICES 1110, 1110 (2006) ("Estimates of the prevalence of substance use disorders range from 10 to 70 percent, depending on diagnostic assessment methods.").

[35] Douglas Ziedonis & Connie Nickou, *Substance Abuse in Patients with Schizophrenia*, *in* SCHIZOPHRENIA AND COMORBID CONDITIONS: DIAGNOSIS AND TREATMENT 187, 187 (Michael Y. Hwang & Paul Bemanzohn, eds., 2001).

[36] Swartz et al., *supra* note 34, at 1110.

[37] Of course, all of these problems become interrelated. *See* Jeffrey Draine et al., *Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons with Serious Mental Illness*, 53 PSYCHIATRIC SERVICES 565, 565-66 (2002).

[38] Mark Olfson et al., *Prediction of Homelessness Within Three Months of Discharge Among Inpatients With Schizophrenia*, 50 PSYCHIATRIC SERVICES 667, 667 (1999) ("The risk of becoming homeless for persons with schizophrenia and related disorders is more than ten times greater than the risk for the general population."); *see also* Robert W. Buchanan & William T. Carpenter, *Schizophrenia: Introduction and Overview*, *in* 1 KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1096, 1098 (Benjamin J. Sadock & Virginia A. Sadock eds., 7th ed. 2000) ("Patients with a diagnosis of schizophrenia are reported to account for 33 to 50 percent of homeless Americans."). The causal mechanism that links schizophrenia and homelessness is not clear. Some research suggests that symptoms of schizophrenia lead fairly directly to homelessness, while other research supports a more indirect, "downward drift" theory. *See* Ramin Mojtabai, *Perceived*

mental hospitals of last resort";[39] for example, the more than 3,000 inmates who require daily mental health care make the Los Angeles County jail "*de facto* the largest mental institution in the country."[40] Homelessness and incarceration are undesirable enough experiences in and of themselves, but for people with schizophrenia, the stresses of these experiences can lead to the additional undesirable experience of exacerbated psychotic symptoms.[41] Furthermore, being either homeless or incarcerated often hinders access to appropriate treatment, leaving people with schizophrenia who are living on the streets or in jails in the worst of all possible worlds: increasingly ill, with diminished care.[42]

Reasons for Loss of Housing and Continued Homelessness Among Homeless Persons With Mental Illness, 56 PSYCHIATRIC SERVICES 172, 172 (2005) (describing direct and indirect theories of the relationship between schizophrenia and homelessness).

[39] MARVIN I. HERZ & STEPHEN R. MARDER, SCHIZOPHRENIA: COMPREHENSIVE TREATMENT AND MANAGEMENT 275 (2002) (stating that "jails and prisons have increasingly become surrogate mental hospitals for individuals with severe mental illnesses"); Marisa Elena Domino et al., *Cost Shifting to Jails After a Change to Managed Mental Health Care*, 39 HEALTH SERVICES RES. 1379, 1380 (2004) ("Just as public mental hospitals once served as the institutions of last resort for the care and confinement of mentally ill persons, jails have become the last secure environment in most communities for the control of mentally ill persons when they are unmanageable and noncompliant.").

[40] HERZ & MARDER, *supra* note 39, at 275.

[41] *See* sources cited *supra* note 25; *see also* Gregory L. Acquaviva, *Mental Health Courts: No Longer Experimental*, 36 SETON HALL L. REV. 971, 980 (2006) ("While incarceration is unpleasant, inadequate mental health care escalates the mentally ill's stressful ordeal, causing crises and a plethora of avoidable problems."); Mark J. Heyrman, *Mental Illness in Prisons and Jails*, 7 U. CHI. L. SCH. ROUNDTABLE 113, 116 (2000) (discussing how the stress of incarceration may trigger mental illness); Marjorie A. Silver, *Lawyering and Its Discontents: Reclaiming Meaning in the Practice of Law*, 19 TOURO L. REV. 773, 803 (2004) ("[J]ail is the worst possible place for the mentally ill. Imprisonment is enormously stressful, and the offenders decompensate further.").

[42] *See* John Richard Elpers, *Public Psychiatry*, *in* 2 KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 3185, 3192 (Benjamin J. Sadock & Virginia A. Sadock eds., 7th ed. 2000) ("Securing and maintaining appropriate living situations is a major problem for persons with mental illness. Treatment is impossible if adequate housing, food, and clothing are not available."); David P. Folsom et al., *Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients With Serious Mental Illness in a Large Public Mental Health System*, 162 AM. J. PSYCHIATRY 370, 370 (2005) ("Although the rates of mental and physical illnesses are high among homeless persons, their access to health services is

B. ANALYSIS AND PSYCHOSIS

Saks writes that "[p]sychoanalysis was by no means the obvious treatment for my illness."[43] Indeed, psychoanalysis remains a controversial therapy for people with schizophrenia.[44] As developed in the late 1800s by Sigmund Freud, psychoanalysis aims to alleviate psychological distress by providing insight into the unconscious sources of the distress.[45] The essential ingredients of Freudian, or classical, psychoanalysis are (in addition to a couch[46]) an analyst who elicits and interprets the contents of the patient's unconscious mind, and a patient who reveals the contents of her unconscious mind through such processes as dream recording and free association.[47] The key to the analytic relationship is transference, a process whereby the patient projects onto the analyst feelings that more properly belong to relationships with other people, especially early caregivers such as parents.[48] Psychoanalysis is an intensive as well as extensive—and expensive—kind of therapy, often consisting of fifty-minute "hourly" sessions four or five days per week for many years.

Freud himself did not advocate psychoanalysis for treating psychotic disorders. Instead, Freud considered psychoanalysis appropriate only for

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more difficult. They often do not have a regular source of health care, and the daily struggle for food and shelter may take priority over mental health care.") (references omitted); Paul F. Stavis, *Why Prisons are Brim-Full of the Mentally Ill: Is Their Incarceration a Solution or a Sign of Failure?*, 11 GEO. MASON U. CIV. RTS. L. J. 157, 157 (2000) ("[I]n jails and prisons . . . psychiatric treatment . . . is sub optimal, if it exists at all.").

[43] SAKS, *supra* note 7, at 187.

[44] HERZ & MARDER, *supra* note 39, at 195 ("In recent years there has been a great controversy over the relative efficacy of psychodynamically oriented psychotherapy versus supportive therapy.").

[45] *See* STEPHEN A. MITCHELL & MARGARET J. BLACK, FREUD AND BEYOND: A HISTORY OF MODERN PSYCHOANALYTIC THOUGHT 5 (1995) ("As his clinical experience grew, Freud realized that what was most crucial to a permanent removal of symptoms was for the objectionable, unconscious material to become generally accessible to normal consciousness.").

[46] The purpose of the couch is to aid transference. *See* NANCY MCWILLIAMS, PSYCHOANALYTIC DIAGNOSIS: UNDERSTANDING PERSONALITY STRUCTURE IN THE CLINICAL PROCESS 242 (1994) (explaining that "illumination of the transference is the main reason that analysts continue to use the couch"); *see also infra* note 48 and accompanying text (discussing transference).

[47] MITCHELL & BLACK, *supra* note 45, at 5-9.

[48] *Id.* at 53 (noting that "Freud viewed the transference as the centerpiece of the analytic process, providing access to the patient's hidden and forbidden wishes as she expressed and tried to gratify them with the analyst").

people experiencing symptoms of neuroses. Freud divided the world of psychological disorders into two types: psychotic and neurotic, with loss of contact with reality as the defining feature of a psychotic disorder.[49] People with schizophrenia are, Freud thought, poor candidates for psychoanalysis because of their impaired relationship to the external world, and in particular their inability to form a proper transference relationship with an analyst.[50] As the American Psychoanalytic Association explains, "The person best able to undergo psychoanalysis is someone who, no matter how incapacitated at the time, is basically, or potentially, a sturdy individual."[51]

For many modern mental health professionals, most of whom are neither trained psychoanalysts nor especially allegiant to Freud's theories,[52] a more pressing concern than impaired transference are empirical studies reporting that psychoanalysis is not an effective therapy for people with schizophrenia. Most empirical research has concluded that supportive reality-based psychotherapy, which addresses the everyday problems of living with schizophrenia, produces better outcomes than insight-oriented psychotherapy, such as psychoanalysis, which focuses on understanding the meaning of schizophrenia's symptoms.[53] The few studies that set out to demonstrate psychoanalysis's effectiveness seem to have failed.[54]

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[49] *Id.* at 152 ("Freud distinguished between the 'transference neuroses,' which included various analyzable neurotic conditions like obsessionalism and hysteria, and the 'narcissistic neuroses,' which included various psychotic conditions like schizophrenia and severe depression that were not amendable to the analytic process.").

[50] *See id.* at 87 ("Freud's patients were neurotic; he considered psychosis inaccessible to analytic treatment, because the totality of emotional withdrawal it entailed made impossible a transference of repressed oedipal wishes and fears onto the person of the analyst."); *see also* W.W. MEISSNER, FREUD AND PSYCHOANALYSIS 223-28 (2000).

[51] http://apsa.org/aboutpsychoanalysis/askapsychoanalyst/treatment/tabid/255/Default.aspx (last visited Feb. 10, 2008).

[52] For example, a 2001 study of the theoretical orientations of a group of psychologists who practice psychotherapy found that only 7.9% identified themselves as psychoanalytic, with an additional 20.9% self-reporting as psychodynamic. John C. Norcross et al., *Psychologists Conducting Psychotherapy in 2001: A Study of the Division 29 Membership*, 39 PSYCHOTHERAPY: THEORY, RESEARCH, PRACTICE, TRAINING 97, 99 (2002).

[53] The American Psychiatric Association's Practice Guideline for the Treatment of Patients with Schizophrenia does not recommend psychoanalysis at all, and does not recommend any psychotherapy until the "stable phase." Am. Psychiatric Ass'n, *Practice Guideline for the Treatment of Patients with*

An additional problem for non-Freudians is the psychoanalytic idea that unconscious energy is the source of schizophrenia's symptoms—the idea that, as one of Saks's analysts explained it, she was "talking about threatening and scary ideas" (that someone was trying to kill her; that her brain would explode) because she felt threatened and scared herself: "The violence is your defense against fear."[55] Or as Saks summarizes, "my psychosis served to protect me from painful thoughts and feelings."[56] Some psychotherapists reject the idea that any good can come from trying to find meaning in psychotic symptoms.[57] Even those

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Schizophrenia, 161 AM. J. PSYCHIATRY (FEB. 2004 SUPP.) 2, 6 (2004). During the acute and stabilization phases, only supportive therapy is recommended. *Id.* at 4-5. *See also* Anthony F. Lehman et al., *Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Client Survey*, SCHIZOPHRENIA BULL. 1, 7 (1998) ("Individual and group psychotherapies adhering to a psychodynamic model (defined as therapies that use interpretation of unconscious material and focus on transference and regression) should not be used in the treatment of persons with schizophrenia. . . . [T]here is a consensus that psychotherapy that promotes regression and psychotic transference can be harmful to persons with schizophrenia.").

[54] *See* GLEN O. GABBARD, PSYCHODYNAMIC PSYCHIATRY IN CLINICAL PRACTICE 189 (4th ed. 2005) ("Despite a rich clinical tradition of individual psychoanalytically oriented psychotherapy of schizophrenia, research studies have been hard pressed to demonstrate that the average schizophrenic patient is likely to reap significant benefit from such efforts.") (citation omitted); Douglas Turkington et al., *Cognitive Behavior Therapy for Schizophrenia*, 163 AM. J. PSYCHIATRY 365, 365 (2006) (noting that "a series of controlled trials conducted in the 1960s and 1970s showed that psychoanalytically oriented psychotherapy was ineffective, and at times even harmful, for patients with schizophrenia").

[55] SAKS, *supra* note 7, at 190.

[56] *Id.* at 213.

[57] *See* DAVID G. KINGDON & DOUGLAS TURKINGTON, COGNITIVE THERAPY OF SCHIZOPHRENIA xi (2005) ("[M]any practitioners continue to believe that the content of psychotic symptoms should be ignored and that any psychological work . . . is liable to lead to increased distress and exacerbation of symptoms, as a result of having opened up disturbing areas."). A good number of scholars find the whole psychoanalytic enterprise suspect. *See, e.g.*, EDWARD ERWIN, A FINAL ACCOUNTING: PHILOSOPHICAL AND EMPIRICAL ISSUES IN FREUDIAN PSYCHOLOGY 296 (1995) ("Has the effectiveness of Freud's therapy been established? No. How much of his theory has been confirmed? Virtually none of it."); Frederick Crewes, *The Verdict on Freud*, 7 PSYCHOL. SCI. 63, 68 (1996) (arguing that "there is literally nothing to be said, scientifically or therapeutically, to the advantage of the entire Freudian system or any of its component dogmas"). Although psychoanalytic theory originated with Freud, other theorists have proposed variations on Freud's ideas. These later theories differ in detail from Freud's theories but retain the general psychodynamic idea

who believe that attempts to understand schizophrenia's symptoms can be therapeutic are apt to disagree with the details of psychoanalytic theory, such as its focus on early childhood experiences.[58] Cognitive-behavioral therapists, for example, might focus on the present meaning of psychotic symptoms, such as delusional beliefs, encouraging people with schizophrenia to express those beliefs so that their reality can be tested and alternative explanations can be considered.[59] Cognitive-behavioral therapy and psychoanalysis are similar in that the goal of both is to understand psychotic symptoms; these therapies are different, though, in the type of understanding that is sought.[60]

Saks has nothing but praise for psychoanalysis, even if at times she had difficulty with some particular aspects of a particular analytic relationship. And if outcome is assessed at the end of her story, then the years of psychoanalysis must be considered a success. But at various points along the way, Saks's experience with psychoanalysis might instead serve as evidence against the efficacy of psychoanalysis for the treatment of schizophrenia. For example, of her treatment with Mrs. Jones, her analyst in England, Saks writes: "As helpful as my relationship with Mrs. Jones was proving to be, the intensity of what I was feeling for her opened a kind of door, and the psychotic thoughts marched right through it, growing more and more violent every session."[61]

Saks might respond to the observation that at times psychoanalysis seemed to be making her psychotic symptoms worse, not better, by proposing that the purpose of psychoanalysis is not (or is not only) to alleviate the symptoms of psychosis in the short term but to understand the unconscious forces that are causing the symptoms. Or in more psychoanalytic terms, she might say that understanding the symptoms is cathartic—that understanding the symptoms is necessary for not merely

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(the idea that the psyche consists of different levels that interact), and include the work of among others Carl Jung, Erik Erikson, Karen Horney, Erich Fromm, and Harry Stack Sullivan. *See* MITCHELL & BLACK, *supra* note 45, at 21.

[58] For Freudians, the present is important primarily for what it reveals about the past. *See* STEPHEN A. MITCHELL, INFLUENCE AND AUTONOMY IN PSYCHOANALYSIS 83 (1997) ("The patient only seems to live in the present; within their psychic reality, their inner world, patients are still living and struggling with the parents of their childhood, their infantile sexual and aggressive conflicts, the childhood fantasies and dreads.").

[59] Turkington et al., *supra* note 54, at 367-68.

[60] *See id.*

[61] SAKS, *supra* note 7, at 96.

alleviating but eliminating them.[62] To those who disagree with the basic principles of psychoanalytic theory, such responses are likely to be unsatisfactory. But that Saks credits so much of her success to psychoanalysis might cause some who have dismissed this therapy out of hand perhaps now to give it a second look. At the very least, Saks's successful experience with psychoanalysis should lend support to recommendations that treatment for schizophrenia include not only pharmacological therapies—namely, antipsychotic medication—but also non-pharmacological, psychosocial therapies as well.

III. CRITIQUE

Overcoming schizophrenia to the fullest extent possible very likely requires, over the course of the illness, both talk therapy and antipsychotic medication. Antipsychotic medications usually can alleviate some if not most of the acute symptoms of schizophrenia, but these drugs possess important limitations, particularly the potential to cause serious side effects. Furthermore, becoming not just less sick but truly well—or, as Saks says, "finding a life"[63]—takes more than medication. What, though, of people who refuse treatment for schizophrenia? When if ever is involuntary treatment justified?

Presently, an assortment of legal rules governs the administration of involuntary treatment—rules that specify different criteria for involuntary medication than for involuntary hospitalization, for example, and different rules for people who are competent to make their own treatment decisions than for people who lack this competency.

Behind these legal rules is a philosophical commitment to the primacy of individual autonomy. In short, involuntary treatment is viewed as bad because it does not respect individual choices, and not respecting individual choices is viewed as essentially the same thing as not respecting the personhood of the choice-maker. But a close examination of the relationship between individual autonomy and involuntary treatment raises several difficult questions. For example, does administering involuntary medication to someone whose psychotic symptoms prevent him from even knowing that he is experiencing symptoms of psychosis advance or infringe autonomy? And which is worse, compromised autonomy or unmedicated psychosis?

Threads of these questions are present in Saks's account of her life with schizophrenia. Saks spent enormous energy attempting to avoid antipsychotic medication; the enormity of her desire to be free of the

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[62] *See* MITCHELL & BLACK, *supra* note 45, at 4.

[63] SAKS, *supra* note 7, at 336.

medication was perhaps equaled only by the enormity of the successes she achieved while taking the medication. In her book, Saks has nothing good to say, directly, about involuntary medication. Indirectly, though, her experiences say a great deal about what is at stake when someone refuses treatment for acute symptoms of psychosis.

A. INVOLUNTARY MEDICATION: UNMITIGATED EVIL OR LESSER OF EVILS?

1. Medication Ambivalence: Needed and Unwanted

Medication, and Saks's "intense ambivalence" toward it,[64] occupies a central place in her story. Several particular issues fuel this ambivalence, issues such as whether antipsychotic medication is anything more than a crutch for a weak will, whether the harmfulness of medication's side effects outweighs the desirability of diminished psychosis, and whether medication should ever be administered without consent.

By the end of the book, Saks seems to have recognized that trying to resist psychotic symptoms with willpower alone is like trying to hold back the ocean with a broom.[65] She also seems to have decided, after numerous opportunities to compare life with medication's side effects to life with schizophrenia's symptoms, that for her the side effects are preferable to the symptoms.[66] Unlike the question of willpower, the question of side effects is objectively difficult. Antipsychotic medications as a class of drugs possess numerous flaws: they never actually cure psychotic disorders;[67] they rarely alleviate psychotic symptoms completely;[68] and they always pose a risk of side effects,

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[64] SAKS, *supra* note 7, at 214.

[65] *Id.* at 304.

[66] *Id.* at 334.

[67] GERALD C. DAVISON & JOHN M. NEALE, ABNORMAL PSYCHOLOGY 344 (9th ed. 2004) (noting that antipsychotic medications are "not a cure" for schizophrenia); LIEBERMAN ET AL., *supra* note 33, at 303 ("antipsychotic drugs do not cure schizophrenia"); *see also* SUSAN NOLEN-HOEKSEMA, ABNORMAL PSYCHOLOGY 359-60 (2d ed. 2001) ("People with schizophrenia typically must take neuroleptic drugs prophylactically—that is, all the time to prevent new episodes of acute symptoms.").

[68] HERZ & MARDER, *supra* note 39, at 76 ("All forms of schizophrenia improve with antipsychotics. However, the extent to which patients improve varies considerably. Whereas many patients improve to the point that they are nearly free of psychotic symptoms, others continue to manifest severe positive symptoms."); LIEBERMAN ET AL., *supra* note 33, at 327 ("For the great majority of patients, medications help with symptom control but do not clearly preserve

some exceptionally debilitating,[69] some permanent,[70] and some life-threatening.[71] Many people, though, like Saks, eventually find a medication regimen that has a combination of symptom-alleviating and side effect-producing properties they can live with. Still, the goal is always the smallest symptom-alleviating dose possible.[72] For many reasons—because schizophrenia tends to be an episodic illness;[73] because long-term use of a particular medication sometimes diminishes its effectiveness,[74] or causes new side effects to develop, or old side effects to intensify[75]—questions concerning antipsychotic medication rarely can be addressed and answered once and for all. Thus, even

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or restore premorbid levels of social and vocational functioning and do not lead to normal functioning.").

[69] Perhaps the worst of the acute side effects is akathisia. "Akathisia, characterized by a state of subjective and motor restlessness, is a common and unpleasant side effect of antipsychotic medication. Case reports have described both suicidality and violence as being precipitated by this distressing condition." E. Cem Atbaoglu et al., *The Relationship of Akathisia With Suicidality and Depersonalization Among Patients With Schizophrenia*, 13 J. NEUROPSYCHIATRY & CLINICAL NEUROSCIENCES 336, 336 (2001); *see also* JULIEN, *supra* note 9, at 353 (describing akathisia as "a syndrome of the subjective feeling of anxiety, accompanied by restlessness, pacing, constant rocking back and forth, and other repetitive, purposeless actions").

[70] The most well-known potentially permanent side effect is tardive dyskinesia, which causes involuntary movements that can be severely disabling. *See* JULIEN, *supra* note 9, at 353.

[71] *Id.* at 362 ("[T]he greatest concern with clozapine is the risk of developing severe, life-threatening (although reversible) agranulocytosis.").

[72] *See* DAVISON & NEALE, *supra* note 67, at 346 ("Current clinical practice calls for treating patients with the smallest possible doses of drugs.").

[73] *See id.* at 319 ("People with schizophrenia typically have a number of acute episodes of their symptoms; between episodes they often have less severe but still very debilitating symptoms.").

[74] *See* Howard C. Margolese et al., *Therapeutic Tolerance and Rebound Psychosis during Quetiapine Maintenance Monotherapy in Patients with Schizophrenia and Schizoaffective Disorder*, 22 J. CLINICAL PSYCHOPHARMACOLOGY 347, 352 (2002) (discussing development of therapeutic tolerance as a result of long-term administration of a particular antipsychotic); Anne-Noël Samaha et al., *"Breakthrough" Dopamine Supersensitivity during Ongoing Antipsychotic Treatment Leads to Treatment Failure over Time*, 27 J. NEUROSCIENCE 2979, 2984-85 (2007) (discussing possible neuronal bases for diminished efficacy of antipsychotics).

[75] *See* Stephen R. Marder, *Schizophrenia: Somatic Treatment*, *in* 1 KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1199, 1209 (Benjamin J. Sadock & Virginia A. Sadock eds., 7th ed. 2000) ("Concerns about the long-term adverse effects of antipsychotic medications . . . have led to a search for methods of treating patients with the lowest effective dose of medication.").

people who have come to terms with their need for antipsychotic medication must cope with the possibility of perpetual adjustment and re-adjustment of their medication.[76]

If medication presents difficult practical questions when someone with schizophrenia seeks it voluntarily, medication presents equally difficult philosophical questions when someone with schizophrenia refuses this treatment. Saks was administered forced medication during one hospitalization, several months after she started law school.[77] In the book's narration of this time, Saks describes the experience as "brutal."[78] Even by the book's end, despite such intervening statements as "medication kept me alive,"[79] Saks's view of involuntary medication has changed little if at all: "And I know better than most how the law treats mental patients, the degradation of being tied to a bed against your will and being force-fed medicine you didn't ask for and do not understand. I want to see that change, and now I actively write and speak out about the crying need for that change."[80]

Saks's suggestion that being administered forced medication was an unmitigated evil—degrading and nothing else—is troubling. In her case, even given the exceptionally harmful circumstances under which she was forced to take antipsychotic medication—harmful physically and harmful psychologically—the medication arguably produced a large amount of good. Large enough even, it might well seem to Saks's readers at least, to justify its harms.

Saks compares her experience in New Haven, where as a first-year law student she was hospitalized and administered involuntary medication, with her earlier experience when she was a graduate student in England, where for long stretches of time her treatment consisted only of sessions with her psychoanalyst, Mrs. Jones. "I had been cripplingly ill in England. Psychoanalytic treatment kept me out of the hospital while I actually completed my Oxford degree. In the States, in exactly the same situation, I was hospitalized, tied up, and forced to drink foul antipsychotic meds—a year of my life wasted."[81]

But this comparison is far from fair, as the situations were far from exactly the same. In England, Saks's symptoms were mostly of

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[76] Lehman et al., *supra* note 53, at 5 ("Reassessment of the dosage level or the need for maintenance antipsychotic therapy should be ongoing.").
[77] SAKS, *supra* note 7, at 144-45.
[78] *Id.* at 157.
[79] *Id.* at 298.
[80] *Id.* at 331-32.
[81] *Id.* at 187-88.

depression, at least initially.[82] And when the psychotic symptoms did emerge, it would be difficult to say that the treatment she received was, at least in the short term, anything more than minimally effective. It did keep her out of the hospital, but it did not cause the symptoms to abate:

> The delusions expanded into full-blown hallucinations . . . Days went by when I simply could not bear to be around anyone; unless I was with Mrs. Jones, I stayed alone in my room, with the door locked and the lights out. . . . For two straight years, I did my work, met my obligations, made it through the day as best I could, and then fled to Mrs. Jones, where I promptly took the chains off my mind and fell apart.[83]

Additionally, the daily demands of law school were much different than those she had faced in England. "Although Oxford had been challenging, there hadn't been such constraints on my time and efforts there. Within days of beginning my classwork at Yale, I was on a treadmill that seemed to have no 'stop' button."[84] As she worked to complete her second law school writing assignment, Saks's psychotic symptoms intensified. She asked her classmates if they had ever killed anyone.[85] Her speech became tangential, a jumble of words held together by the loosest of associations.[86] After a meeting with a professor, she climbed out of his office window and spent an hour on the roof, laughing, and singing.[87] When the professor took her to the emergency room, her conversation with a hospital attendant was all about killing—the people who had killed Saks (several times, in just that one day); the possibility that the attendant might himself be the next person killed.[88] In the emergency room, she was restrained, forced to swallow doses of an antipsychotic medication, and admitted to the hospital on an emergency hold.[89]

Without question, it would have been far better had Saks consented to the medication than been forced to take it. But nothing she writes provides any confidence that she would voluntarily have taken that first

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[82] *Id.* at 57-100.
[83] *Id.* at 99-100.
[84] *Id.* at 122.
[85] *Id.* at 136.
[86] *Id.* at 137. For example, she reports that she told her classmates, "I think someone's infiltrated my copies of the cases. We've got to case the joint. I don't believe in joints. But they hold your body together." *Id.*
[87] *Id.* at 139.
[88] *Id.* at 143.
[89] *Id.* at 145-46.

dose of antipsychotic medication anytime soon, if ever. Her attitude toward medication at that time was that "pills were bad, drugs were bad."[90] A short time before the hospitalization, Saks had visited the student health center where the psychiatrist she saw encouraged her to take an antipsychotic medication. Her response: "There was no way I was going to take their stupid drug."[91] She did begin sessions with a psychoanalyst, and at their first meeting she asked him, "Are you going to make me take pills? Because I don't want to do that. I cannot do that. Drugs are bad, you know."[92]

Despite the book's strong implication that given the chance Saks would go back and undo the forced medication,[93] she also writes that the medication did help her, and did so quickly. In asking to be released from the restraints, Saks told one of the doctors that the medication was working, that her thinking was clearer: "And, in fact, it was."[94] The improvement continued, so that "after weeks of steady medication, the psychosis was beginning to lift."[95] After several months, Saks was well enough to leave the hospital.

When Saks returned to law school the next fall, the psychotic symptoms also returned, quickly and forcefully, even though she was meeting with an analyst four times a week.[96] This time, she decided to take the antipsychotic medication voluntarily (although still quite reluctantly). Whether Saks would have come to this decision absent the previous year's involuntary medication and hospitalization can never be known for sure, but her earlier absolutist "drugs are bad" stance is cause for serious doubt. The forced medication cut through what otherwise might have remained a vicious circle: she could not know the benefits of the medication unless she took it, but she could not decide to take it unless she knew the benefits.

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[90] *Id.* at 123.
[91] *Id.* at 126.
[92] *Id.* at 133.
[93] In addition to the passage about wanting to change the laws regarding involuntary medication, *see supra* text accompanying note 80, Saks also explains that she chose to write her Note for the Yale Law Journal on the topic of restraints in part because "on some level, I wanted the words on the page to do the impossible—go back and change the outcome for that young woman [herself] tied to a bed at the Yale Psychiatric Institute and Yale-New Haven Hospital's MU10." SAKS, *supra* note 7, at 212.
[94] SAKS, *supra* note 7, at 151.
[95] *Id.* at 176.
[96] *Id.* at 193.

2. The Legal Rules: Least Restrictive Alternatives, Decisional Competency, Substituted Judgment, and More

Knowledge of antipsychotic medication's benefits is just one component of a voluntary decision to take such medication. Another, even more essential, component is a recognition that schizophrenia's symptoms—the people no one else sees, the voices no one else hears, the beliefs no one else shares—are just that: symptoms of an illness. Many people with schizophrenia lack this insight.[97] They do not recognize that the voices, for example, are hallucinations; they believe that no one else can hear the voices because the voices' messages are meant especially for them, or that other people only claim not to hear the voices because those people are participants in vast government-sponsored conspiracies to cover up the truth about the voices. Saks writes that for many years, she believed that everyone had the same kind of odd experiences as she did.[98] The only difference, she believed, was that other people dealt with these experiences more effectively.

Recently, researchers who study the issue of insight among people with schizophrenia have proposed that lack of awareness of psychotic symptoms is a kind of neurological impairment, similar to the lack of awareness of a physical disability, such as blindness or paralysis, that people with other brain illnesses and injuries, such as a stroke or Alzheimer's, sometimes experience.[99] This research pointing to a

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[97] *See* DSM-IV-TR, *supra* note 13, at 304 ("A majority of individuals with schizophrenia have poor insight regarding the fact that they have a psychotic illness."); DAVISON & NEALE, *supra* note 67, at 342 (noting that "many patients with schizophrenia lack insight into their impaired condition and refuse any treatment at all"); June R. Husted, *Insight in Severe Mental Illness: Implications for Treatment Decisions,* 27 J. AM. ACAD. PSYCHIATRY & L. 33, 39 (1999) ("Impaired insight is a very common symptom of schizophrenia.").

[98] SAKS, *supra* note 7, at 93.

[99] Xavier F. Amador & Andrew A. Shiva, *Insight into Schizophrenia: Anosognosia, Competency, and Civil Liberties*, 11 GEO. MASON U. CIV. RTS. L.J. 25, 27-28 (2000) ("Poor insight in schizophrenia bears remarkable similarities to anosognosia in neurological disorders. Patients with schizophrenia who have poor insight, and neurological disorder patients with anosognosia, exhibit the following characteristics: a very severe lack of awareness of their illness, the belief persisting despite conflicting evidence, confabulations to explain the observations that contradict their belief that they are not ill, and a compulsion to prove their self-concept."); *see also* Xavier F. Amador et al., *Awareness of Illness in Schizophrenia and Schizoaffective and Mood Disorders*, 51 ARCH. GEN. PSYCHIATRY 826, 828-29 (1994); J.P. McEvoy et al., *Why Must Some Schizophrenic Patients Be Involuntarily Committed? The Role of Insight*, 30 COMPREHENSIVE PSYCHIATRY 13 (1989).

neurological basis for poor insight regarding schizophrenia's symptoms contradicts earlier theories about lack of insight, particularly theories proposing that lack of insight is psychologically motivated, whether as a type of unconscious defensiveness such as denial, or as a conscious choice.[100]

Lack of insight is the most common reason why people with schizophrenia refuse treatment,[101] but it is not an adequate legal ground for administering involuntary treatment. There are two traditional types of involuntary treatment for mental illnesses, hospitalization and medication, each with its own set of criteria. Every state allows involuntary hospitalization when someone, because of a mental illness, is dangerous to himself or to other people.[102] Most states also allow involuntary hospitalization when someone is "gravely disabled," meaning (usually) that he is unable to provide for his own basic needs

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[100] *See* Kress, *supra* note 20, at 1274 n.19 (referencing psychological theories of lack of insight).

[101] Peter F. Buckley et al., *Lack of Insight in Schizophrenia: Impact on Treatment Adherence*, 21 CNS DRUGS 129, 133 (2007) ("Lack of insight is the main cause of treatment nonadherence in patients with schizophrenia."); *The Treatment of Schizophrenia: Making it Work*, HARV. MENTAL HEALTH LETTER, June 2007, at 4 ("The main reason for neglecting medication is lack of insight into the illness.").

[102] *See* Alexander Scherr, *Daubert & Danger: The "Fit" of Expert Predictions in Civil Commitments*, 55 HASTINGS L.J. 1, 29 (2003) ("Every state has enacted a form of civil commitment law."); Christopher Slobogin, *An End to Insanity: Recasting the Role of Mental Disability in Criminal Cases*, 86 VA. L. REV. 1199, 1246 n.172 (2000) (noting that "[e]very state allows commitment of those who are mentally ill and dangerous").

such as food, clothing, and shelter.[103] These statutes are based on the state's *parens patriae* power and its police power.[104]

But someone who satisfies the criteria for involuntary hospitalization might not satisfy the criteria for involuntary medication. Many courts have ruled that involuntary treatment must be the "least restrictive" means of achieving whatever government interest is justifying the involuntary treatment.[105] And traditionally, courts have regarded

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[103] *See* Scherr, *supra* note 102, at 55 ("An increasing number of states permit commitment on a finding that the person is 'gravely disabled.'"); Ilissa L. Watnik, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1191 (2001) (noting that "many states have incorporated either a 'passive harm' (deterioration) standard or a 'gravely disabled' or 'unable to provide for basic needs' standard into their civil commitment laws"). Most states define gravely disabled only in terms of physical survival. A few states, though, include psychological well-being. *See, e.g.*, WIS. STAT. § 51.20(1)(a)(2.e) (West 2008) (defining dangerous as including "severe mental, emotional or physical harm"); WYO. STAT. ANN. § 25-10-101(a)(ii)(c) (2007) ("serious mental debilitation [or] destabilization from lack of or refusal to take prescribed psychotropic medications for a diagnosed condition").

[104] *See* Addington v. Texas, 441 U.S. 418, 426 (1979) ("The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.").

[105] *See, e.g.*, Lake v. Cameron, 364 F.2d 657, 660 (D.C. Cir. 1966) ("Deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection."); DeAngelas v. Plaut, 503 F. Supp. 775, 780-81 (D. Conn. 1980) (holding state statute unconstitutional "insofar as it fails to require findings . . . that commitment of the accused is the least restrictive alternative"); Eubanks v. Clarke, 434 F. Supp. 1022, 1028 (E.D. Pa. 1977) ("[D]ue process requires that the state place individuals in the least restrictive setting consistent with legitimate safety, care and treatment objectives."); Stamus v. Leonhardt, 414 F. Supp. 439, 452-53 (S.D. Iowa 1976) (finding state law unconstitutional for "failing to require that less restrictive alternatives be considered prior to ordering full-time hospitalization"); Lessard v. Schmidt, 349 F. Supp. 1078, 1103 (E.D. Wis. 1972) ("We conclude that the Wisconsin civil commitment procedure is constitutionally defective insofar as it . . . fails to require those seeking commitment to consider less restrictive alternatives to commitment."). Some states also mandate the least restrictive alternative by statute. *See, e.g.*, ALA. CODE § 22-52-10.1(a) (2006) ("The least restrictive alternative necessary and available for the treatment of the respondent's mental illness shall be ordered."); ARIZ. REV. STAT. § 36-540(B) (2003) ("The court shall consider all available and appropriate alternatives for the treatment and care of the patient. The court shall order the least restrictive treatment alternative available."); GA. CODE

medication as more "restrictive" than hospitalization.[106] So someone who is subject to involuntary treatment because he is a threat to his own safety, for example, cannot be administered involuntary medication unless involuntary hospitalization is ineffective in diminishing his dangerousness.[107]

Additionally, many courts have ruled that involuntary medication may not be administered, except in emergency situations, unless the person to be treated is not competent to make his own decisions about whether to consent to or to refuse medical treatment.[108] The right of

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ANN. § 37-3-161 (1995) ("It is the policy of the state that the least restrictive alternative placement be secured for every patient at every stage of his medical treatment and care."); ILL. COMP. STAT. ANN. 450 5/3-811 (2004) ("The court shall order the least restrictive alternative for treatment which is appropriate."); MINN. STAT. ANN. § 253B.09(1)(a) (2007) (mandating that "the court shall commit the patient to the least restrictive treatment program or alternative programs which can meet the patient's treatment needs").

[106] *See, e.g.*, Bee v. Greaves, 744 F.2d 1387, 1396 (10th Cir. 1984) ("[L]ess restrictive alternatives, such as segregation . . . should be ruled out before resorting to psychotropic drugs."); Rennie v. Klein, 653 F.2d 836, 844 (3rd Cir. 1981) ("[T]here is a difference of constitutional significance between simple involuntary confinement to a mental institution and commitment combined with enforced administration of antipsychotic drugs."); Rogers v. Okin, 634 F.2d 650, 656 (1st Cir. 1980) ("[R]easonable alternatives to the administration of antipsychotics must be ruled out."); *In re* Guardianship of Roe, 421 N.E.2d 40, 52 (Mass. 1981) ("We can identify few legitimate medical procedures which are more intrusive than the forcible injection of antipsychotic medication."). *Cf.* ILL. COMP. STAT. ANN. 405 5/2-107.1(a-5)(4)(F)(2005 & Supp. 2007) (requiring that "other less restrictive services have been explored and found inappropriate" before allowing involuntary medication).

[107] *See, e.g.*, Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 248 (Alaska 2006) (reasoning that because "API has not maintained that Myers posed an imminent threat of harm to herself or anyone else after she was committed for treatment at API," the "state's power of civil commitment sufficed to meet its police-power interest, so we fail to see how the issue of medication implicates the state's police power at all"); *In re* K.K.B., 609 P.2d 747, 751 (Okla. 1980) ("If there is no emergency, hospital personnel are in no danger; the only purpose of forcible medication in these circumstances would be to help the patient. But the basic premise of the right to privacy is the freedom to decide whether we prefer to be helped, or to be left alone.").

[108] *See, e.g.*, *Myers*, 138 P.3d at 244 (interpreting state statute to mandate that "the court may not authorize nonconsensual psychotropic medication if it finds that the patient is presently competent; in such cases, the court must honor the unwilling patient's wishes"); Riese v. St. Mary's Hosp. & Med. Ctr., 271 Cal. Rptr. 199, 210 (Ct. App. 1987) ("[T]he task for the court is simply to determine whether a patient refusing medication is competent to do so despite his or her

competent people to refuse medical treatment has roots in both the common law[109] and the Constitution,[110] and every state now recognizes this right by statute.[111] Standards for determining competency to make decisions about medical treatment range, in theory, from the mere expression of a treatment decision to an actual appreciation of both the diagnosed illness and the proposed treatment.[112] In reality, most states have adopted amalgamated standards that require some sort of capacity

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mental illness."); Rogers v. Comm'r of the Dep't of Mental Health, 458 N.E.2d 308, 314 (Mass. 1983) ("We conclude that a distinct adjudication of incapacity to make treatment decisions (incompetence) must precede any determination to override patients' rights to make their own treatment decisions."); Rivers v. Katz, 495 N.E.2d 337, 341, 341-42 (N.Y. 1986) ("[N]either the fact that appellants are mentally ill nor that they have been involuntarily committed, without more, constitutes a sufficient basis to conclude that they lack the mental capacity to comprehend the consequences of their decision to refuse medication that poses a significant risk to their physical well-being."); Steele v. Hamilton County Cmty. Mental Health Bd., 736 N.E.2d 10, 21 (Ohio 2000) (court must find that "the patient does not have the capacity to give or withhold informed consent regarding his/her treatment"); State *ex rel.* Jones v. Gerhardstein 416 N.W.2d 883, 894 (Wis. 1987) ("While dangerousness may legitimately justify the state's authority to involuntarily commit an individual, it does not justify the abrogation of the individual's right of informed consent with respect to psychotropic drugs.").

[109] Justice Cardozo famously proclaimed, for example, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." Schloendorff v. Soc'y of N.Y. Hosps., 105 N.E. 92, 93 (N.Y. 1914).

[110] *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.").

[111] *See* S. Elizabeth Wilborn Malloy, *Beyond Misguided Paternalism: Regulating the Right to Refuse Medical Treatment*, 33 WAKE FOREST L. REV. 1035, 1054-55 (1998) ("Today, all states and the District of Columbia have recognized the right to refuse treatment through the enactment of a variety of natural death statutes, including living will laws, durable power of attorney for health care laws, do not resuscitate ("DNR") order laws, and health care surrogate laws.") (footnotes omitted).

[112] *See* Loren H. Roth, Alen Meisel & Charles W. Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 280 (1977) (discussing five types of competency standards: "1) evidencing a choice, 2) reasonable outcome of choice, 3) choice based on rational reasons, 4) ability to understand and 5) actual understanding").

to understand the diagnosis and the treatment.[113] This requirement of capacity for understanding, rather than actual understanding, means that in some cases, someone with schizophrenia will be competent to refuse treatment for psychotic symptoms that he does not know that he has.[114]

In many states, there are yet more barriers to administering involuntary medication even to someone who is incompetent to make his own treatment decisions. The first is a substituted judgment standard of decision-making for people who are incompetent.[115] This standard

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[113] *See, e.g.*, IDAHO CODE ANN. § 39-4503 (2002 & Supp. 2007) ("Any person of ordinary intelligence and awareness sufficient for him or her generally to comprehend the need for, the nature of and the significant risks ordinarily inherent in . . . treatment . . . is competent to consent thereto on his or her own behalf."); MD. CODE ANN., HEALTH–GEN. § 5-601(l)(1) (LexisNexis 2005) (defining as incompetent someone who is "unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, is unable to make a rational evaluation of the burdens, risks, and benefits of the treatment or course of treatment, or is unable to communicate a decision"); S.C. CODE ANN. § 44-22-10(12) (2002) ("'Patient unable to consent' means a patient unable to appreciate the nature and implications of his condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner."); VA. CODE ANN. § 54.1-2982 (2005) (defining as incompetent someone who is "unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision"); WIS. STAT. ANN. 51.61(1)(g)(4)(a)-(b) (West 2008) (identifying as incompetent someone who either "is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives" or "is substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness, developmental disability, alcoholism or drug dependence in order to make an informed choice as to whether to accept or refuse medication or treatment").

[114] *See, e.g.*, Virgil D. v. Rock County (*In re* Virgil D.), 524 N.W.2d 894, 895 (Wis. 1994) ("[A] patient may refuse the involuntary administration of psychotropic drugs if, after a psychiatrist has adequately explained the advantages and disadvantages of, and the alternatives to, medication or treatment, he or she is able to express an understanding of the advantages, disadvantages, and alternatives. The standard does not require the patient to have an appreciation of the nature of his or her mental illness.").

[115] *See In re* C.E., 641 N.E.2d 345, 354 (Ill. 1994) (concluding that "section 2-107.1 permits the court's consideration of the 'substituted judgment' of the mental health recipient"); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 431 (Mass. 1977) ("[W]e now reiterate the substituted judgment doctrine as we apply it in the instant case."); MASS. GEN. LAWS ANN. 201 § 14(c) (West 2004) (mandating a substituted judgment

mandates that someone who is incompetent to consent to medical treatment may be administered only those treatments that a surrogate decision-maker concludes the incompetent person would choose, were he competent to make such a choice.[116] And psychiatric advance directives may override whatever provisions a state has enacted regarding the medical treatment of people who are incompetent to make their own treatment decisions. Like medical advance directives, these "psychiatric wills," as they are sometimes called, allow people while they are competent to specify what treatments they do and do not wish to receive should they become incompetent.[117] The advance directive thus replaces the decision of the surrogate with the now-incompetent person's own decision that he made while he was competent. Every state recognizes by statute the validity of advance directives for medical treatment,[118] and many states also explicitly recognize the validity of advance directives for mental health treatment.[119] Even in those states that do not provide for an explicit statutory right, no court has rejected psychiatric advance directives as per se invalid.[120]

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standard); WASH. REV. CODE ANN. § 71.05.217 (2002) ("If the patient is unable to make a rational and informed decision about consenting to or refusing the proposed treatment, the court shall make a substituted judgment for the patient as if he or she were competent to make such a determination.").

[116] *See* United States v. Charters, 829 F.2d 479, 497 (4th Cir. 1987) ("Courts employing substituted judgment have required that if a patient is medically incompetent, the decision-maker must attempt to determine what the patient would have done if he were competent."); *In re* C.E., 641 N.E.2d 345, 355 (Ill. 1994) (noting that the substituted judgment standard "requires the parties to inquire into the values and preferences of the patient and attempt to make a decision as the patient would, were he competent").

[117] *See* Justine A. Dunlap, *Mental Health Advance Directives: Having One's Say*, 89 KY. L.J. 327, 345 (2000) ("Advance directives . . . create a means by which persons can communicate choices for a prospective period of incompetence.").

[118] Kellen Rodriguez, *Suing Health Care Providers for Saving Lives*, 20 J. LEGAL MED. 1, 3 (1999) (reporting that "statutes have been enacted in every state that provide legal mechanisms for a person to declare, in advance of a life-threatening event or condition, the type of life-sustaining medical treatments they would want taken if they become incapacitated").

[119] Breanne M. Sheetz, *The Choice to Limit Choice: Using Psychiatric Advance Directives to Manage the Effects of Mental Illness and Support Self-Responsibility*, 40 U. MICH. J.L. REFORM 401, 408 (2007) ("Between 1991 and 2006, twenty-seven states enacted statutes authorizing psychiatric advance directives in some form.").

[120] *Cf. id.* at 409-11 (discussing state and federal case law supporting the validity of psychiatric advance directives); Elizabeth M. Gallagher, *Advance*

In addition to the two traditional types of involuntary treatment, hospitalization and medication, many states also provide for a type of involuntary treatment variously called outpatient commitment,[121] assisted outpatient treatment,[122] and mandated outpatient treatment.[123] Most outpatient commitment statutes do not change the criteria for involuntary treatment; instead, they merely allow a court to order someone who meets the criteria for involuntary treatment to receive that treatment in either an inpatient or an outpatient setting.[124] This most common type of outpatient commitment is often referred to as "hospital diversion."[125] Additionally, "conditional discharge" outpatient commitment allows someone to be released from inpatient treatment, subject to the condition that he receive outpatient treatment.[126] In some

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Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals, 4 PSYCHOL. PUB. POL'Y & L. 746, 772 (1998) (discussing reasons why courts are likely to find psychiatric advance directives valid).

[121] *See, e.g.*, Howard Telson, *Outpatient Commitment in New York: From Pilot Program to State Law, Report of the Bellevue Hospital Center Outpatient Commitment Pilot Program*, 11 GEO. MASON U. CIV. RTS. L.J. 41 (2000).

[122] *See, e.g.*, Kress, *supra* note 20.

[123] *See, e.g.*, Joel M. Silberberg, Terri L. Vital & S. Jan Brakel, *Breaking Down Barriers to Mandated Outpatient Treatment for Mentally Ill Offenders*, 31 PSYCHIATRIC ANNALS 433 (2001).

[124] Marvin S. Swartz et al., *A Randomized Controlled Trial of Outpatient Commitment in North Carolina*, 52 PSYCHIATRIC SERVICES 325, 325 (2001) (reporting that "[i]n all but a small minority of states, the criteria for outpatient commitment are identical to those for inpatient commitment"); *see, e.g.*, IOWA CODE ANN. § 229.14 § 229.14(1) (b)-(c) (West 2000) (allowing court to order either inpatient or outpatient commitment); MONT. CODE ANN. 53-21-127 (2006) (same); N.H. REV. STAT. § 135-C:45 (2006) (same); OR. REV. STAT. ANN. § 426.130(1)(b)(C) (West 2003) (same); R.I. GEN. LAWS § 40.1-5-8(j) (1997) (same).

[125] *See, e.g.*, Joan B. Gerbasi et al., *Resource Document on Mandatory Outpatient Treatment*, 28 J. AM. ACAD. PSYCHIATRY & L. 127, 129 (2000); John Monahan et al., *Mandated Community Treatment: Beyond Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 1198, 1200 (2001).

[126] *See, e.g.*, MO. REV. STAT. § 632.385(1-2) (2000) ("The head of a mental health facility shall release a patient, whether voluntary or involuntary, from the facility to the least restrictive environment . . . when he believes that such release is in the best interests of the patient. . . . Release to the least restrictive environment may be conditioned on the patient receiving outpatient care as prescribed by the head of the mental health facility from which the patient is being released."); N.H. REV. STAT. § 135-C:50 (2006) ("The administrator of a receiving facility may grant a conditional discharge under this chapter to any person who consents, by an informed decision, to participate in continuing treatment on an out-patient basis, who agrees to be subject to any rules adopted

states, hospital diversion and conditional release outpatient commitment statutes expand the scope (but not the reach) of involuntary treatment, allowing administration of involuntary medication even to someone who, although he satisfies the criteria for involuntary treatment, is competent to make his own treatment decisions.[127] In most states, though, outpatient commitment statutes allow involuntary medication to be administered only to someone who is incompetent to make his own treatment decisions.[128]

In a few states, outpatient commitment statutes expand the reach of involuntary treatment. Perhaps the best-known of these statutes is New York's "Kendra's Law,"[129] which was enacted in response to the 1999 death of Kendra Webdale.[130] While standing on the platform in a New York City subway station, Webdale was pushed onto the tracks by Andrew Goldstein, who had a long history of schizophrenia but was not taking any antipsychotic medication at the time.[131] Under "preventive" or "early intervention" statutes like Kendra's Law, people who do not satisfy the criteria for involuntary inpatient treatment may be committed to involuntary outpatient treatment.[132] Kendra's Law does not, however,

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by the commissioner relative to conditional discharge, and who understands the conditions of his discharge."); *see also* Paul F. Stavis, *Conditional Discharge: A Very Old Idea Whose Time Has Returned*, 63 NEWSLETTER OF THE N.Y. STATE COMMISSION ON QUALITY OF CARE, Apr.-May 1995, *available at* http://www.cqcapd.state.ny.us/counsels_corner/cc63.htm (discussing conditional release).

[127] *See, e.g.*, TENN. CODE ANN. § 33-6-602(2) (2007) (providing that "the person shall be eligible for discharge subject to the obligation to participate in any medically appropriate outpatient treatment, including, but not limited to, psychotherapy, medication, or day treatment, under a plan approved by the releasing facility and the outpatient qualified mental health professional").

[128] *See, e.g.*, ALASKA § 47.30.825(c) (2006) (providing that "[a] patient who is capable of giving informed consent has the right to give and withhold consent to medication and treatment in all situations that do not involve a crisis or impending crisis"); HAW. REV. STAT. ANN. § 334E-1(a) (LexisNexis 2004) ("Before any nonemergency treatment for mental illness can commence, informed consent . . . shall be obtained from the patient, or the patient's guardian, if the patient is not competent to give informed consent.").

[129] N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2006).

[130] *In re* K.L., 806 N.E.2d 480, 482 (N.Y. 2004).

[131] *Id.*

[132] *See, e.g.*, ALA. CODE § 22-52-10.2 (2006) (listing as criteria for outpatient commitment that "(i) the respondent is mentally ill; (ii) as a result of the mental illness the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently; and (iii) the respondent is unable to make a rational and

allow administration of involuntary antipsychotic medication as part of an outpatient commitment treatment plan.[133] The preventive outpatient commitment statutes of most other states similarly do not provide for involuntary medication,[134] although a few states' statutes do.[135]

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informed decision as to whether or not treatment for mental illness would be desirable"); GA. CODE ANN. § 37-3-1(12.1) (1995 & Supp. 2007) (authorizing outpatient commitment for someone "(A) [w]ho is not an inpatient but who, based on the person's treatment history or current mental status, will require outpatient treatment in order to avoid predictably and imminently becoming an inpatient; (B) [w]ho because of the person's current mental status, mental history, or nature of the person's mental illness is unable voluntarily to seek or comply with outpatient treatment; and (C) [w]ho is in need of involuntary treatment"); MONT. CODE ANN. § 53-21-126(1)(d) (2006) (listing as grounds for commitment that "the respondent's mental disorder, as demonstrated by the respondent's recent acts or omissions, will, if untreated, predictably result in deterioration of the respondent's mental condition to the point at which the respondent will become a danger to self or to others or will be unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety"); N.C. GEN. STAT. ANN. § 122C-263(d)(1)(c) (West Supp. 2007) (including as criterion for outpatient commitment that "the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness").

[133] N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney 1999). Under Kendra's Law, like most preventive outpatient commitment laws, *see* sources cited *supra* note 132, physicians may prescribe medications to people who are committed to outpatient treatment, but absent a further court order (authorizing inpatient commitment) no one may be forced to take medication. *See* N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney 1999) (providing that "if [the] assisted outpatient refuses to take medications as required by the court order . . . [a] physician may consider such refusal or failure when determining whether the assisted outpatient is in need of an examination to determine whether he or she has a mental illness for which hospitalization is necessary").

[134] *See, e.g.*, CAL. WELF. & INST. CODE § 5348(c) (West 1998 & Supp. 2008) (providing that "[i]nvoluntary medication shall not be allowed absent a separate order by the court"); HAW. REV. STAT. ANN. § 334-129(b) (LexisNexis 2007) (stating that "[n]o subject of the order shall be physically forced to take medication or forcibly detained for treatment under a family court order for involuntary outpatient treatment"); N.C. GEN. STAT. 122C-273(a)(3) (West 2000 & Supp. 2007) (stating "[i]n no case may the respondent be physically forced to take medication or forcibly detained for treatment unless he poses an immediate danger to himself or others. In such cases inpatient commitment proceedings shall be initiated").

[135] *See, e.g.*, GA. CODE ANN. § 37-3-1(12.2) (1995 & Supp. 2007) ("'Outpatient treatment' means a program of treatment for mental illness outside a hospital facility setting which includes, without being limited to, medication and prescription monitoring . . . ."); MONT. CODE ANN. 53-21-127(6) (2006) ("The

Outpatient commitment is presently "the most contested issue in mental health law."[136] Those who support outpatient commitment argue that it is less restrictive and more effective than inpatient commitment, allowing people to remain in the community while still receiving the mental health treatment necessary to prevent them from becoming a danger to themselves or others.[137] In particular, advocates of outpatient commitment believe that while people with schizophrenia generally are no more likely to engage in violent behaviors than anyone else, the opposite is true of people with schizophrenia who are both experiencing acute psychotic symptoms and not taking antipsychotic medication: they are especially likely to engage in violent behaviors.[138] Outpatient commitment, its supporters argue, increases medication compliance (and thereby decreases violent behaviors) in two ways: indirectly, by mandating participation in some form of outpatient therapy, which allows treatment providers to monitor and encourage medication compliance; and directly, under some states' statutes, by providing mechanisms for enforcing medication compliance.

Opponents of outpatient commitment contend that it infringes the freedom, perhaps unconstitutionally, of people who are mentally ill without providing any benefit, either to individuals who are committed to outpatient treatment or to society.[139] Outpatient commitment might

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court may authorize the chief medical officer of a facility or a physician designated by the court to administer appropriate medication involuntarily if the court finds that involuntary medication is necessary to protect the respondent or the public or to facilitate effective treatment."); *see also In re* S.C., 15 P.3d 861, 862-63 (Mont. 2000) (rejecting petitioner's claim that district court erred in authorizing involuntary medication without first determining that she was incompetent to refuse treatment).

[136] John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patients*, 92 VA. L. REV. 391, 401 (2006).

[137] *See* Kress, *supra* note 20, at 1300-08 (discussing benefits of outpatient commitment as compared to inpatient commitment, including enhancing liberty and diminishing dangerousness); E. Fuller Torrey & Mary Zdanowicz, *Outpatient Commitment: What, Why, and for Whom*, 52 PSYCHIATRIC SERVICES 337, 337-38 (2001) (writing that outpatient commitment can increase treatment compliance, decrease incidents of violent behavior, and also decrease hospitalizations).

[138] *See supra* note 20.

[139] *See* Michael Allen & Vicki Fox Smith, *Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 342, 343 (2001) (proposing that "outpatient commitment confers no apparent benefit beyond that available through access to effective community services"); Jennifer Honig & Susan Stefan, *Outpatient Commitment Debate: New Research Continues to Challenge the Need for*

even be counter-productive, its opponents argue, because it diverts resources from people who want treatment to people who do not.[140]

Empirical assessments of outpatient commitment programs have reported mixed results. Many studies have found that outpatient commitment is associated with such positive outcomes as decreased frequency and duration of future hospitalizations and increased compliance with outpatient treatment even once the commitment order has ended.[141] But almost all of these studies possess an important flaw: nonrandom assignment of subjects to the experimental (outpatient commitment) and control groups.[142] Two studies that did randomize assignment reported differing results. One study, of people treated at Bellevue Hospital in New York City, found that outpatient commitment did not achieve any statistically significant benefits as compared to intensive but voluntary outpatient treatment,[143] while the other study, conducted by Duke University in North Carolina, reported that extended outpatient commitment (longer than six months) decreased the incidence of both hospitalizations and violent behaviors.[144] But despite the improvement of their randomized designs, both the New York and the North Carolina studies possess other methodological problems, particularly with the (lack of) uniformity of outpatient services

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Outpatient Commitment, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 109, 122 (2005) ("[O]ur drive to provide mental health treatment to people who do not want it must be constrained not only by concerns that to do so is ultimately ineffective, but also by the realization that to do so may violate their rights.").

[140] Allen & Smith, *supra* note 139, at 342 (arguing that "unless treatment resources are consistently provided along with outpatient commitment, orders for involuntary treatment may hurt the people most in need of voluntary mental health services and supports by diverting limited resources from proven and successful programs").

[141] *See, e.g.*, Mark R. Munetz et al., *The Effectiveness of Outpatient Civil Commitment* 47 PSYCHIATRIC SERVICES 1251, 1253 (1996); Gustavo A. Fernandez & Sylvia Nygard, *Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina*, 41 HOSP. & COMMUNITY PSYCHIATRY 1001, 1004 (1990).

[142] *See* Virginia Aldige Hiday, *Outpatient Commitment: The State of Empirical Research on its Outcomes*, 9 PSYCHOL. PUB. POL'Y & L. 8, 12-14 (2003) (discussing nonrandom assignment of early outpatient commitment studies).

[143] Henry J. Steadman et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52 PSYCHIATRIC SERVICES 330, 336 (2001).

[144] Swartz et al., *supra* note 124, at 329; Marvin S. Swartz et al., *Can Involuntary Commitment Reduce Hospital Recidivism? Findings from a Randomized Trial with Severely Mentally Ill Individuals*, 156 AM. J. PSYCHIATRY 1968, 1974 (1999).

provided.[145] The one consistent finding of outpatient commitment research thus far has been that conducting a randomized, well-controlled study is exceptionally difficult.[146]

3. The Principle Behind the Rules

Legal rules that limit involuntary treatment are largely if not entirely explainable in terms of autonomy.[147] The desire to minimize infringements of autonomy explains, for example, why dangerousness is usually a necessary condition for involuntary hospitalization,[148] why incompetency to make medical treatment decisions is almost always a necessary condition for involuntary medication,[149] why "least restrictive" is the typical standard for deciding among different possible types of

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[145] *See* Paul S. Appelbaum, *Thinking Carefully About Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 347, 348 (2001).

[146] For a discussion of the hurdles researchers face in designing randomized, controlled studies of outpatient commitment programs, see generally Marvin S. Swartz et al., *The Ethical Challenges of a Randomized Controlled Trial of Involuntary Outpatient Commitment*, 24 J. MENTAL HEALTH ADMIN. 35 (1997); *see also* Hiday, *supra* note 142, at 13-15.

[147] *See* Marsha Garrison, *The Empire of Illness: Competence and Coercion in Health-Care Decisionmaking*, 49 WM. & MARY L. REV. 781, 799 (2007) ("[V]irtually every aspect of medical decision making can be, and typically is, analyzed in terms of patient autonomy. Autonomy has come to play a 'preemptive role' in discourse about patient decision making and care."); *see also* Rivers v. Katz, 495 N.E.2d 337, 341 (N.Y. 1986) ("[W]here notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with furtherance of his own desires."); John D. Arras, *Physician Assisted Suicide and Euthanasia: A Tragic View*, 13 J. CONTEMP. HEALTH L. & POL'Y 361, 381 (1997) ("[T]he imposition of medical treatment against one's will represents a violation of personal autonomy and physical integrity totally incompatible with the deepest meaning of our traditional respect for liberty.").

[148] *See* Elyce H. Zenoff & Alan B. Zients, *If Civil Commitment is the Answer for Children, What Are the Questions?*, 51 GEO. WASH. L. REV. 171, 205 (1983) ("A 'dangerous to self or others' standard usually governs the involuntary commitment of adults on the ground that society should respect the autonomy of those who do not want treatment, unless they are likely to harm someone.") (footnote omitted).

[149] *See Rivers*, 495 N.E.2d at 341 (ruling that people who are involuntarily hospitalized may still refuse medication so long as they are competent because the right of self-determination "extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness") (citation omitted).

involuntary treatment,[150] and why "substituted judgment" is the generally accepted standard for surrogate decision-making.[151]

Arguments that involuntary treatment is undesirable because it compromises autonomy often presuppose a conception of autonomy as nothing more than the act of making a (competent) choice.[152] According to such a view, respecting people's choices is tantamount to respecting them as persons, and therefore people who are competent to make their own treatment decisions should be allowed to choose to refuse treatment, regardless of the likely consequences. People are permitted to make all sorts of foolish, reckless, misconceived, or otherwise inadvisable decisions; refusing treatment for acute psychotic symptoms is essentially no different than eating Big Macs for lunch every day, participating in such activities as hang gliding, sky diving, bungee jumping, snow boarding, and rock climbing, or failing to save enough money for retirement. That the government does not override these other choices means that it should not override the choice to refuse treatment for psychotic symptoms.[153]

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[150] *See* Watnik, *supra* note 103, at 1185-86 ("The doctrine of the least restrictive alternative (or least restrictive environment or setting) refers to treatment in a setting that preserves the individual's freedom and autonomy to the greatest extent possible.").

[151] *See In re* Guardianship of Brandon, 424 Mass. 482, 497 n.22 (Mass. 1997) ("The function of a substituted judgment hearing is to secure to incompetent persons the same right to choose or reject treatment that is accorded to competent persons by the law of consent."); Norman L. Cantor, *The Bane of Surrogate Decision-Making: Defining the Best Interests of Never-Competent Persons*, 26 J. LEGAL MED. 155, 179 (2005) ("In effect, the surrogate is effectuating the previously competent patient's autonomy interest as best that can be done, by making a substituted judgment about what the now-incompetent patient would want done if able to choose.").

[152] *See, e.g.*, Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 93 (1982) (arguing that "as long as a person is capable of expressing a preference about hospitalization and treatment, the state should not be able to substitute its judgment for that preference"); Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1756 (1992) ("[I]ndividuals appreciate having their autonomy respected and being allowed to exercise choice.").

[153] *See* Morse, *supra* note 152, at 95-96 ("[I]f we do not override even the most horrendously irrational decisions of normal persons that endanger their lives or the welfare of their families, we have no justification for authorizing a greater deprivation of liberty for those who are termed mentally disordered.") (footnote omitted).

One response to the argument that involuntary treatment is undesirable because it limits autonomy is to suggest that mental illness might limit autonomy to a greater degree, or in a more important way, than does involuntary treatment. As one group of psychiatrists has argued, "Strategies for protecting the autonomy of patients who refuse treatment must consider the erosion of autonomy that psychosis produces."[154] Judge David Bazelon similarly asked, "How real is the promise of individual autonomy for a confused person set adrift in a hostile world?"[155] Even the Supreme Court has noted that people who are "suffering from a debilitating mental illness and in need of treatment" are not "wholly at liberty."[156]

Relatedly, some philosophers have proposed that autonomy is more than just making choices.[157] True autonomy, they contend, must include

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[154] Harold I. Schwartz et al., *Autonomy and the Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication*, 39 HOSP. & COMMUNITY PSYCHIATRY 1049, 1054 (1988); *see also* COMMITTEE ON GOVERNMENT POLICY, GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, FORCED INTO TREATMENT: THE ROLE OF COERCION IN CLINICAL PRACTICE, NO. 137 at 43 (1994) ("[S]ometimes involuntary psychiatric treatment is necessary, can be effective, and can lead to freedom from the constraints of illness." (quoted in Darold A. Treffert, *The MacArthur Coercion Studies: A Wisconsin Perspective*, 82 MARQ. L. REV. 759, 776 (1999))).

[155] David L. Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 907-08 (1975); *see also* Paul S. Appelbaum, *Crazy in the Streets*, *in* ETHICS OF PSYCHIATRY: INSANITY, RATIONAL AUTONOMY, AND MENTAL HEALTH CARE 537, 547 (Rem B. Edwards ed., 1997) ("Meaningful autonomy does not consist merely in the ability to make choices for oneself. Witness the psychotic ex-patients on the streets, who withdraw into rarely used doorways, rigidly still for hours at a time . . . . Can the choices they make, limited as they are to the selection of a doorway for the day, be called a significant embodiment of human autonomy?").

[156] Addington v. Texas, 441 U.S. 418, 429-30 (1979) ("One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free from stigma . . . . Such 'freedom' from involuntary commitment and treatment for a mentally ill person would be purchased at a high price.").

[157] *See* ALAN GEWIRTH, SELF-FULFILLMENT 113 (1998) ("There is also a positive phase of freedom, consisting in the power or ability to act as you choose."); Alexander McCall Smith, *Beyond Autonomy*, 14 J. CONTEMP. HEALTH L. & POL'Y 23, 30 (1997) ("Enthusiasts of autonomy have sometimes talked themselves into an almost existentialist position, portraying the value of autonomy as lying in the mere capacity to make the choice rather than in the capacity to make a fulfilling choice. They have, therefore, depicted autonomy in a neutral light, as being desirable in itself, and not for what it can bring to a

positive freedom—not merely freedom from external force (negative freedom) but also freedom from internal constraint.[158] Allowing someone who is experiencing acute psychotic symptoms to refuse treatment might promote negative autonomy but only by sacrificing positive autonomy; or conversely, compelling treatment might sacrifice negative autonomy but promote positive autonomy. Under this more comprehensive view of autonomy, whether involuntary treatment is justified might depend upon whether the gain in positive freedom outweighs the loss in negative freedom.

This more comprehensive view of autonomy also provides a principled rationale for disallowing, in some cases, the choice to refuse treatment for an acute psychotic episode but not to disallow other kinds of destructive choices. Although these other choices might in many ways be equally as harmful as refusing treatment for psychotic symptoms, many of these other choices do not destroy positive freedom. The choice, for example, to consume excessive amounts of artery-clogging food does not, at least in the short run and perhaps also in the long run in many cases, preclude someone from achieving her most

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life."); ONORA O'NEILL, SELF-LEGISLATION, AUTONOMY AND THE FORM OF LAW 9 (2004), http://www.phil.cam.ac.uk/u_grads/Tripos/Ethics/course_material/self_legislation_ult_05.pdf ("Although some existentialists and libertarians have made bold (and implausible) claims about the moral significance of autonomy, which they see as mere, sheer individual choice, most advocates of this conception of autonomy see it as (at most) one important moral value among others.").

[158] Even theorist J.S. Mill, who supported limiting individual choices only on account of harm to others ("[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."), argued against respecting autonomous decisions to become a slave. JOHN STUART MILL, *On Liberty*, *in* MILL: TEXTS COMMENTARIES 121 (Alan Ryan ed., 1997) ("[A]n engagement by which a person should sell himself, or allow himself to be sold, as a slave, would be null and void . . . . The principle of freedom cannot require that he should be free not to be free."). *Cf.* Thomas Hurka, *Why Value Autonomy?*, 13 SOC. THEORY & PRAC. 361 (1987) ("To be autonomous . . . is to direct oneself where different directions are possible."). For cautions regarding the dangers of the positive freedom concept, see ISAIAH BERLIN, *Two Concepts of Liberty*, *in* FOUR ESSAYS ON LIBERTY 132 (1969); *cf.* Jeremy Waldron, *Homelessness and the Issue of Freedom*, 39 UCLA L. REV. 295, 304 (1991) (noting that positive freedom has been criticized as "a controversial, dangerous, and question-begging conception" of freedom). For background discussions of autonomy, see generally THE INNER CITADEL: ESSAYS ON INDIVIDUAL AUTONOMY (John Christman ed., 1989); GERALD DWORKIN, THE THEORY AND PRACTICE OF AUTONOMY (1988); LAWRENCE HARWORTH, AUTONOMY: AN ESSAY IN PHILOSOPHICAL PSYCHOLOGY AND ETHICS (1986).

important, most self-defining[159] goals. Even someone far along the path to a heart attack likely is able to pursue a vocation, participate in friendships and romantic relationships, and decide how to raise his children. The choice to refuse medication for schizophrenia is different. Someone experiencing an acute psychotic episode likely is unable to do any of these things. The choice to remain acutely psychotic can in effect be the choice to give up the capacity to make choices.

There is another, arguably more straightforward, response to the argument that not respecting a choice to refuse treatment for psychotic symptoms is wrong because other bad choices are respected: the response that refusing treatment is a worse choice.[160] Legislatures have disallowed a relatively small although not trivial number of choices because those choices are especially harmful—choices such as to ride a motorcycle without a wearing helmet or drive a car without wearing a seatbelt, or to consume addiction-causing drugs such as cocaine and heroin.[161] It is true that legislation disallowing these kinds of choices has been justified to a large extent on relatively non-controversial economic grounds; people who are injured in motorcycle and automobile accidents, and people who are addicted to cocaine and heroin, cost society a lot of money.[162] But disallowing these choices is perhaps better

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[159] Some philosophers might add "highest order" goals. *See, e.g.*, DWORKIN, *supra* note 158, at 15-16 (defining second-order preferences as "the choice of the kind of person one wants to become"); JOSEPH RAZ, THE MORALITY OF FREEDOM 294 (1988) ("[P]eople have second-order goals, i.e. goals about what kind of goals they should have.").

[160] For a more extensive development of this argument, see generally Dora W. Klein, *Involuntary Treatment of the Mentally Ill: Autonomy is Asking the Wrong Question*, 27 VT. L. REV. 649 (2003).

[161] One recently proposed list of such activities includes people's choices to ride motorcycles without wearing helmets or drive cars without wearing seatbelts; to use heroin, marijuana, cocaine, or LSD; to obtain a medical treatment unauthorized by the Food and Drug Administration; to work more hours than is permitted by the Fair Labor Standards Act; to be prostitutes or drug dealers; and to clone themselves or their children. Cass R. Sunstein, *Second-Order Perfectionism*, 75 FORDHAM L. REV. 2867, 2877 (2007).

[162] *See, e.g.*, Love v. Bell, 465 P.2d 118, 121 (Colo. 1970) (upholding mandatory motorcycle helmet law in part because "[p]ersons often become public charges because of their prolonged hospitalization for serious injury, and families are often required to be supported by public welfare as a result of the death of their breadwinner"); State v. Odegaard, 165 N.W.2d 677, 679 (N.D. 1969) ("[W]e are not convinced that the legislature may not take reasonable measures to prevent persons from becoming public charges, which often is the result of the costs of long hospitalization in brain injury cases."). The same is true, of course, of people who refuse treatment for psychotic symptoms. *See*

justified on the grounds that these particular choices risk causing an unacceptably large harm to personal well-being. Whatever benefits someone might experience from consuming heroin or riding a motorcycle without a helmet simply cannot justify the pain and disability of a narcotics addiction or a head injury. The same can, in some cases, be said of disallowing the choice to refuse treatment for an acute psychotic episode. Whatever benefit someone might experience from refusing treatment might not be enough to justify the huge amount of suffering that untreated psychosis can cause.[163]

Additionally, in some cases a choice to refuse treatment amounts to a choice to become a danger to self or others, or to become gravely disabled. In the 1960s, large numbers of people were released from psychiatric institutions.[164] This deinstitutionalization was made possible by the development of medications that were at least somewhat effective in treating the symptoms of schizophrenia, a disorder that had previously been essentially untreatable.[165] But the community mental health care that was supposed to help people with schizophrenia manage their illness outside of a hospital setting never materialized.[166] Today, the

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U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL (1999) *available at* http://www.surgeongeneral.gov/library/mentalhealth/chapter6/sec2.html (estimating that the total indirect cost of schizophrenia from reduced or lost productivity was almost $15 billion in 1990). A recent study concluded that in 1997 the total cost to Medicaid of inpatient admissions for treatment of schizophrenia was approximately $806 million, with approximately $106 million attributable to "gaps in antipsychotic treatment." Steven C. Marcus & Mark Olfson, *Outpatient Antipsychotic Treatment and Inpatient Costs of Schizophrenia*, 34 SCHIZOPHRENIA BULL. 173, 177 (2008).

[163] *See infra* notes 172-173, 175, 177 and accompanying text.

[164] JULIEN, *supra* note 9, at 346-48 ("Prior to 1950, effective drugs for treating psychotic patients were virtually nonexistent, and psychotic patients were usually permanently or semi-permanently hospitalized; by 1955, more than half a million psychotic persons in the United States were residing in mental hospitals. In 1956, a dramatic and steady reversal in this trend began. By 1963, fewer than 220,000 were institutionalized."); *see also* LELAND V. BELL, TREATING THE MENTALLY ILL: FROM COLONIAL TIMES TO THE PRESENT 159-60 (1980).

[165] *See* JULIEN, *supra* note 9, at 346-47; *see also* BELL, *supra* note 164, at 176-77; JOHN Q. LAFOND & MARY L. DURHAM, BACK TO THE ASYLUM: THE FUTURE OF MENTAL HEALTH LAW AND POLICY IN THE UNITED STATES 87 (1992).

[166] *See* BELL, *supra* note 164, at 176-77; RAEL JEAN ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW

experiences of some people with schizophrenia follow a predictable cycle: acute psychotic symptoms causing behaviors that justify involuntary treatment, involuntary treatment that alleviates the psychotic symptoms at least to such a degree that involuntary treatment is no longer justified, termination of involuntary treatment, and finally the return of acute psychotic symptoms causing behaviors that justify involuntary treatment.[167]

This cycle has motivated many commentators to ask, "Why?"[168] Why does the law mandate waiting until someone becomes a threat to his own or other people's physical safety, or becomes unable to provide for such basic human needs as food and shelter, before allowing involuntary treatment? And why, even under preventive outpatient commitment statutes intended to reduce such cycling, are the requirements for involuntary medication—by far the more effective treatment for acute psychosis—no less stringent than the requirements for involuntary hospitalization? The quick and ready answer to these questions is that involuntary treatment, particularly involuntary

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ABANDONED THE MENTALLY ILL 86-106 (1990); LAFOND & DURHAM, *supra* note 165, at 153-54.

[167] *See* Jan C. Costello & James J. Preis, *Beyond Least Restrictive Alternative: A Constitutional Right to Treatment for Mentally Disabled Persons in the Community*, 20 LOY. L.A. L. REV. 1527, 1532 (1987) (discussing the "revolving door" treatment of some people who are chronically mentally ill). Andrew Goldstein's history typifies the cyclical treatment histories of some people with schizophrenia: in the three years before Kendra Webdale's death, Goldstein had "received 199 days of inpatient and emergency room services, on 15 different occasions, in six different hospitals." *Commission Investigates Tragic Subway Incident*, 77 NEWSLETTER OF THE N.Y. STATE COMMISSION ON QUALITY OF CARE, Fall-Winter 1999-2000, *available at* http://www.cqcapd.state.ny.us /newsletter/77dix.htm.

[168] *See, e.g.*, Janet Kornblum, *Families Often 'Lost' in Trauma of Mental Illness: Stigma, Guilt, Denial Keep Common Signals in the Dark*, USA TODAY, Feb. 8, 2008, at 10D ("Because it is so difficult under most state laws to have a person hospitalized, families often have to wait until there is an emergency . . . . 'And then you have to call the police or you have to call the crisis team at the hospital to come into your house and take your family member to the hospital. And I want to tell you that it's one of the most traumatic events that will ever happen to you.'"); Daniel Mosley, *State's Mental Commitment Process is Too Weak*, VIRGINIAN-PILOT & LEDGER-STAR, July 25, 2007, at 9 ("It is a torturous process. And every time she is taken to the hospital, she is handcuffed like a criminal. Over the years, her baseline has become increasingly less lucid. Waiting for her condition to reach a crisis every time before a round of treatment cannot be helping."); Kate Stanley, *Instead of Psychiatric Care, He Got Jail*, STAR TRIB. (Minneapolis-St. Paul), June 1, 2003, at 1 ("It's folly to wait until someone with mental illness gets dangerous before stepping in.").

medication, is inconsistent with respect for autonomy.[169] But is respect for autonomy necessarily what someone in the midst of an acute psychotic episode needs above all else?

B. AUTONOMY ABOVE ALL ELSE?

In describing one of her scholarly works on consent to treatment, Saks writes:

> As someone who benefits from medication, I know that the question of when one should be allowed to refuse is a complicated one. But I also believe that individual autonomy is vitally important, even precious—after all, it's central to who we are as humans on the planet, with free will and self-ownership.[170]

Although Saks directly raises the issue of autonomy and involuntary treatment only briefly, much of her book arguably serves as evidence against the view that autonomy is the only value that matters in decisions about involuntary treatment. From beginning to end, Saks's descriptions of her life without medication paint a picture of unqualified suffering. For example, her description of the night preceding the involuntary medication and hospitalization:

> My whole body shook as I made my way back to my room. And once there, I couldn't settle down. I couldn't sleep. My head was too full of noise. Too full of lemons,[171] and law memos I could not write, and mass murders that I knew I would be responsible for. Sitting on my bed, I rocked back and forth, moaning in fear and isolation.[172]

And her description of one of her last efforts to discontinue the medication, many years later:

> The days and nights were harder now. The sheer physical effort of containing my body and my thoughts felt like trying to hold back a team of wild horses. Sleep was spotty, and filled with dreams that left me awake

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[169] *See* sources cited *supra* notes 147-151.

[170] SAKS, *supra* note 7, at 262.

[171] Lemons had become part of Saks's schizophrenic ideation. *E.g.*, *id.* at 136 ("'Come to the Florida sunshine bush! Where they make lemons. Where there are demons.'"); *id.* at 139 ("My head was buzzing. Lemons and memos and mass murders.").

[172] *Id.* at 138.

> and sweating in terror. . . . All around me were thoughts of evil beings, poised with daggers. . . . The room was full of swirling, taunting demons, forces coming through the walls and ceiling. Ed couldn't see them, but I knew they were there. Any minute now, something terrifying would happen to us both.[173]

At the time she was forced to take antipsychotic medication, Saks wanted a lot of things—she wanted to refuse medication, but she also wanted to return to law school, to develop friendships, to someday have a family of her own.[174] Almost certainly, those wants were incompatible. Without medication, her illness would very likely have worsened, she might well have drifted deeper into her delusions and perhaps even become resistant to antipsychotic medication's effects.[175] How allowing Saks to refuse medication would have demonstrated respect for her autonomy in anything except the most formalistic of

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[173] *Id.* at 272-76.

[174] *Id.* at 168.

[175] Early treatment is most likely to be effective. *See* DSM-IV-TR, *supra* note 13, at 309 (listing "treatment with antipsychotic medication soon after the onset of the illness" as a factor associated with a better prognosis); HERZ & MARDER, *supra* note 39, at 152 (reporting that "prolonged psychotic episodes may be associated with enduring damage"); LIEBERMAN ET AL., *supra* note 33, at 316 ("[A] delay in treatment of the first episode of schizophrenia and in the treatment of acute exacerbations is associated with poorer clinical outcomes.") (citations omitted); *id.* at 356 ("A meta-analysis of 42 research reports from 28 studies found that the shorter duration of untreated psychosis was associated with greater response to antipsychotic treatment, including improvement in severity of global psychopathology, positive symptoms, negative symptoms, and functional outcomes.") (citations omitted). One researcher described the need for early treatment this way:

> Acutely active psychosis is a dangerous mental state, if not a medical emergency, because of its aberrant experiences, loss of insight, and distortions of judgment. It requires immediate treatment, including antipsychotic medication, to reduce the danger of such distortions to life and social network. The threat of chronically active psychosis is time rather than mortality and stigma, time immersed in the negative symptoms or cognitive distortions of disorder. If prolonged, it may well create deficits that add to severity beyond the level ultimately determined by the original brain pathophysiology.

Thomas H. McGlashan, *Schizophrenia in Translation: Is Active Psychosis Neurotoxic?*, 32 SCHIZOPHRENIA BULL. 609, 613 (2006).

senses is not clear.[176] Furthermore, even if allowing her to refuse medication would have demonstrated respect for her autonomy in some meaningful way, it is still not clear why respecting her autonomy would have been preferable to giving her a chance to return to school and to seek out and participate in relationships. Why respect the one choice that might well deny her all her other choices?

When Saks's doctors told her that they believed her prognosis to be poor, that they expected she would be unable to return to school and would instead spend large portions of her life hospitalized, they were not being purposefully cruel or manifesting ignorance about the usual course of a psychotic illness like hers.[177] In explaining how she has managed to thrive in spite of schizophrenia when so many others with this disorder do not, Saks credits the psychoanalysts she has worked with, as well as her family's financial resources and her own stubbornness.[178] But a reader might well wonder what kind of a difference any of those factors would have made had Saks not been forced to take antipsychotic medication. If the emergency room doctor had simply sent Saks back to her dormitory and allowed her to proceed down her desired medication-free path, no one can say for sure what turn Saks's story would have taken at that point. But what is certain is that even with all the advantages of her financial resources, all the talent of her analysts, and all the strength of her personality, that story would not be the same story she tells in *The Center Cannot Hold.*

CONCLUSION

In *The Center Cannot Hold: My Journey Through Madness*, there is a great deal to admire and only a little to regret. Saks's book will undoubtedly change the way that people think about schizophrenia, diminishing the fear and stigma that surround this disorder. And that psychoanalysis was part of Saks's story might well contribute to a re-evaluation of that particular therapy's effectiveness in the long-term treatment of schizophrenia. Whatever else psychoanalysis (or any other

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[176] "Formalistic" here means a conception of autonomy that includes nothing more than the mere act of making a choice. *See supra* notes 157-158 and accompanying text.

[177] According to the American Psychiatric Association, "[e]ducational progress [of someone diagnosed with schizophrenia] is frequently disrupted, and the individual may be unable to finish school. Many individuals are unable to hold a job for sustained periods of time and are employed at a lower level than their parents ("downward drift"). The majority (60%-70%) of individuals with [s]chizophrenia do not marry, and most have limited social contacts." DSM-IV-TR, *supra* note 13, at 302.

[178] SAKS, *supra* note 7, at 334.

kind of talk therapy) might be able to do over the course of many years, though, it is not an efficient weapon against the acute symptoms of psychosis—the demons, the voices, the fog of confusion and disorganization. Antipsychotic medication is far from a panacea. But to someone who is in the firm grip of schizophrenia's most terrifying symptoms, antipsychotic medication is the therapy that stands the best chance, that offers the best hope. It would be regrettable if Saks's criticisms of forced medication made it harder to provide this therapy to others who are journeying through their own madness.