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Memoir as Witness to Mental Illness

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MEMOIR AS WITNESS TO MENTAL ILLNESS

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INTRODUCTION

During a trial, a witness's job is to supply the facts by telling the jury what she saw, heard, or otherwise experienced that is relevant to the legal questions the jury must answer.[1] The jury's job is to decide how much weight and credibility to accord a witness's testimony.[2] Jurors are expected, even instructed,[3] to rely on their own knowledge about the world when deciding whether and how much to believe a witness.[4] Most of the time, jurors' own experiences are sufficient to allow them to accurately assess a witness's testimony.[5] However, jurors are sometimes called upon to assess testimony that their own experiences have not prepared them to assess accurately.[6] In these cases, expert witnesses can provide jurors with the knowledge that they need to evaluate the evidence properly.[7] By definition, an expert witness is some-

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[1] Blackburn v. Murphy, 737 S.W.2d 529, 531 (Tenn. 1987) (stating that "it is the function of the witness to state evidentiary facts and the function of the jury to draw such conclusions as the facts warrant") (alteration and citation omitted); State v. Smith, 30 La. Ann. 457, 458 (1878) ("It was the province of the witness to state facts, and of the jury to draw inferences, opinions, and conclusions from those facts."). *Cf.* MODEL CODE OF PROF'L RESPONSIBILITY EC 5-9 (AM. BAR ASS'N 1980) ("The roles of an advocate and of a witness are inconsistent; the function of an advocate is to advance or argue the cause of another, while that of a witness is to state facts objectively.").

[2] *See* 1 LEONARD B. SAND ET AL., 1 MODERN FEDERAL JURY INSTRUCTIONS: CRIMINAL ¶ 7.01 Witness Credibility (2017), *available at* LEXIS ("[Y]ou should look at all of the evidence in deciding what credence and what weight, if any, you will want to give to the . . . witnesses.").

[3] *See id.* at ¶ 5.02 Testimony, Exhibits, Stipulations, and Judicial Notice ("You should consider the evidence in light of your own common sense and experience, and you may draw reasonable inferences from the evidence."); United States v. Cruz-Valdez, 773 F.2d 1541, 1546 (11th Cir. 1985) (en banc) ("[J]urors are correctly instructed to use their common sense and to evaluate the facts in light of their common knowledge of the natural tendencies and inclinations of human beings.") (internal quotation marks and citation omitted).

[4] *See Cruz-Valdez*, 773 F.2d at 1546.

[5] SAND ET AL., *supra* note 2, at ¶ 7.01 Witness Credibility cmt. ("Use your common sense and your everyday experience in dealing with other people. And then decide what testimony you believe.").

[6] *See* Young v. Dep't of Transp., 744 A.2d 1276, 1278 (Pa. 2000) ("Expert testimony is often employed to help jurors understand issues and evidence which is outside of the average juror's normal realm of experience.").

[7] *See id.* As the Supreme Court of Missouri explained in 1896:

> The witnesses, as a general rule, must state facts, from which the jurors are to form their opinion. But when the facts are all stated, upon a subject

one who has knowledge that would be helpful to jurors—helpful both because jurors are unlikely to have this knowledge and because this knowledge is important to properly understanding something at issue in the case.[8]

Cases involving claims of serious mental illness are one kind of case that jurors might not be able to evaluate properly without input from expert witnesses.[9] People with serious mental illnesses often experience things that a juror, unless he has had these same experiences, is likely to find unbelievable. For example, Eric Clark believed that aliens had taken over the bodies of people in his town,[10] and Russell Weston believed that the key to preventing a worldwide deadly plague was hidden inside a safe in the U.S. Capitol building.[11] If called upon to assess a claim of insanity in these cases, jurors

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> of inquiry, if an intelligent opinion cannot be drawn therefrom by inexperienced persons, such as constitute the ordinary jury, an exception is made to the general rule, and persons who, by experience, observation, or knowledge, are peculiarly qualified to draw conclusions from such facts, are, for the purpose of aiding the jury, permitted to give their opinion. The exception is allowed from necessity.

Benjamin v. Metro. St. Ry. Co., 34 S.W. 590, 593 (Mo. 1896).

[8] Under the Federal Rules of Evidence, expert testimony is admissible only if it will "help" the trier of fact. *See* FED. R. EVID. 702(a) cmt. (stating that an expert witness's opinion is allowed only if the expert's specialized knowledge "will *help the trier of fact* to understand the evidence or to determine a fact in issue" (emphasis added)). If an expert proposes to offer testimony that is not beyond jurors' own knowledge, then the testimony is not helpful and therefore inadmissible. *See* Nichols v. Am. Nat. Ins. Co., 154 F.3d 875, 883 (8th Cir. 1998) (stating expert testimony "is not helpful if it draws inferences or reaches conclusions within the jury's competence").

[9] *See* Ake v. Oklahoma, 470 U.S. 68, 80-81 (1985) ("[P]sychiatrists ideally assist lay jurors, who generally have no training in psychiatric matters, to make a sensible and educated determination about the mental condition of the defendant at the time of the offense."). As the Georgia Court of Appeals explained:

> [T]he State was required to show that Porter had knowledge of her husband's actions . . . It was for the jury to decide whether Porter had the requisite knowledge, but it was important that their decision be made upon all the facts. If, indeed, Porter suffered from a psychological condition that caused her not to become aware of painful facts, the only way the jury could know about such a condition was through expert testimony. Psychological diagnosis was not within the jury's ken. Once armed with this testimony, they could choose to believe it or not in concluding whether Porter had the requisite knowledge, and they could then fairly decide her fate.

Porter v. State, 532 S.E.2d 407, 416 (Ga. Ct. App. 2000).

[10] Clark v. Arizona, 548 U.S. 735, 735 (2006).

[11] United States v. Weston, 206 F.3d 9, 19-20 (D.C. Cir. 2000) (Tatel, J., concurring).

who have not experienced psychotic symptoms, or who have not interacted with someone who is experiencing such symptoms, might well conclude that a defendant simply made up these beliefs after having committed a crime to support a defense of insanity.[12] An expert witness can provide the jurors with the knowledge necessary to accurately assess these beliefs. For example, the expert witness can explain that delusions, which are beliefs not based in reality,[13] are in fact a common symptom of illnesses such as schizophrenia and bipolar disorder.[14] This knowledge can help the jury to not automatically dismiss the defendant's reported delusions as too bizarre or too convenient to possibly be real.

Expert witnesses can supplement jurors' knowledge of serious mental illnesses, but what about supplementing people's knowledge beyond the narrow trial context? For example, misconceptions about serious mental illnesses cause people to hold erroneous beliefs about the insanity defense, and these erroneous beliefs can influence, not just the outcome of a single trial, but the availability of the defense in general.[15] How can the public be informed about serious mental illnesses so that these erroneous beliefs can be corrected?

This article proposes that memoirs of mental illness can serve as a kind of expert witness for the public. One reason why people distrust criminal defendants' claims of serious mental illness is that criminal defendants have obvious motives to lie.[16] Additionally, because the immediate conse-

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[12] *See infra* Part I.B (discussing widespread belief that people fake insanity).

[13] AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 87 (5th ed. 2013).

[14] *Id.* at 87, 152.

[15] Although this article focuses on the insanity defense, the same misconceptions about serious mental illnesses may affect other aspects of the legal system where mental illness is relevant, such as competency to stand trial and competency to be executed. *See, e.g.*, Christopher Seeds, *The Afterlife of* Ford *and* Panetti*: Execution Competence and the Capacity to Assist Counsel*, 53 ST. LOUIS U. L. J. 309, n.129 (2009) ("The Court's opinion in *Panetti* responds to the fear, held by many, that death row prisoners fake insanity to avoid execution. The validity of such claims is questionable. But concerns persist, as evidenced in Justice Thomas's dissent in *Panetti*, which reiterates those expressed twenty years before.") (emphasis added) (citation omitted).

[16] *See infra* Part I.B (discussing widespread belief that people fake insanity).

quence of being found not guilty by reason of insanity is indefinite civil commitment,[17] the insanity defense is typically reserved for cases in which the defendant has been charged with a very serious offense,[18] which means that someone asserting an insanity defense usually has a very strong motive to lie. But thousands of people experience the very same kinds of symptoms when there is no obvious motive to report fictitious psychotic symptoms and when there are obvious disincentives, such as civil commitment and forced medication, to admitting such psychotic symptoms.[19] Reading the memoirs of people who have themselves experienced these symptoms may help dispel the suspicion that someone claiming to hold beliefs that are demonstrably false must be lying.[20]

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[17] *See* Jones v. United States, 463 U.S. 354, 368 (1983) ("The committed acquittee is entitled to release when he has recovered his sanity or is no longer dangerous.").

[18] Kent Greenawalt, *"Uncontrollable" Actions and the Eighth Amendment: Implications of* Powell v. Texas, 69 COLUM. L. REV. 927, 961 (1969) ("Since a finding of not guilty by reason of insanity is likely to result in indefinite civil commitment, the defense is usually raised only for the most serious crimes, particularly murder."); David B. Wexler, *Incompetency, Insanity, and Involuntary Civil Commitment*, *in* MENTAL HEALTH AND CRIMINAL JUSTICE 139, 153 (L. Teplin ed., 1984) ("[I]f successful invocation of the insanity defense can lead automatically to a period of confinement longer than a criminal sentence, then criminal defendants charged with any but the most serious of offenses will generally choose not to assert the defense . . . and will therefore probably not be treated at all.").

[19] *Cf. Mental Health by the Numbers*, NATIONAL ALLIANCE ON MENTAL ILLNESS, https://www.nami.org/learn-more/mental-health-by-the-numbers (last visited March 5, 2019) (stating that one in twenty-five adults, 9.8 million, have a serious mental illness that substantially interferes with life).

[20] Prosecutors often offer expert testimony for a similar reason in cases in which an abused child has changed her account of abuse or behaved in some other way that a juror might interpret as a sign of untruthfulness. *Cf.* 1 JOHN E.B. MYERS, EVIDENCE IN CHILD ABUSE AND NEGLECT CASES § 5.49 at 561-63 (3d ed. 1997). Prosecutors often offer expert testimony for a similar reason in cases in which an abused child has changed her account of abuse or behaved in some other way that a juror might interpret as a sign of untruthfulness. As one scholar reports:

> Courts permit expert testimony to explain why sexually abused children delay reporting abuse, why children recant, why children's descriptions of abuse are sometimes inconsistent, why some abused children are angry, why some children want to live with the person who abused them, why a victim might appear "emotionally flat" following the assault, why a child might run away from home . . . .

Id.; *see also* State v. R.B., 873 A.2d 511, 520 (N.J. 2005) (citations omitted) (allowing expert testimony regarding Child Sexual Abuse Accommodation Syndrome because "it helps to dispel preconceived, but not necessarily valid, conceptions jurors may have concerning the likelihood of the child's truthfulness as a result of her delay in having disclosed the abuse or sought help."); People v. Taylor, 552 N.E.2d 131, 136 (N.Y. 1990) ("Because cultural

Of course, a person writing a memoir might also have a motive to lie. For example, James Frey infamously confessed to fabricating much of his best-selling 2003 book, *A Million Little Pieces*, which was originally marketed as a non-fiction account of his drug addiction.[21] On the other hand, while no memoirist likely presents an account that is completely accurate in all of the details,[22] the consistency that emerges across numerous writers about their experiences of serious mental illness provides one means of establishing the accuracy of these memoirs. Frey's book was compelling in part because it was very different from other memoirs of addiction.[23] Conversely, most memoirs of mental illness are useful precisely because they present very similar accounts of the experience of psychotic symptoms. For example, although the specific content of delusional beliefs may vary,[24] what

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myths still affect common understanding of rape and rape victims and because experts have been studying the effects of rape upon its victims only since the 1970's, we believe that patterns of response among rape victims are not within the ordinary understanding of the lay juror. For that reason, we conclude that introduction of expert testimony describing rape trauma syndrome may under certain circumstances assist a lay jury in deciding issues in a rape trial.").

[21] *See* Samantha J. Katze, *A Million Little Maybes: The James Frey Scandal and Statements on a Book Cover or Jacket as Commercial Speech*, 17 FORDHAM INTELL. PROP. MEDIA & ENT. L.J. 207, 213-15 (2006). Frey was sued by readers who claimed that they were fraudulently induced to purchase the book. *In re* "A Million Little Pieces" Litigation, 435 F. Supp. 2d 1336 (J.P.M.L. 2006) (consolidation order).

[22] *Cf.* Paul Guajardo & David W. Read, *Sin Documentos: Legally Instructive Narratives in Mexican-American Memoirs and United States Immigration Law*, 24 TEX. HISP. J. L. & POL'Y 1, 14–15 (2017) ("Certainly, memory is sometimes faulty, and of course, readers need to be aware of possible posturing, exaggerations, and biases in texts, but these caveats apply to any literature.").

[23] For example, Frey rejects the surrendering to a higher power approach of Alcoholics Anonymous. *See* Laura Miller, *The Thirteenth Step Books*, NEW YORKER, May 12, 2003, at 110 ("But Frey's most attention-grabbing move is his utter rejection of the Twelve Step approach.").

[24] There are some consistent themes to delusions. The DSM identifies five primary categories of delusions:

> 1. Erotomanic type: This subtype applies when the central theme of the delusion is that another person is in love with the individual.
> 2. Grandiose type: This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery.
> 3. Jealous type: This subtype applies when the central theme of the individual's delusion is that his or her spouse or lover is unfaithful.
> 4. Persecutory type: This subtype applies when the central theme of the delusion involves the individual's belief that he or she is being conspired

is similar is that: (1) these beliefs are almost certainly are not true; and (2) the person holding these beliefs really does believe them to be true.[25] Additionally, decades of scientific research have documented the experience of psychotic symptoms.[26] Memoirs are instructive because they provide concrete examples of psychotic symptoms, not because they provide the sole evidence of these symptoms.[27]

The aim of this article is to demonstrate how memoirs can increase public understanding of legal issues relating to the experience of serious mental illnesses. Part I of this article discusses the insanity defense, including the widespread distrust of claims of insanity. Part II examines several issues relating to civil commitment and involuntary treatment. Although less publicly visible than the insanity defense, the issues of civil commitment and involuntary medication have far greater practical importance in the lives of people who are seriously mentally ill. Additionally, deep divisions exist among both patients and treatment providers regarding when, if ever, these

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against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals.

5. Somatic type: This subtype applies when the central theme of the delusion involves bodily functions or sensations

AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 90-92 (5th ed. 2013).

[25] *Id.* at 92.

[26] *See generally* Susanna L. Blumenthal, *The Deviance of the Will: Policing the Bounds of Testamentary Freedom in Nineteenth-Century America*, 119 HARV. L. REV. 959 (2006) (discussing the tension between scientific and legal definitions of delusions beginning in the 1800s); *see also* Joshua C. Tate, *Personal Reality: Delusion in Law and Science*, 49 CONN. L. REV. 891, 897 (2017) ("The doctrine of insane delusion entered the common law in the nineteenth century as an embrace of a concept that was, at the time, cutting-edge science.").

[27] For this reason, the use of memoirs or "stories" to illustrate psychotic symptoms avoids the problems associated with the use of stories in some other contexts. *See, e.g.*, Daniel A. Farber & Suzanna Sherry, *The 200,000 Cards of Dimitri Yurasov: Further Reflections on Scholarship and Truth*, 46 STAN L. REV. 647, 652 (1994) ("Our own view is that stories are significant only when they are shown to be typical."); Stephan Landsman, *The Crime of Sheila Mcgough. by Janet Malcolm. New York: Alfred A. Knopf. 1999. Pp. 161. $22.*, 98 MICH. L. REV. 2154, 2167 (2000) ("A single idiosyncratic anecdote is not proof of anything."); William M. Richman, *Evolved into Firms*, 80 IOWA L. REV. 419, 430 n.23 (1995) ("If a story, though true, is not typical—i.e., representative of many other stories that could be told—then it cannot support generalizations, theorizing, or concrete law reform proposals.").

measures are appropriate.[28] Part III discusses what can be learned from mental illness memoirs, focusing on the ways that memoirs can serve an expert witness function by increasing understanding of serious mental illnesses. Specifically, this part demonstrates how a greater understanding of psychosis can change misperceptions about the insanity defense and inform debates about civil commitment and involuntary treatment.

I. THE INSANITY DEFENSE

A. *A Brief Overview*

Among various jurisdictions in the United States, current definitions of "insanity" vary greatly.[29] Some states follow the "M'Naughten test," named for the historically important case of Daniel M'Naughten, who attempted to kill the British Prime Minister and did kill the Prime Minister's secretary because M'Naughten believed that the Prime Minister was planning to kill him.[30] In considering this case, the House of Lords stated that a defendant would be not guilty by reason of insanity if:

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[28] *See* John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patients*, 92 VA. L. REV. 391, 401 (2006) ("Mandating adherence to mental health treatment in the community through outpatient commitment has now become the most contested issue in mental health law.").

[29] According to the Supreme Court:

> Seventeen States and the Federal Government have adopted a recognizable version of the *M'Naghten* test with both its cognitive incapacity and moral incapacity components. One State has adopted only *M'Naghten's* cognitive incapacity test, and 10 (including Arizona) have adopted the moral incapacity test alone. Fourteen jurisdictions, inspired by the Model Penal Code, have in place an amalgam of the volitional incapacity test and some variant of the moral incapacity test, satisfaction of either (generally by showing a defendant's substantial lack of capacity) being enough to excuse. Three States combine a full *M'Naghten* test with a volitional incapacity formula. And New Hampshire alone stands by the product-of-mental-illness test. The alternatives are multiplied further by variations in the prescribed insanity verdict: a significant number of these jurisdictions supplement the traditional "not guilty by reason of insanity verdict" with an alternative of "guilty but mentally ill." Finally, four States have no affirmative insanity defense, though one provides for a 'guilty and mentally ill' verdict.

Clark, 548 U.S. at 750-52 (footnotes omitted).

[30] Jennifer S. Bard, *Re-Arranging Deck Chairs on the Titanic: Why the Incarceration of Individuals with Serious Mental Illness Violates Public Health, Ethical, and Constitutional*

> [A]t the time of the committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong.[31]

Many states currently define insanity in terms of one or both parts of the M'Naughten test.[32] The Model Penal Code recommends a version of M'Naughten that substitutes "lacks substantial capacity" for complete lack of capacity:

> A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.[33]

Other influential insanity tests include the "irresistible-impulse test" and the "product test."[34]

Although the precise, technical differences among the various tests of insanity can be philosophically interesting, it is unclear whether these differences have a meaningful effect on a defendant's likelihood of being found not guilty by reason of insanity.[35] Some research suggests that jurors regard

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Principles and Therefore Cannot Be Made Right by Piecemeal Changes to the Insanity Defense, 5 HOUS. J. HEALTH L. & POL'Y 1, 31 (2005).

[31] *Id.* at 33.

[32] *Clark*, 548 U.S. at 750-52.

[33] MODEL PENAL CODE § 4.01 (AM. LAW INST., Official Draft and Revised Comments 1985).

[34] *See Clark*, 548 U.S. at 749-51. As the Court explained:

> The volitional incapacity or irresistible-impulse test, which surfaced over two centuries ago (first in England, then in this country), asks whether a person was so lacking in volition due to a mental defect or illness that he could not have controlled his actions. And the product-of-mental-illness test was used as early as 1870, and simply asks whether a person's action was a product of a mental disease or defect.

Id. (footnotes omitted).

[35] According to one scholar:

any insanity test as essentially a test of fitness for moral (and legal) responsibility.[36] At least one scholar has proposed a test that would define insanity not in terms of any specific cognitive or volitional deficiency, but instead, in terms of moral fitness for criminal condemnation.[37]

B. *Distrust of Claims of Insanity*

> In at least some areas of law, cultural preconceptions not only influence the application of legal standards, they may supplant them altogether. This phenomenon has been documented by researchers who, after studying the impact of different insanity tests on jury decision making, have consistently concluded that the actual legal formulations do not make much of a difference. Jurors tend to decide cases consistently regardless of the specific legal standards that supposedly govern their decision making.

Russell D. Covey, *Criminal Madness: Cultural Iconography and Insanity*, 61 STAN. L. REV. 1375, 1380 (2009) (footnote omitted). *See also* John Q. La Fond & Mary L. Durham, *Cognitive Dissonance: Have Insanity Defense and Civil Commitment Reforms Made A Difference?*, 39 VILL. L. REV. 71, 91 (1994) ("For many years, legal scholars and psychiatrists have debated the strengths and weaknesses of various insanity defense formulations. Much of the debate has focused on the theoretical implications of specific formulations for conviction or acquittal. Ironically, this debate has virtually ignored whether different insanity tests make a practical difference."). *But see* Christopher Slobogin, *The Guilty but Mentally Ill Verdict: An Idea Whose Time Should Not Have Come*, 53 GEO. WASH. L. REV. 494, 522 (1985).

[36] *See* Joshua Dressler, *Some Very Modest Reflections on Excusing Criminal Wrongdoers*, 42 TEX. TECH L. REV. 247, 257 (2009); Amanda C. Pustilnik, *Prisons of the Mind: Social Value and Economic Inefficiency in the Criminal Justice Response to Mental Illness*, 96 J. OF CRIM. L. & CRIMINOLOGY 217, 247 (2005) ("Actual insanity defense trials, though rare, also demonstrate that jurors equate imposing liability on people with concededly severe mental illnesses with supporting the norm of individual responsibility.").

[37] Professor Stephen Morse, a leading scholar on the insanity defense, has proposed:

> Although a workable, restricted test similar to present tests can be constructed, I would like to suggest a new alternative: A defendant is not guilty by reason of insanity if, at the time of the offense, the defendant was so extremely crazy and the craziness so substantially affected the criminal behavior that the defendant does not deserve to be punished. . . .Legal insanity is a social, moral, and legal issue, not a medical or psychiatric issue. The question in insanity defense cases is not whether the defendant suffered from a mental disorder; the real issue that juries decide—no matter what test they use—is whether the defendant's behavior related to the offense was so crazy, so irrational, that the defendant should be excused.

Stephen J. Morse, *Excusing the Crazy: The Insanity Defense Reconsidered*, 58 S. CAL. L. REV. 777, 820–21 (1985) (footnote omitted).

The widespread public distrust of the insanity defense has been well documented. Recent statements of this distrust include:

> ○"Studies have consistently shown that the public is deeply suspicious of the insanity defense."[38]
> ○"[M]any hold the belief that the presentation of mental health evidence as a defense (or as mitigation at sentencing) is some kind of a trick."[39]
> ○"There is an unrealistic belief about the frequency with which the insanity defense is used, leading people to assume that guilty mentally healthy people often fake insanity to plead the defense."[40]
> ○"The concerns over faking the insanity defense as a legal loophole are now firmly engrained."[41]
> ○"It is very hard to make an insanity claim in a criminal context because the American public, which is generally suspicious of insanity pleas, tends to view them as fakery simulated by the defendant to avoid paying for a crime."[42]

The fear that a plea of insanity is "fakery" is not a recent development.[43] Modern media coverage, however, likely exacerbates this problem. As one scholar explained, "The widespread public belief that defendants frequently

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[38] Scott Brooks, *Guilty by Reason of Insanity: Why a Maligned Defense Demands a Constitutional Right of Inquiry on Voir Dire*, 20 GEO. MASON L. REV. 1183, 1183 (2013).
[39] Andrea D. Lyon, *The Blame Game: Public Antipathy to Mental Health Evidence in Criminal Trials*, 21 NEW CRIM. L. REV. 247, 255 (2018).
[40] Beatrice R. Maidman, *The Legal Insanity Defense: Transforming the Legal Theory into A Medical Standard*, 96 B.U. L. REV. 1831, 1846 (2016) (citing MATTHEW T. HUSS, FORENSIC PSYCHOLOGY: RESEARCH, PRACTICE, AND APPLICATIONS 165 (2009)).
[41] Michael J. Vitacco, *Insanity Acquittees in the Community: Legal Foundations and Clinical Conundrums*, 43 FORDHAM URB. L.J. 847, 851 (2016).
[42] Carla Spivack, *Killers Shouldn't Inherit from Their Victims-Or Should They?*, 48 GA. L. REV. 145, 214 (2013).
[43] According to one recent writer:

> In 1873, a prominent New York attorney declared, "Many a murder is now committed upon a cold-blooded calculation of the chances in favor of escaping the just consequences, through the convenient and elastic defence of insanity." The defense, he claimed, was so often abused that "people are beginning to be alarmed lest there be not sane persons enough left to try the criminals."

Brooks, *supra* note 38, at 1197 (footnotes omitted).

use the insanity defense to avoid punishment is largely attributable to high profile cases and the attention that the media gives them."[44]

Of course, the fear that insanity claims are fakery is not a wholly illogical fear. A perfectly sane criminal defendant might well view a false claim of insanity as a way to be found not guilty.[45] Undoubtedly, some criminal defendants do successfully fake insanity.[46] However, every criminal defense is subject to falsification.[47] Self-defense has been claimed in numerous cases where the government asserted that the crime scene was staged to look like the defendant had acted in self-defense.[48] Similarly, defendants can

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[44] Julie E. Grachek, *The Insanity Defense in the Twenty-First Century: How Recent United States Supreme Court Case Law Can Improve the System*, 81 IND. L.J. 1479, 1487 (2006) (footnote omitted).

[45] *See,* Ehren Park Reynolds, *Protecting the Waterfront: Prosecuting Mob-Tied Union Officials Under the Hobbs Act and Rico After Scheidler*, 10 BOALT J. OF CRIM. L. 2, 69 n. 6 (2005) ("In April 2003, Gigante pleaded guilty to obstruction of justice charges arising out of a thirty-year ruse to fake insanity.").

[46] *Id.*

[47] *See* United States v. Williams, 698 F.3d 374, 387 (7th Cir. 2012) ("The problem the lawyer faced—a client who wants to concoct a false alibi or other defense—is not rare.") (Hamilton, J., dissenting).

[48] *See, e.g.*, Barnes v. Commonwealth, No. 2016-CA-001677-MR, 2018 WL 2754474, at *2 (Ky. Ct. App. June 8, 2018) ("Based on lack of blood on the gun and details provided by Det. Hill and Freels, the Commonwealth developed its theory of the case—Miller's pistol had been wiped clean of prints and Barnes had staged the scene to appear as self-defense."); Hampton v. State, No. 03-14-00700-CR, 2017 WL 1315336, at *4 (Tex. App. Apr. 6, 2017) ("[T]he defensive theory of the case—that Hampton had stabbed Jennings in self-defense—tended to be refuted by the physical evidence at the crime scene, which, according to the testimony of one of the investigating officers, looked as if it had been 'staged' by Hampton to suggest that Jennings had been the aggressor."); State v. Richter, No. 11-2124, 2013 WL 118357, at *3 (Iowa Ct. App. Jan. 9, 2013) ("The State emphasizes that, in addition to Richter's knowledge of the pink notebook, there was other evidence to indicate she staged matters to make it appear as if she killed Wehde in self-defense."); Trevino v. State, 100 S.W.3d 232, 242 (Tex. Crim. App. 2003) (en banc) ("The State argued that Trevino shot Michelle in cold blood and staged the crime scene afterwards to make it look like self-defense.").

readily assert false duress[49] or alibi claims.[50] Yet, there is not the same deep, generalized distrust of self-defense or alibi defenses, or any other defense, as there is of the insanity defense.[51]

A review of recent state and federal opinions shows that there are a few concerns about criminal defendants who might have faked symptoms of a mental illness to support a claim of insanity.[52] However, courts expressed many more concerns about the possibility of fakery regarding issues other

[49] *See, e.g.*, United States v. Harp, 536 F.2d 601, 602 (5th Cir. 1976) ("At the consolidated trial for attempted escape, two of those accused took the stand and presented a transparently frivolous duress defense, claiming that only their co-defendant Chapman had intended to escape."); John Lawrence Hill, *A Utilitarian Theory of Duress*, 84 IOWA L. REV. 275, 328 (1999) ("[T]here is always the possibility that a false duress claim could be used as a cover for bribery and collusion by corrupt witnesses."); Richard H. McAdams, *The Political Economy of Entrapment*, 96 J. CRIM. L. & CRIMINOLOGY 107, 124 (2005) ("[M]embers of a conspiracy could fake a duress defense by claiming that one member threatened the rest.").

[50] *See, e.g.*, Cattoor v. Gammon, 259 F. Supp. 2d 929, 931 (E.D. Mo. 2003) ("When police contacted Cattoor about the For Lovers Only robbery, Cattoor presented his first of three false alibis."); United States v. Dorsey, 677 F.3d 944, 950 (9th Cir. 2012) ("That Dorsey tried to create a fake alibi was not merely ineffective, but also stands high in the hierarchy of evidence tending to show guilt.").

[51] *See* Brooks, *supra* note 38, at 1183; Lyon, *supra* note 39, at 255; Maidman, *supra* note 40, at 1846; Spivack, *supra* note 42, at 214; Vitacco, *supra* note 41, at 851.

[52] *See, e.g.*, Watts v. Yates, 387 F. App'x 772, 776 (9th Cir. 2010) ("Moreover, Watts's refusal to enter an insanity plea following the competency hearing also constituted important new evidence because, like Dr. Zimmerman's reports, it contradicted Dr. Della Porta's conclusion, adopted by the court, that Watts was faking his mental illness to support an insanity plea."); Brown v. Head, 285 F.3d 1325, 1327 (11th Cir. 2002) ("It is evidence which tends to show Brown was faking the crucial (to the diagnosis of the defense experts) symptoms of being delusional, hearing voices, and generally being out of touch with reality and unable to think clearly.").

than insanity. For example, numerous opinions report concerns that defendants in fraud cases were faking physical illnesses.[53] Other cases involved defendants who were found to have faked kidnapping[54] or death.[55]

Extensive research has shown that fears about defendants successfully faking an insanity defense are out of proportion to the actual risk that a defendant will successfully fake an insanity defense.[56] As one scholar summarized:

> There is also much public concern about defendants who fake their mental illnesses in order to escape a conviction and who simply hire clinicians to engage in an expert battle with the prosecution at trial. While these cases make for good media

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[53] *See e.g.*, United States v. Rettenberger, 344 F.3d 702, 704 (7th Cir. 2003) ("A jury concluded that Randall Rettenberger and his wife Julie were partners in a scheme to defraud insurers, plus the Social Security Administration, by pretending that Randall was disabled.").

[54] *See* United States v. Baldwin, 418 F.3d 575, 577 (6th Cir. 2005) ("In February of 2003, a grand jury indicted Anthony Baldwin on three counts of wire fraud and on one count of conspiracy to defraud in connection with an attempt to obtain money by faking his own kidnapping.").

[55] *See e.g.,* United States v. Crews, 496 F. App'x 896, 900 (11th Cir. 2012) ("[T]he district court did not clearly err in denying Crews a two-level reduction for acceptance of responsibility in the light of his attempt to evade punishment by faking a suicide."); United States v. Nagle, 257 F. App'x 518, 519 (3d Cir. 2007) ("The convictions arose out of the defendants' conspiracy to defraud State Farm Insurance Company by faking Nicholson's death."); United States v. Washington, 248 F. App'x 86, 92 (11th Cir. 2007) ("Moreover, the conduct supporting the obstruction enhancement—sending a false distress signal, faking his death, fleeing to South Carolina, holding a funeral service in which he was eulogized by friends and family, assuming a false identity using forged documents, and evading federal authorities for approximately eight months—constituted much more than the mere act of 'sending a false distress signal' and was *not* fully accounted for in the restitution Kevin was ordered to pay.");

[56] It is not as easy to fake insanity as people seem to think. Emergency room psychiatrist Paul Linde provides one example of the ways that someone who is faking a mental disorder can be detected: "'Do you ever see little green men?' I ask. It's one of my mini lie-detector tests for malingering, since this symptom is essentially never reported by a genuinely psychotic person." PAUL R. LINDE, DANGER TO SELF: ON THE FRONT LINE WITH AN ER PSYCHIATRIST 128 (2010) *See also* Perez v. Cain, 529 F.3d 588, 599 (5th Cir. 2008) ("The evidence that Perez used to show insanity was overwhelming. It included . . . expert opinion that it was very unlikely Perez and his family would know how to fake the illness; and objective evidence that once he was given anti-psychotic medication, Perez's condition improved in a manner that a layman would not know how to fabricate."). (arguing that

> play, they are the rare exception and not the rule. In fact, there is overwhelming agreement on a clinical diagnosis between clinicians on both sides of the criminal dispute. One study put the clinician agreement rate at 88%; another at 92%. Moreover, the media and Hollywood exacerbate the fears of a defendant feigning mental illness to avoid criminal punishment. However, such fears are ill-founded. In practice, modern diagnostic instruments and procedures allow clinicians to distinguish correctly those who are truly mentally ill and those who are faking between 92% and 95% of the time. Thus, when defendants fake mental illness, it is extraordinarily difficult for them to "get away with" it.[57]

Despite the consensus of scholars that the public's fears of fakery are exaggerated, these fears are not easily remedied.[58] In fact, attempts to directly challenge misperceptions about the insanity defense can have the unintended consequence of reinforcing misperceptions.[59] A recent article describes one such attempt by a sociologist:

> In a thoughtful attempt at overcoming problematic attitudes toward the insanity defense, one researcher suggested that a flowchart, demonstrating the consequences and "time" completed with an insanity defense would ultimately prove useful

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[57] Henry F. Fradella, *From Insanity to Beyond Diminished Capacity: Mental Illness and Criminal Excuse in the Post-Clark Era*, 18 U. FLA. J. OF L. & PUB. POL'Y 7, 12–13 (2007) (footnotes omitted). *See also* Michael L. Perlin, *"The Borderline Which Separated You from Me": The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375, 1410 (1997) ("Recent carefully-crafted empirical studies have clearly demonstrated that malingering among insanity defendants is, and traditionally has been, statistically low. Even where it is attempted, it is fairly easy to discover (if sophisticated diagnostic tools are used)."); Richard E. Redding, *The Brain-Disordered Defendant: Neuroscience and Legal Insanity in the Twenty-First Century*, 56 AM. U. L. REV. 51, 111 (2006) ("[C]oncerns often voiced about the insanity defense generally—that defendants can readily fake insanity and that there are too many insanity acquittals, are myths that have long since been debunked."); Phillip J. Resnick, *The Andrea Yates Case: Insanity on Trial*, 55 CLEV. ST. L. REV. 147, 154 (2007) ("An Oregon study showed that about 80% of successful insanity cases are uncontested; that is, the experts for the prosecution and defense agree that the defendant was insane.").

[58] *See* Jennifer L. Skeem et al., *Venirepersons's Attitudes Toward the Insanity Defense: Developing, Refining, and Validating a Scale*, 28 L. & HUM. BEHAV. 623, 624-25 (2004).

[59] *See* Vitacco, *supra* note 41, at 851.

> in the reduction of biases. As noted in this thesis, the presentation to college students of information regarding dispositional outcome had an unattended effect: those seeing the information about dispositional outcome became harsher in their sentence and less inclined to support an insanity finding.[60]

While direct challenges might be ineffective or even counterproductive, one indirect method of altering beliefs about the insanity defense that might be effective is first-hand accounts of serious mental illnesses by people who are not criminal defendants.[61] Just as reports of people feigning mental illness can raise fears, accounts of people who are experiencing serious mental illnesses for no obvious gain (and at great obvious detriment) might help remedy such fears. First-hand accounts of serious mental illness can diminish fears of faking by demonstrating that people who are not facing criminal charges, and thus do not have the same motive to lie that a criminal defendant might have, still experience symptoms that would make someone "insane"—that is,, specifically, unable to appreciate the nature or wrongfulness of his conduct,[62] or more generally, so disconnected from reality that it would be unfair to find him morally (or legally) responsible for his behavior.[63]

II. CIVIL COMMITMENT AND INVOLUNTARY TREATMENT

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[60] *Id.*(footnotes omitted). *See also* Caroline B. Crocker & Margaret Bull Kovera, *The Effects of Rehabilitative Voir Dire on Juror Bias and Decision Making*, 34 L. HUM. BEHAV. 212, 220 (2010).

[61] *See* Marc A. Fajer, *Authority, Credibility, and Pre-Understanding: A Defense of Outsider Narratives in Legal Scholarship*, 82 GEO. L.J. 1845, 1859 (1994) (arguing that "first-person stories have significant advantages over third-party stories for countering common pre-understandings"); Mary Kay Kisthardt, *Mental Health, Psychology, and the Law*, 82 UMKC L. REV. 279, 279 (2014) ("First person stories are perhaps the best teachers of the important lessons about mental illness.").

[62] *See* Jamie D. Brooks, *"What Any Parent Knows" but the Supreme Court Misunderstands: Reassessing Nueroscience's Role in Diminished Capacity Jurisprudence*, 17 NEW CRIM L. REV. 442, 477 (2014)

[63] *See* Morse, *supra* note 37, at 820–21 (showing that at their core, tests of insanity can be considered essentially tests of moral responsibility). *Cf. id.* at 501 (finding that the law holds someone blameless when "a mental condition . . . produces a disconnect between an agent's apparent conduct and the potentially blameless intentions that he consciously entertained").

People who are a danger to themselves or others because of mental illness are subject to civil commitment.[64] Civil commitment is justified by two separate government powers: the police power to protect public safety, and the *parens patriae* power to protect people who are unable to protect themselves.[65]

Several controversies surround the practice of civil commitment. First, civil commitment is a kind of preventive detention—it allows for the detention of someone who might cause harm in the future.[66] But preventive detention is generally disfavored.[67] Criminal law punishes people for harms that they have already caused; it does not punish them, or detain them, on the basis of harms that they might cause in the future.[68] Similarly, tort law imposes damages for harms caused in the past but not for harms that might be caused in the future.[69] Thus, one criticism of civil commitment is that its special treatment of people who are mentally ill is not justified; someone who is dangerous but not mentally ill cannot be civilly committed,[70] so why should someone who is dangerous because of a mental illness be subject to this kind of detention?

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[64] O'Connor v. Donaldson, 422 U.S. 563, 582-83 (1975).

[65] *Id.*

[66] *See id.* at 566 n.2.

[67] United States v. Salerno, 481 U.S. 739, 755 (1987) ("In our society liberty is the norm, and detention prior to trial or without trial is the carefully limited exception."). *Cf.* McGee v. Bartow, 593 F.3d 556, 581 (7th Cir. 2010) ("The primary due process concern of the Supreme Court in the area of civil commitment is the necessity of distinguishing between the typical dangerous recidivist and the offender whose dangerousness is caused by some identifiable mental condition that impairs his ability to refrain from activity dangerous to others.").

[68] United States v. Melendez-Carrion, 790 F.2d 984, 1002–03 (2d Cir. 1986) ("Permitting an arrested person thought to be dangerous to remain at liberty unquestionably incurs a risk. The prediction of dangerous conduct, however difficult to make and however unreliable, will undoubtedly be correct in some instances. But all guarantees of liberty entail risks, and under our Constitution those guarantees may not be abolished whenever government prefers that a risk not be taken.") (footnote omitted).

[69] Ariel Porat & Alex Stein, *Liability for Future Harm, in* PERSPECTIVES ON CAUSATION 221, 222 (Richard Goldberg ed. 2011).

[70] Kansas v. Hendricks, 521 U.S. 346, 358 (1997) ("A finding of dangerousness, standing alone, is ordinarily not a sufficient ground upon which to justify indefinite involuntary commitment. We have sustained civil commitment statutes when they have coupled proof of dangerousness with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.'").

Another question about civil commitment is what constitutional limits or requirements might exist. The Supreme Court has held that mental illness alone is insufficient grounds for civil commitment,[71] but the Court has never directly held that dangerousness is constitutionally required.[72] Many states are moving toward civil commitment statutes that have criteria that seem to justify civil commitment on the grounds that untreated mental illness is harmful.[73] This movement raises the question of whether the state ought to force someone to receive treatment for a mental illness. Opponents of involuntary treatment of the mentally ill argue that people have a right to choose to be mentally ill, even if that choice is harmful.[74] Because the state does not compel treatment for other illnesses, such as diabetes or high blood pressure, the argument is that the state is singling out people with mental illnesses, perhaps unfairly or without sufficient justification.[75]

Additionally, civil commitment allows only for the detention of people who are mentally ill and dangerous—it does not necessarily allow for the involuntary administration of psychotropic medications.[76] People who are being detained under traditional civil commitment statutes retain the right to

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[71] *O'Connor*, 422 U.S. at 576 ("[A] state cannot constitutionally confine in a mental hospital, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.").

[72] Some other courts have held this, but not the Supreme Court. *See, e.g.*, Lessard v. Schmidt, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972).

[73] *See, e.g.*, Douglas Mossman, et al., *Risky Business Versus Overt Acts: What Relevance Do "Actuarial," Probabilistic Risk Assessments Have for Judicial Decisions on Involuntary Psychiatric Hospitalization?*, 11 HOUS. J. OF HEALTH L. & POL'Y 365, 382 (2012) ("Almost all states also permit commitment because of what often is termed 'grave disability,' a phrase referring to the condition of persons who do not express wishes or try to harm themselves, but who so neglect their basic needs as to put their lives in peril."); Donald Stone, *Dangerous Minds: Myths and Realities Behind the Violent Behavior of the Mentally Ill, Public Perceptions, and the Judicial Response Through Involuntary Civil Commitment*, 42 L. & PSYCHOL. REV. 59, 62 (2018) (noting "the increasing popularity of a 'gravely disabled' standard").

[74] Catherine E. Blackburn, *The "Therapeutic Orgy" and the "Right to Rot" Collide: The Right to Refuse Antipsychotic Drugs Under State Law*, 27 HOUS. L. REV. 447 (1990).

[75] *Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1215–16 (1974) ("Civil commitment statutes authorize different treatment of the mentally ill and the physically ill by subjecting the former group to compulsory care while allowing the latter group to choose whether to seek treatment.").

[76] Blackburn, *supra* note 74, at 462, 476.

refuse medications,[77] except in emergency situations[78] or if found incompetent to make their own medical treatment decisions.[79] For some mental illnesses, particularly those characterized by psychotic symptoms, detention without medication is unlikely to be very helpful, and in fact can be very harmful.[80]

Those who are detained on the grounds that they are mentally ill and dangerous often are eventually administered involuntary psychotropic medications (either because their untreated psychosis creates an emergency or because they are found incompetent refuse treatment).[81] But once the medications have diminished their dangerousness, they must be released—and then they are free to stop taking the medications.[82] Without medications, the psychotic symptoms, and the dangerousness, often return, resulting in further civil commitment.[83] The obvious long-term ineffectiveness of this system has prompted some legislatures to enact outpatient civil commitment programs, which involve less physical confinement but more involuntary medication.[84]

The growing popularity of outpatient commitment programs, with their emphasis on coercing people to take medications, has renewed debates about the desirability of involuntary treatment.[85] One of the most important,

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[77] *Id.* at 476; Samuel Jan Brakel & John M. Davis, *Taking Harms Seriously: Involuntary Mental Patients and the Right to Refuse Treatment*, 25 IND. L. REV. 429, 433-34 (1991).
[78] Blackburn, *supra* note 74, at 505-06.
[79] Brakel & Davis, *supra* note 77, at 469-70.
[80] *Id.* at 453 ("Substantial clinical harms can result to patients who are not treated in a timely fashion.").
[81] *See* Elyn R. Saks, *Competency to Refuse Psychotropic Medication: Three Alternatives to the Law's Cognitive Standard*, 47 U. MIAMI L. REV. 689, 737 n.113 (1993).
[82] Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment – The American Experience*, 43 ISR. J. PSYCHIATRY RELATED SCI. 209, 216 (2006).
[83] *See id.* at 215-17.
[84] *See* Howard Telson, *Outpatient Commitment in New York: From Pilot Program to State Law*, 11 GEO. MASON U. CIV. RTS. L. J. 41, 41 (2000) ("Outpatient commitment was developed to promote compliance when symptoms of mental illness cause individuals to neglect or reject community mental health services. It was conceptualized as a less restrictive alternative to inpatient psychiatric treatment. Some states have permitted outpatient commitment for individuals who do not meet the criteria for involuntary hospitalization, but predictably deteriorate without treatment.").
[85] Monahan, *supra* note 28, at 401-02. *Compare* Samuel Jan Brakel & John M. Davis, M.D., *Overriding Mental Health Treatment Refusals: How Much Process Is "Due"?*, 52 ST. LOUIS

yet most contentious, questions regarding serious mental illnesses is when (if ever) the state is justified in compelling people who are experiencing psychotic symptoms to take medications over their objections.[86] Almost all scholars who have considered this question believe that involuntary medications may be justified if someone lacks competence to make her own treatment decisions.[87] Generally, competence to make treatment decisions requires some degree of understanding about the illness and the proposed treatment.[88] However, disagreement exists regarding how deep this understanding ought to be in order for someone to be considered competent.[89] Is it enough that someone knows that his doctor believes that he has an illness that requires a certain treatment, or must he accept that the illness actually exists?[90] This question is extremely important for people who are experiencing symptoms of a serious mental illness, but who might not understand what they are experiencing to be an illness.[91] On one hand, some scholars argue that respect for autonomy requires a very restrictive definition of incompetence to make treatment decisions, so that only those who lack the most basic understanding of what their doctors say is an illness will meet the standard

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U. L.J. 501, 585 (2008) (arguing that "if the patient cannot be convinced to accept the prescribed treatment, rejecting it and any plausible alternative courses including trial and error, the physician should be allowed to initiate treatment over the patient's objection with minimal legal interference"), *with* Stone, *supra* note 73, at 83 (2018) ("We should return to the standard of real evidence that the person is currently a danger to himself or others before we resort to confining someone against his will.").

[86] *See* Candice T. Player, *Involuntary Outpatient Commitment: The Limits of Prevention*, 26 STAN. L. & POL'Y REV. 159, 163-64, 210 (2015).

[87] *See id.* at 164, 190.

[88] *See id.* at 221-25.

[89] *See id.*

[90] For a brief but thorough discussion, see *id.* at 221. Player describes the minimum level of understanding necessary for competence:

> A person who is competent to refuse treatment must possess at least a rudimentary understanding of the basic features of his illness and the proposed treatment plan. Whether he believes he has an illness or not, and whether he believes that treatment will help him or not, he must at least understand that his physician believes he has an illness and that his physician believes the recommended treatment could help him. Any less, and we would worry that the person is too impaired or too disoriented for us to view his treatment decisions as competent.

Id. at 221.

[91] Player, *supra* note 86, at 229.

for incompetence.[92] This restrictive standard is necessary, these scholars argue, in order to maintain respect for autonomy and personhood.[93] Other scholars argue that people who are experiencing serious mental illness yet refuse treatment because they do not believe they have an illness are incapable of making a truly autonomous decision regarding treatment. [94] If they do not understand that their thinking is disordered, these scholars argue, then their refusal of treatment is not really an autonomous choice but rather a

[92] As one scholar proposes:

> [T]he central question should be: "Do you *understand* that Doctor X believes that some of your thoughts and behaviors are attributable to Disease Y? Do you understand that according to Doctor X, consequences A, B, C, and D are likely to follow if you refuse the recommended course of treatment?" If the person understands the basic facts of his or her illness in this sense, then provided that his or reasons are at least neither irrelevant nor patently and demonstrably false, he or she is competent to make decisions regarding outpatient treatment and courts should not order outpatient treatment over his or her objection.

Id.

[93] *Id.*

[94] *Id.* at 203.

choice compelled by their mental illness.[95] According to such a view, administering involuntary medications can be more respectful of autonomy than allowing the refusal of medications.[96]

In a country that values civil liberties, should the government ever detain someone because she might cause harm? Or compel her to take medications that she does not want to take? Answering these questions requires an understanding of serious mental illnesses. What kinds of behaviors would cause someone to be found dangerous because of a mental illness? Under what circumstances is involuntary treatment likely to be imposed? For people who have not experienced civil commitment or involuntary treatment, accounts of those who have are perhaps the best way to understand what it means to be subjected to these practices.

III. LESSONS FROM MEMOIRS OF MENTAL ILLNESS

This part presents evidence of serious mental illnesses from a range of memoirs, including first-person accounts as well as accounts of close family members. The memoirs discussed are:

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[95] *Id.* Psychiatrist Paul Appelbaum suggested a distinction between "formal autonomy" and "meaningful autonomy":

> 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, hoping . . . that immobility will help them fade into the grimy urban background, bringing safety and temporary peace from a world which they envision as a terrifying series of threats. 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? Or is their behavior rather to be understood on the level of a simple reflex—autonomous only in a strictly formal sense?

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). *Accord* Harold I. Schwartz et al., *Autonomy and the Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication*, 39 HOSP. & COMMUNITY PSYCHIATRY 1049, 1054 (1988) ("Strategies for protecting the autonomy of patients who refuse treatment must consider the erosion of autonomy that psychosis produces."); David L. Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 907 (1975) ("How real is the promise of individual autonomy for a confused person set adrift in a hostile world?").

[96] *See* Appelbaum, *supra* note 95, at 547.

In *Crazy*, journalist Pete Earley alternates between presenting an account of Earley's son's psychosis and Earley's research into the mental health system generally.[97]

In *Madness: A Bipolar Life*, Marya Hornbacher provides a first-person account of bipolar disorder.[98]

In *An Unquiet Mind*, Kay Redfield Jamison presents a first-person account of bipolar disorder. Jamison is a psychologist who has also published academic articles about bipolar disorder.[99]

In *Ben Behind His Voices*, Randye Kaye presents an account of her family's experience of her son Ben's schizophrenia.[100]

In *My Lovely Wife in the Psych Ward*, Mark Lukach describes his wife Giulia's experience of bipolar disorder.[101]

In *The Center Cannot Hold*, Elyn R. Saks provides a first-person account of schizophrenia. Saks is a law professor who has also published academic works about mental health law issues, including involuntary treatment.[102]

In *Divided Minds*, Pamela Spiro Wagner and Carolyn S. Spiro provide an alternating account, presenting the different perspectives of identical twins, one who describes her experience of schizophrenia.[103]

A. *The Insanity Defense*

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[97] PETE EARLEY, CRAZY: A FATHER'S SEARCH THROUGH AMERICA'S MENTAL HEALTH MADNESS (2006).
[98] MARYA HORNBACHER, MADNESS: A BIPOLAR LIFE (2008).
[99] KAY REDFIELD JAMISON, AN UNQUIET MIND: A MEMOIR OF MOODS AND MADNESS (1995).
[100] RANDYE KAYE, BEN BEHIND HIS VOICES: ONE FAMILY'S JOURNEY FROM THE CHAOS OF SCHIZOPHRENIA TO HOPE (2011).
[101] MARK LUKACH, MY LOVELY WIFE IN THE PSYCH WARD (2017).
[102] ELYN R. SAKS, THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS (2007).
[103] PAMELA SPIRO WAGNER & CAROLYN S. SPIRO, DIVIDED MINDS: TWIN SISTERS AND THEIR JOURNEY THROUGH SCHIZOPHRENIA (2005).

Perhaps the most important educational function that memoirs of mental illnesses can serve is to provide concrete examples of delusional beliefs. There is no doubt among psychiatrists, psychologists, and other treatment providers that delusional beliefs exist and that they are commonly experienced symptoms of schizophrenia and bipolar disorder.[104] However, the technical definition of delusions, "fixed beliefs that are not amenable to change in light of conflicting evidence,"[105] does little to help a layperson understand what a delusion is, or why someone who is in the grip of a delusional belief might not be morally (or legally) responsible for her behavior.

The specific examples of delusions described in memoirs of mental illnesses can be more helpful. For example, among the symptoms that Earley describes his son Mike exhibiting early in his psychosis are the beliefs that a movie and a bumper sticker contained special messages for him, that he was God's "special messenger," and that wrapping his head in aluminum foil would prevent other people from reading his thoughts:

> [Mike] found a videocassette on the sidewalk while walking to a subway near Times Square. It was Oliver Stone's movie Heaven and Earth, a gut-wrenching account by a Vietnamese woman about the fighting there and its aftermath. Mike had watched it three times, and he had become convinced it contained a secret message aimed at him.
>
> "As soon as you see it, everything will make sense," he told me. "You'll see." . . .
>
> Mike saw an encrypted message in a bumper sticker on the blue sedan ahead of us: "Believe in Him!" It was a signal from God, he told me. They were everywhere. But only he could interpret them. . . . .
>
> . . . [T]he doctor asked Mike, "Who's the president of the United States?"
>
> "That idiot George Bush."
>
> "What day is it today?"

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[104] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 87, *supra* note 26, at 128.

[105] *Id.* at 87.

> Other questions followed: "Can you count backwards by sevens from a hundred? What does the phrase 'Don't cry over spilled milk' mean? How about the words 'a heavy heart'?"
>
> Mike answered each question easily. Then he explained that he was God's personal messenger and that he was indestructible. . . .
>
> I returned to my ex-wife's house where Mike was watching television, only now he'd wrapped aluminum foil around his head so no one could read his thoughts.[106]

Lukach describes his wife Giulia telling him that she hears the Devil telling her that she is worthless. Lukach recounts a conversation that occurred just before her first hospitalization: "'I talked to the Devil last night, Mark,' she said, speaking very loudly and quickly. 'He said everything is *not* going to be okay. He said that there is no way out of this. I can't be saved. I'm not worth saving. We might as well just give up.'"[107] During her hospitalization, she continued to receive messages from the Devil; for example, she did not want Lukach to visit her, shouting, "Get out! The Devil is here and he wants you. You need to leave now!"[108]

Pamela Spiro Wagner writes of her early delusions and hallucinations, which she experienced as a college student:

> People start whispering behind my back, talking about what they're going to do to me, but no one will tell me anything to my face. Gemma, the red-haired Unitarian who is my roommate and with whom I was once best of friends, now hates me with a passion. She and her friends—once *my* friends—start playing a cat-and-mouse game with me, but my safety depends on pretending not to notice. I learn to recognize that the red sweater she sometimes wears signals bad days, days when they are going to torment me, though I never let on I know that anything at all is afoot.
>
> Confused, exhausted, buffeted by voices that now seem to be in cahoots with Gemma and the others, I begin to stay in bed day and night.

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[106] EARLEY, *supra* note 97, at 7-8, 15, 20.
[107] LUKACH, *supra* note 101, at 26.
[108] *Id.* at 47.

> . . . I suspect that Gemma has put something in my food, some poison. My stomach is tight and it's harder and harder to eat anything. In a way this is a relief, as it gives me an excuse not to go to the dining room with Gemma and the others anymore, which is obviously no longer safe.[109]

She describes the experience of similar although intensified symptoms years later:

> I need to have a tooth filled. . . .
> A few days later, I come to understand that amalgam is not all the dentist filled the tooth with. I realize from various signs and evidence around me that he implanted a computer microchip for reasons I can't yet determine. The computers at the drugstore across the street, programmed by the Five People, have tapped into my TV set and monitor my activities with a special radar. If I go out, special agents keep every one of my movements under surveillance. A man lighting a cigarette near the drugstore uses his lighter to signal to another just down the street, warning him of my approach. Another alerts conspirators inside. Nothing I do, indoors or out, goes unremarked.[110]

The experience of delusional beliefs is often central to a claim of insanity because it is often a delusional belief that makes the defendant unable to appreciate the nature or wrongfulness of his or her actions.[111] If Eric Clark believed that he was shooting an alien that was a threat to his life and the lives of other people, then he could not have intended to shoot a police officer.[112] Assessing a claim like Clark's requires an understanding that such beliefs are possible. Memoirs can help provide this understanding.

B. *Civil Commitment and Involuntary Treatment*

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[109] WAGNER & SPIRO, *supra* note 103, at 105-06.
[110] *Id.* at 205.
[111] *See* Clark v. Arizona, 548 U.S. at 735.
[112] *See id.* at 745.

Memoirs of mental illness can also help inform discussions about the proper rules regarding civil commitment and involuntary treatment by allowing those who have never personally been subject to these rules to understand something of what it is like for those who have.

1. "Thank You" Theory

One issue concerning civil commitment and involuntary treatment is whether people who have been civilly committed or administered involuntary treatment later, in retrospect, come to believe that these measures were beneficial.[113] Some writers, especially some psychiatrists, have proposed that many people do later appreciate treatment that they opposed at the time; this idea is often called the "thank you" theory of involuntary treatment.[114]

Memoirs of mental illness do not provide much support for this theory. For example, Earley describes a conversation with a nurse, in which he expresses ambivalence about the actions he needed to take to have his son committed, including fabricating a claim that his son had threatened him.[115] The nurse says, "Twenty years ago, you could get someone committed into a mental hospital just by accusing them of being crazy. . . . But now the law has swung so far the other way that you can't get them help even though you know they will thank you later."[116] However, Earley never suggests that his son does eventually thank him.[117]

Additionally, none of the first-person accounts provide any clear statements of gratitude for involuntary treatment. Saks acknowledges the benefits of the treatment but remains opposed to the fact that it was administered against her wishes.[118] For example, she writes of one of her first hospitalizations:

> For a place that existed ostensibly to promote the mental health of the vulnerable people in its care, YPI had been a brutal experience for me. I'd spent the better part of two days locked up, tied down, and forced to swallow a medication that

[113] Player, *supra* note 86, at 210.
[114] *Id.*
[115] EARLEY, *supra* note 97, at 24-25.
[116] *Id.*
[117] *See id.* at 24-31.
[118] *See* SAKS, *supra* note 102, at 157.

> (while not without its benefits) quickly made its side effects apparent: my face felt wooden and looked like a mask; my gait had slowed until it resembled a stroke victim's shuffle more than my own long-legged stride.[119]

And later, describing one of many attempts to discontinue antipsychotic medication, Saks writes:

> By day five, I was completely and floridly psychotic, convinced that evil beings were about to destroy me. I gibbered; I cowered. I couldn't work, and the end of the final term was coming up. Finally, White [her psychiatrist] insisted: back to the Navane, and increase it again. The effect was almost immediate, but instead of being relieved, I was angry. *I'm sick of this*. It all came down to supporting the patient's choice—didn't it? If I was competent when I decided to stop taking the meds, then it was a competently made decision.[120]

Jamison is less clear about her ultimate feelings about forced treatment, seeming to regret both the violence of the forced treatment as well as the violence that resulted in that treatment:

> I have, in my psychotic, seizure like attacks—my black, agitated manias—destroyed things I cherish, pushed to the utter edge people I love, and survived to think I could never recover from the shame. I have been physically restrained by terrible, brute force; kicked and pushed to the floor; thrown on my stomach with my hands pinned behind my back; and heavily medicated against my will.
>
> I do not know how I have recovered from having done the things that necessitated such actions. . . .
>
> . . . . After each of my violent psychotic episodes, I had to try and reconcile my notion of myself as a reasonably quiet-spoken and highly disciplined person, one at least generally sensitive to the moods and feelings of others, with an enraged,

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[119] *Id.*

[120] *Id. at* 210.

> utterly insane, and abusive woman who lost access to all control or reason.[121]

Hornbacher writes of more than a dozen hospitalizations, many that she resisted.[122] Although she never addresses the issue directly, the book's closing, which describes her acceptance of another hospitalization, might be seen as an indirect "thank you" for previous hospitalizations:

> By the time we get to the hospital, I'm no longer under the impression that I'm sane. Once I've started cutting, I know I'm not likely to stop until I've done some serious damage, and I don't want that any more than anyone else does. The last place I want to be is the hospital, but I'm not stupid. I know when it's time to go in. I am so terrified of myself and of the vast, frightening world, that the psych ward, with its safe locked doors, sounds like a relief.[123]

2. Lack of Insight

Another issue in the middle of the involuntary treatment debate is the extent to which people who are experiencing psychotic symptoms are capable of recognizing these symptoms as signs of a disorder.[124] Recent research suggests that some people experiencing psychotic symptoms are neurologically incapable of understanding their illnesses.[125] Lack of insight is one reason why people refuse antipsychotic medications.[126] However, several other reasons, including medication side effects and psychological struggle with the idea of being ill, also can cause someone to refuse medications.[127]

Several first-person writers explain at least some of their resistance to medication as a preference for the disease over the treatment. Wagner

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[121] JAMISON, *supra* note 99, at 120-21.
[122] *See generally* HORNBACHER, *supra* note 98.
[123] *Id.* at 270.
[124] Xavier F. Amador & Andrew A. Shiva, *Insight into Schizophrenia: Anosognosia, Competency, and Civil Liberties*, 11 GEO. MASON U. CIV. RTS. L.J. 25, 27 (2000).
[125] *Id.* at 25.
[126] *See id.* at 38-39.
[127] *See id.* at 26, 37-38.

flatly states, "I don't care that Zyprexa would help. I hate it more than anything, even more than being insane."[128] Jamison offers a more comprehensive account of her assessment of the costs and benefits of medications:

> My manias, at least in their early and mild forms, were absolutely intoxicating states that gave rise to great personal pleasure, an incomparable flow of thoughts, and a ceaseless energy that allowed the translation of new ideas into papers and projects. Medications not only cut into these fast-flowing, high-flying times, they also brought with them seemingly intolerable side effects. It took me far too long to realize that lost years and relationships cannot be recovered, that damage done to oneself and others cannot always be put right again, and that freedom from the control imposed by medication loses its meaning when the only alternatives are death and insanity.[129]

Relatedly, Saks and Jamison both write about their beliefs that taking medication was a form of weakness. Jamison writes: "I genuinely believed—courtesy of strong-willed parents, my own stubbornness, and a WASP military upbringing—that I ought to be able to handle whatever difficulties came my way without having to rely upon crutches such as medication."[130] Saks similarly writes: "For so many years, I'd resisted the 'crutch' of the meds—to use them meant I was weak of will, weak of character."[131]

Saks's early resistance to identifying her experiences as symptoms of an illness that required medication, rather than reactions to situational stressors that she needed some temporary help to manage, is evident in a conversation with her psychiatrist, who is encouraging her to accept her need for medication:

> By week four [of decreased antipsychotic medications], I'd arrived in the land of full-fledged psychosis. *The people in the sky poison me. I in turn will poison the world.*

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[128] WAGNER & SPIRO, *supra* note 103, at 298.
[129] JAMISON, *supra* note 99, at 5-6.
[130] *Id.* at 99.
[131] SAKS, *supra* note 102, at 282.

> "I think you're having thoughts that are scaring you because you need to be on more medication now," said White [her psychiatrist].
>
> "No!" I was practically shouting. "It has nothing to do with drugs. It's a massive attempt at medical and physiological, not to say psychological, derailment which was a result of deregulation of the rail!"
>
> "It's hard to admit you need medications," said White. "But you do."
>
> *Defeat, defeat.* "There's no need. I'm not sick. I'm wicked. La di da. I'm ever so well, thank you, ever so well."
>
> But we both knew I'd hit the damn wall again. And as soon as he increased the Navane, I started feeling better. But this has nothing to do with me being sick. It's just about being able to study. I'm not sick, I just need some help so that I can study."[132]

She describes holding similar beliefs years later:

> In spite of my history, in spite of the diagnoses and the prescriptions, the frequent delusions and the evil visitations . . . I still wasn't convinced that I had a mental illness. Nor was I convinced I really needed medication. To admit to any of it was to admit that my brain was profoundly broken, and I just couldn't do that. . . .
>
> . . . Yes, the pills helped, but each time I put them in my mouth, it was a reminder that some people—smart people I trusted and respected—believed that I was mentally ill, that I was defective; every dose of Navane was a concession to that. More than anything, I wanted to be healthy and whole; I wanted to exist in the world as my authentic self—and I deeply believed that the drugs undermined that.[133]

Unlike Jamison, who expresses some regrets about the years that she resisted psychotropic medications, Saks views her resistance to medication as a "necessary stage of development"::

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[132] *Id.* at 204.

[133] *Id.* at 244-45.

> As exasperating and frightening as my years-long process of tinkering with my meds was for my friends and physicians, I understand now that it was hugely important for me to do it; it was a necessary stage of development that I needed to go through to become my full-fledged self. It was the only way I could come to terms with the illness.[134]

3. *Family*

Another issue raised by many memoirs is what consideration, if any, should be given to family members' suffering when deciding when civil commitment or involuntary medication is appropriate.[135] As Lukach tells his wife, bipolar disorder was not something that only happened to her; it happened to her family as well: "Families lose when people treat mental illness like it impacts only one person. This is your illness, but it's actually all of ours."[136]

In their memoirs, family members write of their desperation for their loved ones to be admitted to a hospital and administered medications.[137] Witnessing the devastation that untreated psychotic symptoms are causing, these family members are willing to endure the potentially relationship-ending consequences of advocating for involuntary treatment because they believe that treatment is the only way to save their loved one's life.[138] In the final

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[134] *Id.* at 282.

[135] Currently, no formal consideration is given to the emotional suffering of family members. Two psychiatrists suggest that some consideration should be given, writing "the civil rights of an individual may be at odds with the heartbreak of a caring family and . . . the concerns of loved ones cannot simply be ignored," but they do not suggest what that consideration should be. DINAH MILLER, & ANNETTE HANSON, COMMITTED: THE BATTLE OVER INVOLUNTARY PSYCHIATRIC CARE xx (2016).

[136] LUKACH, *supra* note 101, at 220.

[137] *See* EARLEY, *supra* note 97, at 22; KAYE, *supra* note 100, at 171.

[138] At least one psychiatrist has recognized that this is a common if not universal problem:

> I do everything I can to get patients to come in voluntarily. If the patient needs to be committed despite all my efforts, I do everything I can to protect their relationship with their loved ones who brought them for help. Even when a committed patient gets well, and even if he comes to agree that hospitalization was necessary, he may never forgive the parent or spouse who initiated the commitment. Still, if you have to do it to save their life, then I tell the family, "We have to do this."

MILLER & HANSON, *supra* note 135, at 123 (reporting statement of Dr. J. Raymond DePaulo Jr., the chief psychiatrist at Johns Hopkins Hospital).

pages of his book, Earley writes that another parent of a seriously mentally ill child told him,

> [P]arents with mentally ill children were given a choice: Either you could become despondent and wallow in pity, or you could have a good cry and start fighting back. I now understood that fighting back meant doing whatever was necessary as a parent, even if it meant having your own child hate you.[139]

Lukach describes his conflicted feelings regarding forced medications during his wife's first hospitalization, when a nurse informs him that a judge has ruled that Giulia will be held under California section 5250[140]:

> "The judge signed off on the doctor's request," she said. "Giulia has been upgraded to a 5250." . . .
>
> "So now this means Giulia can't refuse her medication, right?" I said.
>
> "Right," the nurse said.
>
> "So did she get her medication?" I pressed. . . .
>
> "She got her medicine this morning, right after the hearing," she said quietly.
>
> "Did she take the medication voluntarily?" I asked.
>
> "She did not take the pills by herself. But she got her medication."
>
> I knew what that meant. I closed my eyes and imagined three nurses walking into Giulia's room, offering her pills, knowing she would refuse them, and then holding her

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[139] EARLEY, *supra* note 97, at 360.

[140] CAL. WELF. & INST. CODE § 5250 (West 2014). Under California law, involuntary medications may only be administered to someone who has been found incompetent to refuse treatment:

> If any person subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15, and for whom antipsychotic medication has been prescribed, orally refuses or gives other indication of refusal of treatment with that medication, the medication shall be administered only when treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient, and upon a determination of that person's incapacity to refuse the treatment, in a hearing held for that purpose.

CAL. WELF. & INST. CODE § 5332(b) (West 2001).

> down as they rolled up her hospital gown to expose her thigh for an injection. This is what a 5250 meant. And I had showed up early, in a shirt and tie, to argue that Giulia needed the 5250. But the image of it, the nurses pressing on her body, Giulia tensed and yelling and resisting whatever way she could, and them injecting her anyway, and knowing with certainty that it had happened, felt so tragic that it eclipsed the anger that had been boiling over.[141]

Jamison, in a later memoir that is primarily about her relationship with her husband and only indirectly about her experience of bipolar disorder, provides another example of the terrible choice that those who love someone with a mental illness sometimes must make: the choice to imperil the relationship for the sake of obtaining treatment. In Jamison's case, her husband was a physician, and she describes how she discovered that he was prepared to administer to her an injection of antipsychotic medication:

> Glancing around his office, I saw his black doctor's bag in the corner of the room, sitting on top of a file cabinet. It seemed odd, although I had never thought about it before. Why did he have his doctor's bag in his home study instead of at the office we rented together to see patients?
>
> I asked him if I could see what he kept inside his bag. He was uncomfortable with the idea and only reluctantly took it down for me to open. There was not much inside—prescription pads, his stethoscope, a blood pressure cuff, a reflex hammer—but after rummaging around for a while, I found at the bottom of the bag what I think I knew I would find. Beneath the instruments of his practice lay a syringe and a vial of antipsychotic medication.
>
> I didn't have to ask. It was for me, in case I became manic. Seeing the syringe triggered memories of being forcibly medicated after I first had become psychotic years earlier. I felt trapped and, more fundamentally, betrayed.[142]

Even when things are going well, the fear of relapse because of discontinuing medications can be consuming. Earley describes one encounter

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[141] LUKACH, *supra* note 101, at 54-55.

[142] KAY REDFIELD JAMISON, NOTHING WAS THE SAME 22-23 (2009).

with his son when he believed that his son might have stopped taking his medication:

> I telephoned him at his job and asked him to stop by my house that night. I knew he'd be angry when I confronted him. But I didn't care. . . .
>
> . . . "Is this how it's going to be between us from now on?" he asked. "Are you going to freak out all of the time—worry all of the time whether or not I am taking my medication, whether or not I'm going to go crazy again?"
>
> "No," I said. But it was a lie. . . .
>
> . . . I wanted to believe Mike would never go off his medication, never have another relapse. But I knew too much now to be so confident. . . . I'd talked to too many other parents. Every one of them had also wanted to believe that their child would beat the odds, that everything would work out for the best, that their son and their daughter would be different. But none of them had.
>
> I told Mike it was going to take time for me to learn how to not worry.
>
> "Just stay on your meds," I pleaded. "Please stay on your meds."[143]

4. Imminence of Harm

Civil commitment is permitted only when someone is presently a danger to himself or someone else.[144] Involuntary medication requires an

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[143] EARLEY, *supra* note 97, at 282-83.

[144] Definitions of dangerousness vary:

> Dangerousness is usually interpreted to mean physical harm to self, including attempted suicide, or to others, including overt acts and threats of violence. At one time, most states required evidence of recent and overt threats or actions to establish that the individual posed a danger to others, but many states now allow predictions of future dangerousness to be established based on recent behavior. Some states require that the danger be imminent, or likely to occur immediately or in the near future, while others have eliminated the imminence requirement, as long as the danger is substantial. Other statutes do not define dangerousness or include a timeframe, but simply require that the person pose a threat of harm to herself or others.

emergency, unless the person being medicated is incompetent to refuse treatment.[145] These standards are intended to protect the civil liberties of people with mental illnesses.[146] However, these standards all but guarantee that someone will experience significant psychological, social, and perhaps legal harms before they can be hospitalized or medicated against their wishes.[147] The current rules might establish the proper trade-offs. Still, it is easy for people, the public in general and lawmakers in particular, to imagine how they might feel if they are detained or medicated against their wishes.[148] It is likely harder to imagine how a parent of a psychotic child feels when she is told that there is nothing that can be done to help her obtain treatment for her obviously seriously mentally ill child until something terrible is about to happen, or has already happened.

Kaye describes the years of watching the onset of her teenage son's schizophrenia, waiting until he was "sick enough" to be hospitalized:

> The sergeant arrived about ten minutes later. He listened to the tape and said, "[l]et's get this kid to City Hospital." They called for an ambulance. Since Ben had been quietly cooperative with Officer Weir and had agreed to the trip to the hospital "to confer with a different doctor about the medications" he had been taking, there was no need to bring him into the hospital in handcuffs. I was grateful for that much. . . .
>
> At the hospital, Ben went quietly inside with the admitting nurse. A few hours later, at 1 a.m., a nurse allowed me into the room to see him. I sat with Ben for another hour while we waited for the doctor. Ben was generally quiet and sullen, but every so often he spoke to me.

Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 CASE W. RES. L. REV. 657, 669–71 (2016) (footnotes omitted).

[145] *See* Brakel & Davis, *supra* note 89, at 536-37, 542.

[146] *See* Player, *supra* note 86, at 187.

[147] *See* Brakel & Davis, *supra* note 89, at 518; Player, *supra* note 86, at 201-02.

[148] Player, *supra* note 86, at 202 ("[C]ommitments to autonomy and personal sovereignty limit the power of governments to prevent citizens from harming no one other than themselves.").

"Mom, you know I have a special gift. I can see wavy lines coming out of certain objects. Everything has an energy. I can see it. Most people can't." . . .

I had to be at work at the radio station in two and a half hours. I went into the treatment room, kissed my sleeping son, and went back home for whatever sleep I could get. It would have to do. I made it through our morning radio show on automatic pilot. I was also in a state of heightened alert. *Please admit Ben to the psychiatric floor. He needs to be observed. He needs so much more help than I can give him. Please.*

At 10 a.m. I got the call from a hospital nurse. "You can come and pick up your son," she said.

"What? No. You can't. He has to be admitted," I said.

"I'm sorry," said the nurse. "He had a good night's sleep, and he keeps telling us that he's fine now. He seems all right. We can't keep him here against his will. He's over eighteen, and we don't have an order for involuntary commitment from his psychiatrist."

There was no way out. I reluctantly picked Ben up from the hospital to start the cycle again. . . .

Things got worse after that. In addition to the mood swings, Ben continued to become more and more isolated. He turned away from people and toward the written word. He couldn't go to a restaurant or a movie without his pens and paper, a spiral notebook or scraps from his pocket. He wrote things down during conversations. He wrote during television shows. He could not stop writing. He was retreating into what he called his poetry. When he showed it to me, all I could see were symbols and scribbling. . . .

For the next six months, I watched and waited. It was more of the same. He dropped all of his classes except for Poetry 101, which he barely passed. He lost jobs soon after he landed them. He got four traffic tickets and missed the court dates. His car was filled with old food, papers, garbage, but never enough gas or oil. Eventually it died an oil-deprived death, and Ben abandoned it at a local gas station. He owed money all over town; he had bounced checks one after the other, some for as little as five dollars. . . .

The pile of things lost from his life got bigger, his sense of pride and accomplishment got smaller, and his delusions got grander.

"It doesn't matter," he said. "I like solitude, anyway. Unless I can be with people who are as deep as I am, who delve into their consciousness like I do, I'd rather just write poetry." . . .

For fifteen months I had waited for the chance to get Ben some more consistent help, more thorough observation of his symptoms, monitoring of his recovery. That could only happen in a twenty-four-hour facility—a hospital setting, a psychiatric facility. Everyone kept telling me that their hands were tied. Ben wasn't "sick enough."

Not sick enough? What is "sick enough"? Threatening someone? Disturbing the peace? Causing a scene so embarrassing that he'd never want to show his face in Trumbull again? What does it take to get the kind of attention that might actually do some good?

If I couldn't make him well, did I have to let him get sicker to get better? So the two possible options, success and dismal failure, could at least get us out of the useless cycle we were in. We began the search for an apartment for Ben. . . .

Four weeks. That's all it took from moving day to Ben's first hospitalization for mental illness.

On the way to the hospital, I tried to say as little as possible, to avoid saying the wrong thing. Would Ben stay in the car or try to get out? What was he thinking? The fifteen minutes to the hospital ticked away way too slowly. Ben was pretty quiet. He stared straight ahead for a while. Once he turned to me and said, "Don't look at me like that, Mom!"

"Like what, Ben?"

"Like you think I'm evil or something. I know what you're thinking." . . .

. . . If I hadn't known better, I would have thought I was talking to someone on LSD or falling down drunk. But he wasn't either of those things. . . .

> The admitting nurse had a list of questions to ask me. She began with "Has your son threatened to hurt himself? Any talk of suicide?"
>
> "No," I admitted.
>
> She went down the list. "Has he threatened you in any way?"
>
> "No, not really." Another "no" checked off on the form.
>
> "Is he a danger to himself or to others? Is he capable of taking care of himself?"
>
> *Oh, please, don't turn him away. Not now.* Then I remembered the stove.
>
> "Well, last time he was in his apartment, he left the stove on. He could have started a fire," I said.
>
> That did it. *The nurse checked off a "yes" at last.* Ben had finally made it to "sick enough." He was a danger to himself. . . .
>
> ...I went home, knowing for the first time in months that nothing bad could happen to Ben while I was away from him.[149]

Earley describes taking his son to the emergency room, only to have him released and commit a crime a few days later:

> The [emergency room] doctor said, "Virginia law is very specific. Unless a patient is in imminent danger to himself or others, I cannot treat him unless he voluntarily agrees to be treated." Before I could reply, he asked Mike, "Will you take medicines if I offer them to you?"
>
> "No, I don't believe in your poisons," Mike said. "Can I leave now?"
>
> "Yes," the doctor answered without consulting me. Mike jumped off the patient's table and hurried out the door. I started after him, but stopped and decided to try one last time to reason with the doctor.
>
> "My son's bipolar, he's off his meds, he has a history of psychotic behavior. You've got to do something! He's sick! Help him, please!"

[149] KAYE, *supra* note 100, at 150-74.

He said, "Your son is an adult, and while he is clearly acting odd, he has a right under the law to refuse treatment."

. . .

It was 2 p.m. now, and during the past twenty-four hours I'd watched Mike slip deeper and deeper into his own delusional world. Because it was his mind that was sick, I was being told that I had to back off and leave him to face his madness alone. I had to watch as he gradually continued to lose all touch with reality.

This can't get any worse, I thought.

But I soon discovered it could. . . .

The next morning I was awakened by a call from the Fairfax police.

Mike was being driven to the Woodburn Center for Community Mental Health. It was less than one mile from the Inova Fairfax Hospital emergency room where I'd taken him Friday night, begging for help. The dispatcher wouldn't tell me why he had been arrested.

A tall, thin uniformed officer was waiting outside when I pulled up to the center. Police Officer Vern Albert said Mike had gotten up early at his mother's house and had walked to a nearby Starbucks coffee shop. He'd removed a glass water bottle from a shelf there, hoisted it up into the air, and announced to the store's customers that it wouldn't break if he dropped it because he had supernatural powers. He had let the bottle fall, and it had shattered at his feet. Mike had bolted from the store. But a clerk had recognized him from their high school days together and telephoned the police. While Officer Albert and his partner were interviewing her, they received a call from their dispatcher. A burglar alarm had gone off a few blocks away.

It was Mike. From Starbucks, he'd run into a residential area, entered the backyard of a house, climbed onto its wooden deck, and hurled a patio chair through the plate-glass door, setting off the alarm.

"Luckily, the homeowners were away for the long holiday weekend," Officer Albert said.

Ignoring the piercing sound, Mike had ducked inside the house, switched on a stereo CD player to drown out the

> racket, and begun rummaging through the kitchen cabinets. He'd then made his way upstairs, where he'd gone from bathroom to bathroom, turning on the taps. After checking the bedrooms and discovering no one was around, Mike had stripped and taken a bubble bath. . . .
>
> A few days later the phone rang and I checked the caller ID. It was the Fairfax County police. As I reached for it, I noticed my hand was trembling.
>
> "Mr. Earley," a woman said, "I'm detective V.O. Armel of the Reston substation. I'm calling to tell you two felony warrants have been issued for your son's arrest."
>
> I didn't understand. "Is he okay?" I asked. "What's he done?"
>
> "These charges are from the home break-in," Detective Armel explained. Mike was being charged with violating Virginia Sec. 18.2-137 (intentionally destroying, defacing, and damaging property in excess of $100) and Sec. 18.2-91 (breaking and entering in the daytime with the intent to commit larceny). Both carried up to $10,000 in fines, as well as five-year prison sentences.
>
> Prison. Five years.[150]

These accounts illustrate that there is a cost to allowing someone to refuse treatment for psychotic symptoms, a cost that is important to understand when deciding when someone should be forced to take antipsychotic medications. Of course, it is still possible to decide, either as a general rule or in a particular case, that the harms of involuntary treatment outweigh the harms of untreated psychosis, but that decision cannot properly be made without an understanding of the costs of both options.

IV. CONCLUSION

On the basis their own personal life experiences, most of us can image what it might feel like to be subjected to civil commitment or involuntary treatment. No one wants to be confined to a locked hospital ward unable to leave or forced to take medications over your own objections. On the other hand, many of us—those who have not experienced the symptoms of psy-

[150] EARLEY, *supra* note 97, at 15-32.

chosis or interacted directly with someone who is experiencing such symptoms—cannot imagine what untreated psychosis might feel like. We cannot imagine what our lives would be like if we believed things that everyone else understood to be false. This lack of understanding of what it feels like to experience psychotic symptoms can hinder the formulation of appropriate legal rules regarding civil commitment and involuntary treatment, as well as the insanity defense. This article has proposed that memoirs of mental illness are one way to increase knowledge of what it feels like to experience untreated psychosis. This knowledge is essential to formulating legal rules that will determine when people with serious mental illnesses can be detained, administered medications against their will, or held criminally responsible for their conduct.