A Clinical Reality Check

By Allen Frances
Response Essays
August 8, 2012

Thomas Szasz performed a great service when, fifty years ago, he first began exposing the risks and excesses of what he calls "coercive psychiatry." His friend Jeffrey Schaler now restates the Szaszian case that mental disorder is myth, not disease, and therefore should not be grounds for depriving anyone of free choice. This important topic touches not only on the rights of the individuals involved, but also on the integrity of basic constitutional protections that are both precious and fragile.

Let's start with a summary of where I stand. I agree completely with Schaler and Szasz that mental disorders are not diseases and that treating them as such can sometimes have noxious legal consequences. But I strongly disagree that mental disorders are worthless "myths" and think it greatly over-simplifies a complex clinical and legal conundrum to categorically assert that involuntary treatment should be completely eliminated.

The “myth” issue is best understood by comparing the epistemologies of my old friends, the three umpires:

> First umpire: there are balls and strikes, and I call them as they are.
>
> Second umpire: there are balls and strikes, and I call them as I see them.
>
> Third umpire: they ain’t nothing ‘til I call them.[1]

Schaler and Szasz correctly make mincemeat of the naïve realism of the first umpire. Human beings aren’t gifted with the tools to see reality straight on, and mental disorders most certainly are not diseases. But umpire three (a true Szaszian) also blows the call — just because mental disorders are not diseases does not make them “myths.” Umpire 2 has better vision — mental disorders are constructs, nothing more but also nothing less. Schizophrenia is certainly not a disease; but equally it is not a myth. As a construct, schizophrenia is useful for purposes of communication and helpful in prediction and decisionmaking — even if (as Schaler correctly points out) the term has only descriptive, and not explanatory, power.

Let’s take Schaler and Szasz off their ivory-tower, idealist perch, and thrust them instead into the muddy waters of the clinical situation that actually confronts a psychiatrist working in an emergency room. Suppose the person who meets the criteria for the construct “schizophrenia” also has compelling command verbal hallucinations that are ordering him to murder his daughter. Suppose further that he has no insight or reality testing and feels compelled to follow the commands. He is brandishing a gun and says he must use it. This isn’t myth — this is clinical reality, and it brings us face to face with the real perils, but occasional absolute necessity, of involuntary treatment.

In my view, “coercive psychiatry” can be either a horrible abuse or a lifesaving salvation — depending completely on the specific circumstances. The risks are familiar, of long standing, and are still being realized around

the world, even in our own freedom-loving country. It was abusive psychiatry in medieval times when doctors of the church exorcised the demons they presumed were causing mental illness through the diagnostic and treatment techniques of torture and drowning. In Soviet times, coercive psychiatry was used to suppress political dissenters by calling them crazy and parking them for long stretches in mental hospitals. China reputedly is running its own "psychiatric gulags" to quiet the vociferous economic complaints of peasants cheated by greedy local party officials. And one has to question the well-meaning Australian practice of anesthetizing and intubating psychotic aboriginals so they can be flown to a distant place for hospital treatment.

In the United States, twenty states and the federal government have passed Sexually Violent Predator statutes that allow for the often lifelong preventive detention of rapists beginning after they have already served their full prison sentence. The fig leaf of Supreme Court approval for the constitutionality of this seeming double jeopardy violation of due process is provided by the requirement that the sexually violent predator have a mental disorder. But the judicial spirit of this necessary mandate to preserve constitutional protections is being violated in forensic practice by ignorant and/or unscrupulous psychologists willing to testify that the mere act of being a rapist qualifies the offender as mentally disordered and therefore subject to indefinite involuntary psychiatric commitment. Before heaping what would be completely appropriate condemnation on abusive Chinese practices, we should get our own house in order.

But Schaler and Szasz go way too far in their total rejection of any need ever for involuntary treatment. Szasz' life-long ideological abhorrence to "coercive psychiatry" led him to avoid any training or practice experience in situations that might force him to violate (or reconsider) his principles. Dr. Szasz has never once faced a patient who desperately needed to be protected from hurting himself or someone else. I have evaluated such patients many hundreds of times. While it is never comfortable to coerce someone into treatment, it is sometimes the only safe and responsible thing to do, and occasionally it is life saving. Involuntary commitment should never be done casually, but it should also not be casually rejected on

questionable theoretical grounds by idealists who don't really understand clinical reality. "Coercive psychiatry," however unpleasant, must be available as a necessary last resort when nothing else will do.

Patient reaction to involuntary treatment varies greatly depending on the person, the circumstances, when they are asked, how it is done, and the family's attitude. A minority of patients is angry about the initial commitment and stays angry even after they have gotten better — sometimes feeling abused and humiliated for life. Another minority feels relief — unwilling to volunteer for treatment, they are happy enough to go along with it. The majority are unhappy at the moment when involuntary treatment is imposed on them, but they understand why it was necessary once they have recovered from their acute symptoms.

So what are the middle ground solutions? How do we thread the needle between an arbitrary abuse of psychiatric power and the avoidance of an unpleasant but necessary responsibility? Always work to gain the patient's trust and cooperation so that the need for involuntary treatment will be reduced to a bare minimum. Always discharge the patient as soon as he is ready or convert him to voluntary status as soon as he is willing. Build in tight monitoring and quality control assurances that involuntary commitment is done only when absolutely necessary and is terminated just as soon as is feasible. And perhaps best of all — give patients who have a track record of needing involuntary treatment the opportunity to sign an advance directive when they are well — permitting it in the future should they again need it.

This is an imperfect world which sometimes requires choosing lesser evils. But it has been of inestimable value to have Schaler and Szasz holding our feet to the fire to ensure that in those rare situations when psychiatry must be coercive, the desirable end does indeed justify the unpleasant means.

Note

[1] For more discussion of the three umpires in the context of psychiatry, see this discussion in *Association for the Advancement of Philosophy and Psychiatry Bulletin*, vol 17 no 2, 2010, in which I also participated. (pdf)

Lead Essay

- **Strategies of Psychiatric Coercion** by Jeffrey A. Schaler

  Professor Schaler notes that mental illness differs in several important ways from physical illness, and these ways make a mockery of conventional diagnosis. Nonetheless mental illness plays an important role in our legal system; it permits psychiatrists to exercise a significant degree of coercion. Schaler challenges this arrangement and argues that those whom we may classify as mentally ill are still deserving of their liberties, including the liberty to refuse treatment. Schaler also questions whether "insanity" is an appropriate legal fiction at all.

Response Essays

- **Psychiatrists Create Their Own Reality** by Jacob Sullum

  Jacob Sullum asks the mental health establishment for consistency: If mental disorders are not diseases, what justifies involuntary treatment? Evidence of criminal conduct is a matter for law enforcement, not mental health. And how is it that we punish sexual predators (on the theory that they are responsible) — then treat them afterward (on the theory that they aren't)? Psychiatric diagnoses are ultimately arbitrary, Sullum argues, and they lead to the arbitrary exercise of power.

- **Calling Mental Illness "Myth" Leads to State Coercion** by Amanda Pustilnik

  Amanda Pustilnik argues that the most profound violations of liberty in this area don't come from coercive psychiatry, but from the warehousing of the mentally ill in our criminal justice system. Such people aren't more likely to commit crimes, but they fare badly in the criminal justice system, where unusual behavior leads to convictions, longer sentences, parole violations, and reincarceration.

The Conversation

- **In Search of a Middle Ground** by Allen Frances
- **Reply to Allen Frances** by Jeffrey A. Schaler
- **A Way Forward? Or, Libertarianism Is Not Equal to Indifference** by Amanda Pustilnik
- **Mental Disorders Are Not a Myth** by Allen Frances
- **Finding a Place for the Mentally Ill** by Jacob Sullum
- **Reply to Amanda Pustilnik** by Jeffrey A. Schaler
- **One Last Try at Synthesis** by Allen Frances
- **The Legal and Moral Problems of Involuntary Commitment** by

Jacob Sullum

- **Access to Voluntary Treatment** by Amanda Pustilnik
- **A Summation, but Not a Middle Ground** by Jeffrey A. Schaler
- **Letters: A Libertarian's Proposal to Reform Involuntary Commitment** by The Editors
- **Letters: The Pathology and Reality of Schizophrenia** by The Editors
- **Diagnosis Isn't the Problem. Coercion Is.** by The Editors
- **Recycling Thomas Szasz** by The Editors