



Strategies of Psychiatric Coercion



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Lead Essay
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Introduction

Before I discuss some of the ways the idea of mental illness is used to deprive persons of liberty and justice, I want to be clear with readers about the meaning of certain terms, and in some cases, my opinion of certain psychiatric-legal practices. In order to communicate effectively, we must agree on the meaning of these terms.

“Mental illness” generally refers to how certain people behave. It can also be used to explain why people behave the way they do. It is a fact that there is no literal disease identified by pathologists as mental illness, be it a thought disorder, personality disorder, affective or mood disorder, and/or anxiety-based disorder. In the world of psychiatry and clinical psychology, there are multiple disorders included under each of those rubrics. Mental “disorder” is synonymous with mental “illness.” These are terms used by members of the mental health profession to do and not do certain things to certain people.

Insanity is a legal term. It generally refers to a person's alleged state of mind when he committed a criminal act. There are various ways in which courts have defined insanity. These include whether or not a person knew what he was doing at the time of the criminal act, and whether or not a person knew what he was doing was right or wrong. A person may know what he was doing and know that what he was doing was wrong, but claim, or psychiatrists may claim, that he could not resist the impulse to commit a crime. This is referred to as "irresistible impulse." Under the "Durham rule," jurors were told to figure out whether a defendant's criminal act was the *product* of a mental illness. The jurors were not told what "product" meant, and they were not told what "mental illness" meant. Others believe that mental illness means irrationality. This raises the question, irrational according to whom? Many people, psychiatrists and legal experts alike, use the terms mental illness and insanity interchangeably. Yet mental illness is a pseudo-medical term. I do not believe a psychiatrist can determine via a psychiatric examination or any other way what a defendant's state of mind was six months in the past when he committed a criminal act. I don't think one person can know another's state of mind in the present moment.

The mental health profession includes psychiatrists, psychologists, social workers, and various categories of professional counselors. Since psychiatrists are the major players empowered by the state to commit persons to mental hospitals, make declarations regarding competence to stand trial, prescribe drugs, and give psychiatric examinations in court at the request of a judge, prosecutor and/or defense counsel in order to support an insanity plea, I'm using the word "psychiatrist" to stand for all members of the mental health profession. Many members of the mental health profession play key roles reinforcing belief in mental illness as a treatable literal disease.

I differentiate here between contractual or consensual psychiatry and institutional or coercive psychiatry. There are, in my opinion, as many different schools of personality theory as there are religions, and as my colleague and friend Thomas Szasz points out in his book entitled *The Myth of Psychotherapy: Mental Healing as Religion, Rhetoric and Repression* (1978), treatment approaches to mental illness have more to do with

religion and ethics than medicine and science. Moreover, the fact that drugs change behavior from socially unacceptable to socially acceptable does not mean a person needed that drug in a biological or chemical sense. Many people feel better after a glass of wine in the evening. This does not mean they suffer from wine deficiency.

I am not an anti-psychiatrist. I do not object to people who want to believe or go to a psychiatrist who believes in mental illness. I do not think the state should prohibit people from ingesting strong drugs to change the way they feel, either by prescription or by using those drugs that are currently illegal. I believe in the repeal of all drug prohibition, including prescription drugs. In my opinion, drugs are intrinsically neither safe nor dangerous, neither good nor bad. This all depends on how one uses a drug. My concern here is with institutional or coercive psychiatry. In contractual or consensual psychiatry, the psychiatrist is an agent of the patient. The patient can fire the psychiatrist any time he wants to do so. In institutional or coercive psychiatry, the psychiatrist pretends to be an agent of the patient, but is really an agent of a state institution. The patient cannot fire his psychiatrist.

While from my perspective I would oppose the violation of even one person's rights through psychiatric coercion – while I would oppose even one person being involuntarily committed to a prison called a mental hospital – in reality thousands of people are held in mental institutions across the United States at any given time. Some were forced into a psychiatric facility and cannot get out. Others chose to enter a facility voluntarily and can't get out. A large part of treating mental illness involves forced medication and forced electroshock therapy (ECT).

There are many situations where the idea of mental illness is used to coerce people. I cannot cover all of them here, thus I'm narrowing my focus to three psychiatric strategies used to coerce people. There are more terms, definitions and descriptions we must be clear about before I describe these strategies.

Disease versus Behavior

A disease refers to a histological (tissue) lesion, wound, or cellular

abnormality. Mental illness is not included in standard textbooks on pathology because it refers to behavior, not cellular pathology. This distinction between behavior and disease is important because people tend to confuse the one with the other. Behaviors can be influenced by disease, and vice versa, however behaviors are not diseases, and vice versa. Smoking is a behavior. Lung cancer is a disease. Drinking alcohol is a behavior. Cirrhosis of the liver is a disease.

Diseases are found in a cadaver upon autopsy. Behaviors cannot be found in a cadaver during autopsy for obvious reasons. Disease is something that a person has. Behavior is something that a person does.

When I say there is no such thing as mental illness, I mean the following: The mind, consciousness, and thinking is not susceptible to disease. “It” cannot get sick or diseased. That represented by the pronoun “I” cannot get sick or diseased. The mind cannot be diseased because it is not a biological entity. Strictly speaking, there is no such thing as the mind. Since there is no such thing as the mind, it cannot be ill or diseased. Put another way, the mind can be sick or diseased in a metaphorical sense only. Since the mind cannot be sick or diseased, it also cannot be healthy.

The brain can be diseased, just as any part of the body can be diseased. The human body is susceptible to literal disease; the human mind is not. I can tell you a sick joke and you know what I mean by “sick joke.” I cannot give antibiotics or any other literal medicine to a sick joke. I can’t treat a sick joke. Since the mind cannot be diseased, or, since the mind can be diseased in a metaphorical sense only, like a sick joke, it cannot be treated, or given medicine, to make it healthy, except in a metaphorical way.

None of this is to state or imply that people labeled or “diagnosed” as mentally ill are not engaged in certain behaviors that others may find disturbing. A person plucks out his own eyes; another amputates his penis; another injects saliva under her skin to deliberately create infection. Mental health professionals and laypersons alike “diagnose” or label the persons engaging in such disturbing behaviors as mentally ill. The behaviors clearly exist. They are sick only in the sense that a joke is sick, that is, they are sick in a metaphorical sense, but not in a literal sense.

Description versus Explanation

In my opinion, we must not confuse the accurate description of a phenomenon with an explanation for why the phenomenon exists. Schizophrenia, for example, is a term used to explain why people engage in certain behaviors that others find disturbing. It is also a term, as are the so-called mental disorders listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), used to deprive people of liberty when they have committed no crime and to absolve people of responsibility when they have committed a crime. While there is no such thing as mental illness, and while there can be no such thing as mental illness, people act as though mental illness is as real as cancer in order to do certain things to other people. Many people say, "just because we have not discovered the cause of mental illness does not mean we won't discover a cause." I disagree. We will never discover a cause for mental illness because there is no illness, no disease called mental illness. There is no "it." "It" does not exist. "It" is not a discrete variable. The term and diagnosis of mental illness – and obviously there can be no accurate diagnosis of mental illness since there is no disease to diagnose – is a rhetorical device, a political and behavioral strategy that certain people, as we shall see, benefit from.

While this perspective on mental illness is considered controversial and a minority opinion, it is in many ways simply the application of scientific rules for disease identification and classification. Pathologists do not include mental illness in standard textbooks on pathology. Behavior is not a tissue. Behavior is not a disease. There is nothing particularly controversial about pathology and nosology, the classification of diseases. Saying that schizophrenia is not a disease is no more controversial than saying that cancer is a disease.

So, what is behavior? Behavior means mode of conduct, deportment. It refers to how a person acts. Behavior is an activity. Behavior is the expression of moral agency, the expression of values. We know something about what a person values by what she does. *There is no such thing as an involuntary behavior.* Even in a gun-to-the-head scenario, a person

chooses to act one way versus another. An epileptic seizure is not an involuntary behavior. It is more like a neurological reflex. It is not voluntary; it is not the expression of choice or volition. Knee-jerk is a patellar reflex and is not volitional.

Now, *why* a person engages in certain behaviors is an entirely different matter. When someone states “schizophrenia is a chemical imbalance,” I assert that they are being inaccurate. “Chemical imbalance” is an *explanation* for why a person engages in self-reported imaginings, what is referred to as hallucination, the primary characteristic of schizophrenia. (There is no such thing, no such disease, as schizophrenia.) There are socially acceptable self-reported imaginings, or hallucinations, and socially unacceptable ones. Claiming that Jesus has entered one’s heart may be a socially acceptable self-reported imagining. Claiming that Martians are beaming messages to me through the fillings in my teeth may be a socially unacceptable self-reported imagining. The former is referred to as a valued religious experience. The latter is referred to as schizophrenia, a type of mental illness.

An *explanation* of a behavior may or may not be accurate, but an explanation of the behavior called or labeled as “schizophrenia” should not be confused with that same behavior’s *description*. People tend to confuse the two, just as people confuse behavior and disease, mind and brain, and so on.

Categories of Explanations for Behavior

Explanations for behavior fall into four categories: Theological or spiritual explanations are one; biological explanations are a second and are focused primarily on the structure and function of the nervous system, specifically, how neurons communicate with one another; psychological explanations, including all the different theories about personality, are a third category; and finally we have socio-cultural explanations, a fourth category, where the meaning of a behavior is contingent upon the cultural context within which the behavior occurs.

Socially acceptable and socially unacceptable behaviors vary by cultural context. Literal diseases do not. In the United States, homosexuality is no longer considered a disease. In Uganda, homosexuality is considered a disease, a sin, and a crime. Controversial legislation punishing homosexuality with the death penalty has been proposed in Uganda. Obviously, it is a very backward country, composed of very backward people, when it comes to protecting individual rights. Much of their antipathy towards persons who choose homosexual ways of having sex comes from religious influences.

Using logic and empirical methods, people may gather evidence and try to find out which of the four categories of explanation for behavior is most accurate when it comes to describing, explaining, predicting, and controlling behavior. Yet much of what passes as “science” regarding psychiatric and behavioral research does not utilize Sir Karl Popper’s crucially important method of falsifying a hypothesis. Gathering “evidence” to *support* a hypothesis is the way most behavioral research is conducted. The fact that no two people are identical is generally disregarded when it comes to interpreting behavioral research. While the allele (mutation) of a specific gene responsible for “building” a specific neurotransmitter receptor may be a discrete variable, the behavior that is tested for correlation, ultimately for a causal relationship, is not a discrete variable. No two behaviors are identical.

What we do or don’t do about abnormal behaviors referred to as mental illnesses, or mental disorders, is different from describing and explaining behavior. I refer to this as policy in four domains. How we describe and explain behavior has important implications for legal, clinical, social (sociologically, meaning informal social controls, including relational and self controls, without involvement on the part of the state), and public policy (sociologically, meaning formal social controls where the state is involved).

Keeping in mind what I’ve written above regarding the meaning of and differences among certain terms as a context or background, I would now like to focus on how the idea of mental illness is used by institutional psychiatry. When it comes to legal procedures, including criminal and civil

procedures, all four policy domains are involved in what people do and don't do in the name of mental illness. None of the four policy domains are mutually exclusive.

The Right to Refuse Psychiatric Treatment for Mental Illness

Most people recognize that literal treatment for literal disease is a choice, subject to consent. People have the right to refuse treatment when they have lung cancer, or are otherwise very sick, despite the fact that doing so may mean certain death. When you elect to undergo major surgery, you must sign a consent form. Even when you request a vaccination for influenza, you still must sign a consent form.

There are three relatively uncontroversial situations in which treatment proceeds legally without consent: The first is the medical treatment of children. The second is the treatment of people when they are literally unconscious. And the third is the treatment of persons with contagious disease.

Children may be treated, or poked with a hypodermic syringe to vaccinate, or to collect blood without their consent, mainly because the children are in a custodial or guardian relationship with their parent(s), and their freedom, like their responsibility, is limited. We accept that when a person is a child he or she may not fully comprehend the consequences of refusing treatment. Obviously, the distinction between adult and child is somewhat arbitrary. There are many people who are over twenty-one years of age who still act in immature ways. There are many people who are under twenty-one years of age who act in mature ways. It seems odd that courts will allow fourteen-year-old children to be tried as adults for particularly heinous criminal acts. However, fourteen-year-old children are not granted the freedoms and privileges of adulthood for demonstrating virtuous behaviors and for demonstrating a clear comprehension of the relationship between specific behaviors and their consequences. Most people recognize and accept that children can and should be coerced into receiving medical treatment when their parent(s) deem it necessary to do so. (Obviously, it is preferable to gently explain why the prick of a needle is necessary,

however, children vary by age in terms of their understanding and willingness to submit to pain, regardless of why and who says doing so is necessary.)

The second situation when medical treatment occurs without consent is when a person is literally unconscious. Consider a pedestrian crossing a street at a marked crosswalk during rush-hour traffic. Our imaginary pedestrian is hit by a car, and as he falls to the street he hits his head on the pavement and is knocked unconscious. Someone calls an ambulance, the ambulance arrives, and emergency medical technicians immediately begin to assess the person's condition, treat him as necessary at the scene of the accident, then in the ambulance on the way to the hospital, and then by doctors and medical staff at the hospital. No one waits for our pedestrian-now-patient to regain consciousness so that doctors and other medical personnel can ask him if he *wants* to be treated, that is, if he consents to treatment. He might die if they wait. Our pedestrian-now-patient doesn't have the conscious capacity to say yes or no, give or refuse consent to treatment, so we err in the direction of helping the person. Again, most people accept this second form of treatment without consent, as necessary.

Our third and final situation involves a person who has contracted a contagious disease. Imagine an adult university student who becomes infected with a highly contagious form of viral meningitis. Once university and district medical personnel are alerted to the fact that this student is dangerously ill with a contagious form of meningitis, she is immediately quarantined and treated whether she gives consent or not. Why? Because others at the university can be infected or catch the disease simply by being in the same vicinity as our student sick with meningitis. Anyone in a classroom with her can catch the disease.

In order to protect *others* from her disease, she must be removed, quarantined and treated for her disease, whether she gives consent or refuses to give consent for medical treatment. Remember, she is being sequestered and treated to protect others, as well as herself.

When I use the word contagious here I am referring to a disease that others can contract simply by breathing the same air, dipping into the same food and drinking out of the same cup of water our sick student is using. That kind of contagious disease is a true public health matter. Syphilis and herpes are private health matters, the result of taking a behavioral risk with others. Getting AIDS from contaminated blood is a public health matter. Getting AIDS by practicing unsafe sex is a private health problem. I'm referring to the public health form of contagious disease. Most people accept these three situations or conditions as legal and ethically sound.

Psychiatrists, on the other hand, twist these rather uncontroversial cases in extremely self-serving ways. They do this despite the fact that they tell us over and over again that mental diseases are just like physical diseases, and that mental patients should be treated exactly as people with real, physical diseases are treated. This is the essence of the mental health "parity" controversy. To wit:

On October 3rd, 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was signed into law. This new Federal law requires group health insurance plans (those with more than 50 insured employees) that offer coverage for mental illness and substance use disorders to provide those benefits in no more restrictive way than all other medical and surgical procedures covered by the plan. The Mental Health Parity and Addiction Equity Act does not require group health plans to cover mental health (MH) and substance use disorder (SUD) benefits but, when plans do cover these benefits, MH and SUD benefits must be covered at levels that are no lower and with treatment limitations that are no more restrictive than would be the case for the other medical and surgical benefits offered by the plan.

Mentally ill patients and drug addicts are not the ones who lobbied for this legislation. It was the "advocates," that is, the families of those diagnosed with mental illness and addiction who lobbied for the parity legislation, as well as treatment providers, who lobbied the hardest. Treatment providers

stand to gain the most by the passage of this legislation.

As usual, the advocates and treatment providers plead altruism, that is, no self-interest.[1]

Treatment providers forcibly “treat” people they and others consider “dangerous to self and others,” justifying what they do in the name of compassion and care. They take each of the three conditions I’ve just described – youth, unconsciousness, and danger to others – and blur the distinction between metaphor and literal disease and treatment.

Treatment without consent for “mental illness” is justified by saying the person is *like* a child. Since we base the distinction between adult and child on chronological age, a person is either an adult or a child. If he’s twenty-one, he’s an adult. If he’s twenty, he’s a child. Psychiatrists and mental health professionals empowered by the state to commit someone involuntarily to a psychiatric “hospital” argue that a twenty-five year old person who refuses to bathe and take care of himself is really a child. He does not, in their opinion, exercise responsibility for himself because he cannot do so. He is a threat to himself. He may verbally or nonverbally abdicate all responsibility for himself and ask to be taken care of by others, for fear that he might hurt himself. (Again, I am most concerned with those who do *not* want help, who *reject* “help,” and who are coerced into “treatment” when *they don’t want it*.)

It doesn’t matter to me whether they express a “thank you clause” after they are released from a hospital, or after they are thoroughly drugged with major tranquilizers. In my opinion, when an adult refuses treatment his refusal must be respected. Otherwise, coercion occurs in the name of helping him. The intentions of psychiatrists and this man’s friends and family are irrelevant. They may certainly try to persuade, encourage, even beg him to go into a “treatment” facility. In the end, the man called a child has a right to refuse treatment and that refusal must be respected in the sense that psychiatrists keep their hands off him.

Institutional psychiatrists are agents of the state. They are not agents of the designated patient. The state has no business inside a patient's metaphorical head.

According to psychiatrists who coerce this person into a psychiatric facility, the coercion must occur in order to protect him from himself. He “needs” to be deprived of his liberty, otherwise, “he will die with his ‘rights’ on,” as one staunch defender of involuntary commitment procedures responded to those concerned about violating people's constitutional rights in the name of treating their mental illness. The more a person objects to being coerced into “treatment,” the more likely he is to be diagnosed with serious mental illness. He is labeled a child with mental illness, yet he is not literally a child. He is a metaphorical child, and he does not have a literal illness. He “has” a metaphorical illness. He has committed no crime.

While mental health professionals may consider this to be the same as treating a literal child with a literal disease, the differences are clear; this is one way a person can be committed against his will to a psychiatric facility for “treatment.” Others consider this to be assault and battery committed by psychiatrists and the state, which has empowered them to do this to people. As Murray Rothbard once wrote at a symposium honoring Thomas Szasz, “diagnosis is a weapon.”

Here is another example of distorted thinking on the part of someone who believes strongly in the existence of mental illness. Years ago I had an exchange with someone who was very angry about my views on mental illness. He calls himself a “libertarian.” He said, “I know mental illness is real, it almost killed me.” I wrote back to him explaining that in my opinion, “he” was “it.” There is no “it” separate from himself that almost killed him. *He*, apparently, almost killed himself. He did not want to take responsibility for himself, I informed him.

In the unconsciousness approach, treatment without consent for “mental illness” is justified by saying the person “lacks insight” into his disease. “Depression is anger turned inward,” said Arnold Schwarzenegger in *Terminator 3: Rise of the Machines*. “Psych 101.” Which indeed it is. When a person diagnosed as mentally ill rejects the diagnosis, this rejection is

“diagnosed” as a sign of his mental illness. (Signs and symptoms are different; signs are externally observable markers of disease, while symptoms are a part of the subjective experiences of the patient). Accurate diagnosis of disease requires identification of signs, not symptoms. While symptoms may lead to signs, symptoms alone are unreliable when making an accurate diagnosis of disease. All mental illnesses are based on symptoms alone, not signs. There are no signs of mental illness.) Hijacking the term “anosognosia,” psychiatrists assert that disagreeing with them is a manifestation of their mental illness, a kind of “heads I win, tails you lose” interaction. The doctor is always right, especially when he’s wrong.

Here is the definition of anosognosia from The Treatment Advocacy Center; its executive director, E. Fuller Torrey, was originally a student of Thomas Szasz. He wrote *The Death of Psychiatry*, published in 1975:

Impaired or lack awareness of illness – a neurological syndrome called anosognosia – is believed to be the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications. It is caused by damage to specific parts of the brain, especially the right hemisphere, and affects approximately 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder. When taking medications, awareness of illness improves in some patients.

A person is either conscious or unconscious, especially when they angrily try to reject and resist attempts at coercion in the form of involuntary commitment to a mental hospital. The more a patient resists and fights, the deeper his anosognosia, or “lack of insight.” This is a pathetic attempt on the part of psychiatrists to justify coercion. Obviously a person is conscious when he resists treatment, and obviously he has a right to resist treatment. This is very different from being unconscious after falling and hitting one’s head on the pavement. Nevertheless, mental health professionals assert that disagreeing with them is just another form of unconsciousness, and therefore coercion is justified.

In the third condition, the metaphor of contagion, treatment without consent is justified on the assertion that the person is dangerous to others. A person with a literally contagious disease can unintentionally harm others. Likewise, a person with a metaphorically contagious disease can also allegedly and unintentionally harm others. He can commit acts of violence toward others and must be sequestered or put into a form of quarantine in order to protect the public from him, and he from himself. A literal situation with real contagion is twisted into a metaphorical situation in order to justify coercion in the name of compassion, care, and really, medicine.

So, we see here how the three legal and ethical situations or conditions in which a person can be treated medically without consent, are twisted to serve the best interests of mental health professionals. Again, mental health professionals include psychiatrists, psychologists, social workers, and various categories of professional counselors.

In each of these conditions the idea of mental illness plays a key role in forcing people into a mental hospital. People are deprived of liberty because others think they are a threat to others and themselves. Leaving aside the fact that a person's body is his or her own property, and suicide is a right, not a crime, and the fact that the U.S. Supreme Court has upheld the constitutionality of involuntary treatment for mental illness, it seems to me that a profound injustice is occurring to persons labeled as mentally ill. This is social control masquerading as the literal and ethical practice of medicine. Literal treatment becomes metaphorical treatment, and metaphorical treatment for a metaphorical disease. *Similia similibus curentur*, as the homeopathic school often says – like cures like.

It is important to note that while social “scientists” have been striving for years to accurately predict who is likely to commit acts of violence and who is not likely to do so, we cannot predict who is going to be violent with an accuracy greater than that predicted by chance. In other words, guessing who is going to be violent is as accurate as taking into consideration hundreds if not thousands of personality and demographic characteristics comparing violent to nonviolent people. So while many people clamor for more involuntary commitment to mental hospitals, along with gun control,

in order to prevent mass murders like the one just committed in Aurora, Colorado, we cannot predict who is going to do it and who is not. That is a fact, not fiction.

There is one final detail that we need to address. Even if we could predict who is going to commit a crime or act of violence and who is not with perfect accuracy, as shown in the movie *Minority Report* (2002), people are still being deprived of liberty when they have committed no crime. They are being deprived of their right to due process of law.

Legal Fiction

Involuntary treatment for mental illness and the insanity defense are two sides of the same coin. Both practices rest on the idea of mental illness. Both practices occur via the power of the state. In the involuntary treatment scenario, a person is treated as if he was a criminal and deprived of liberty when he has committed no crime. In the insanity defense, a person is treated as if he was *not* a criminal, and exculpated of criminal responsibility, even when he has committed a crime. If involuntary treatment is abolished as unconstitutional, then it would seem the insanity defense would be abolished as well, and vice versa. Since the idea of mental illness is the key to both, it seems as though it would be easy to get rid of both practices by showing a court that mental illness is a myth, as professor of psychiatry emeritus Thomas Szasz has written about for the past sixty years.

Mental illness will continue to play a role in depriving people of liberty and justice as long as it is considered an apposite legal fiction. As Szasz has pointed out in his book entitled *Insanity: The Idea and Its Consequences* (1987), the greatest racial legal fiction before the Civil War was that negro slaves were three-fifths persons. The greatest medical legal fiction since the Civil War is mental illness, the idea that persons labeled as mentally ill are not full persons, full citizens, entitled to their full constitutional rights. It is as if the Bill of Rights had a postscript at the bottom reading “For mentally healthy people only.”

A legal fiction is something that is false, asserted as true, and something that a court will not allow to be disproved. The late legal scholar Lon Fuller stated that in order to understand something as a legal fiction, one has to first identify the premise upon which the fiction rests, and then identify what purpose is being served by the fictional assertion. Szasz explained how mental illness is legal fiction in light of this point by Fuller in his book *Insanity*. The premise upon which mental illness as legal fiction rests is that the mind can be diseased just as the brain can be diseased. The purpose mental illness as legal fiction serves is to deprive of liberty persons labeled as mentally ill without letting them have due process of law. In other words, the purpose of the greatest medical legal fiction since the Civil War, mental illness, is to deprive people of their right to due process of law without violating their constitutional rights.

Involuntary commitment rests primarily on asserting that a person's mental illness causes them to be a danger to themselves and others. Variations on the insanity defense, for example, from the M'Naghten rules or the irresistible impulse doctrine, or Durham's "product," all attempt to claim that a person cannot form the necessary intent or *mens rea* to be responsible for a crime. There are some legitimate ways in which a person's responsibility for criminal acts is diminished or absent.

One example is when a person harms another in a situation involving self-defense. An auto accident suffered due to a heart attack or an epileptic seizure may be another. Two persons may get into a physical altercation and while neither party intends to kill the other, one person may still be killed, even without any intent.

John Hinckley stalked and shot President Ronald Reagan. It appeared that he had the necessary intent or *mens rea* to be found guilty within the context of criminal law. However, he successfully pled not guilty by reason of insanity. There was no criminal responsibility. He was not punished as he might otherwise have been, and he was sent instead to St. Elizabeth's Hospital in Washington, D.C. for treatment of his "insanity."

Theodore John “Ted” Kaczynski, the “Unabomber,” was charged with a crime for which he wanted to stand trial. He objected to his defense counsel’s attempts to have him examined by a psychiatrist for “schizophrenia.” Kaczynski did not want his political motives for mailing letter bombs to be undermined by a diagnosis of schizophrenia. He clearly understood that both the defense and prosecutors were attempting to do this. Mass killer Anders Breivik has likewise resisted the Norwegian legal system’s classification of insanity, again with the goal of advancing his political beliefs. It is interesting to note that not once have people arrested for Islamic terrorist activities either requested or been coerced into pleading not guilty by reason of insanity.

Conclusion

In sum, two scenarios operate under the name of mental illness, and both lead to state-sponsored psychiatric coercion and injustice. The idea of mental illness is used to assign responsibility where it does not belong and to involuntarily commit people to mental hospitals. The idea of mental illness is also used to remove responsibility where it does belong, in the varieties of the insanity defense that I have briefly described. When liberty is deprived in the name of mental illness, responsibility for behavior is necessarily diminished. Thus involuntary treatment procedures are intimately connected to variations on the insanity defense.

A positive correlation exists between liberty and responsibility. When we increase one, we necessarily increase the other. When we decrease one, we necessarily decrease the other. The myth is that a negative correlation exists between the two. We cannot increase liberty by adopting policies that ultimately diminish personal responsibility.

My colleague and friend for many years, Thomas Szasz, agrees with me on many issues, and disagrees on many issues as well. In terms of abolishing the use of the idea of mental illness as the greatest medical-legal fiction since the Civil War, his belief, as expressed to me in personal communication, is that this can only be done by prohibiting a psychiatrist from being in a court room, testifying as an expert on behavior in a trial. I

believe it can only be done by exposing mental illness as a metaphorical disease, and by showing judges and legislators that mental illness is the greatest medical-legal fiction since the Civil War, in the way that Lon Fuller has brilliantly described legal fiction.

I believe that one of the greatest threats to liberty and responsibility we have known since the Spanish Inquisition can be found in institutional psychiatry, the confusing public health with private health, and the growth of the therapeutic state, that union of medicine and state that has come to replace the theocratic state in so many of its former functions.

Note

[1] See Jeffrey A. Schaler and Richard E. Vatz, “Mental health Trojan horse,” *Washington Times*, December 31, 2009; see also “Mental Health Parity Legislation Should Be Reversed Or Modified Because Questions About Mental Illness, Addiction Remain, Opinion Piece Says,” *Medical Digest.com*.

ALSO FROM THIS ISSUE

Response Essays

- **A Clinical Reality Check** by Allen Frances

Professor Frances agrees that mental disorders are not diseases properly speaking, but he maintains that they are nonetheless useful analytic constructs. As to coercive psychiatric treatment, he argues it can indeed be a horrific abuse. Still, in some especially desperate cases it will be necessary to save lives and to prevent even greater harms. He recommends several practices designed to minimize the frequency and risks of coercive treatments.

- **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
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- **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
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