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New York, New York 10011
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Mr. Richard H. Nolte
Institute of Current World Affairs
535 Fifth Avenue
New York, New York 10017

Dear Mr. Nolte:

In May, Professor Theodore Sarbin of the University of California at Santa Cruz delivered the keynote address to the fifth annual conference of the AAAIMH (which stands for American Association for the Abolition of Involuntary Mental Hospitalization) in the red and gold Mercury Ballroom of the New York Hilton. He characterized the civil commitment process as a moral, rather than medical, activity.

In October, Dr. Lawrence C. Kolb, New York State's Commissioner of Mental Hygiene, addressed the New York City Bar Association's symposium on mental health law in the oak and wine-velvet Tweed Room of its House. He spoke to the "interface of psychiatry and law, and our significance in maintaining the moral standards of American society."

Had the antipodes come together at last? Hardly. For Professor Sarbin's argument was meant to demonstrate psychiatry's illegitimate role in the civil commitment process, and Dr.

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Kolb's point was that psychiatry should be given freer rein.

Sarbin's interesting paper, "Ideological Constraints on the Science of Deviant Conduct," dealt with the "myths and metaphors" that sustain current judicial, psychiatric, and bureaucratic practices in the involuntary commitment process. He began by taking apart the "disease paradigm" or medical model of mental illness--on four grounds. First was the unreliability of psychiatric diagnosis (high rates of disagreement among different psychiatrists examining the same patient--see JLS-9). Second was the invalidity of diagnosis (that psychiatry is biased toward finding pathology and that the attribution of disease doesn't say much about the patient himself) as suggested by Rosenhan's pseudopatient experiment (see JLS-4 and 5). Third was the effect on diagnosis of extraneous factors like social class and political belief--about which more later. Sarbin's fourth ground was the "mythic quality" of mental illness, which he called a "scientifically empty term." On this point he referred to his own research into the experimental literature on schizophrenia. He and a colleague analyzed 300 journal articles published over the past 15 years to discover whether any known objective psychological test (in contrast to subjective, clinical impression) could separate out clinically diagnosed schizophrenics from normals. Sarbin concluded that such a test does not exist. Schizophrenics performed nearly identically on most tests, on the average, to regular people. On others, small differences favored the normal sample; occasionally the schizophrenics did better. From all this Professor Sarbin concluded that diagnosis and the attribution of mental illness "is a moral rather than a scientific enterprise" and that mental illness is not a medical disease located in the individual but is rather deviant behavior displayed by some people which other people--a judge or psychiatrist --wish to control.

What are the ideological beliefs, Sarbin asked, that legitimize the current system? He listed four of them: the apparent appropriateness to involuntary commitment of civil (in contrast to criminal) proceedings; the belief that certain classes of people are more dangerous than others; the mental hospital as a legitimate institution; and the authority of the physician as the appropriate person to deal with deviant conduct (rather than disease).[1] Sarbin traced the historical roots of each of these four beliefs, a fascinating study to which I hope to return in a future missive. "The study of ideological premises reflects how an entrenched group or profession can become so bound to a situation that its members cannot recognize facts that would weaken their power."

Dr. Lawrence E. Kolb, in his address to 300 lawyers and doctors at the Bar Association, might have surprised Professor Sarbin. Here was no psychiatrist hiding behind medical trappints and the disease paradigm to perpetuate the moral authority of his profession in the control of deviance. Rather, he explicitly advertised its moral purposes. Dr. Kolb mentioned "psychopathology" only two or three times in his address, stressing "social adaptation" and "readjustment" in a dozen places. And unlike Professor Sarbin's hypothetical apologist for involuntary hospitalization, Dr. Kolb did not require the specter of homicidal mental patients to bring all odd or asocial behavior within his authority. For Dr. Kolb apparently believes that a wide range of conduct not overtly violent should be controlled through psychiatry.

He acknowledged that the popular belief that patients released into the community are more dangerous than people at

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[1] Professor Sarbin assumed without documentation the connection between diagnosis and the outcome in commitment hearings, a link that I've discovered is rarely direct. But the diagnostic ritual does lend great authority, often unquestioned, to the medical profession and the mental hospital in dealing with conduct not stemming from disease.

large may be baseless. (See JLS-18). Studies conducted before the recent policy of massive de-institutionalization indicated that the reverse was true, and later studies conducted at the time of massive release were at least ambiguous. But in his view, our culture (and our courts) share with other cultures the "tendency to isolate those who are odd or potentially dangerous, frail, weak, or peculiar in their behavior." Dr. Kolb did acknowledge the language from the recent U.S. Supreme Court's Donaldson decision that eccentricity or unattractive appearance or behavior are by themselves insufficient to permit detention in a mental hospital. But he lamented that the Court was not more precise in specifying "the degrees of eccentricity" a community must Constitutionally allow to its members. Dr. Kolb contended that every community has a limited capacity to absorb anti-social behavior and still function effectively; beyond that capacity, "increasing degrees of social unrest and progressive and violent actions toward others" will occur. Implicit in this view is the notion that an individual's eccentricity breeds a reaction in the better-adapted segment of a community, and that a spiral into violence will be the result.

Where Professor Sarbin questioned the legitimacy of civil proceedings as the state's means of maintaining public order (properly a job for the criminal law and the stricter protection it accords the accused), Dr. Kolb objected that any court hearing forces an adversary relationship on the parties where he feels the psychiatrist should have a determinative say. Two-thirds of the admissions to New York State's public mental hospitals are readmissions, Dr. Kolb pointed out, and he blamed this cycle on the availability to patients of legal advocates. Dr. Kolb believes that lawyers, instead of playing adversaries, should work with psychiatric staff to decide "what constitutes the indications for continuing supportive care until changes in the individual allow him to readapt."

Dr. Kolb did not appear to include the civil liberties of patients in the public morality that his Department is entrusted to protect. "Our culture and cultures throughout the world," he asserted, "have recognized that one must reach a certain level of maturity before one is given the privilege of assuming civil responsibilities." Presumably, it is the psychiatrist's job to decide whether a patient is mature enough to regain the privileges of citizenship including, perhaps, Constitutional due process. In a telling slip, Dr. Kolb misquoted New York's mental health statute, saying that it authorized involuntary hospitalization only if essential to the patient's welfare or if the patient's judgment is so impaired that he doesn't understand the need for hospitalization. The law says "and," not "or", and as my readers may recall, patients are often implicitly deemed to have impaired judgment if they disagree with the hospital about whether they need to stay. Dr. Kolb's recollection of the statute would give psychiatric testimony unquestioned sway.

Dr. Kolb urged that more important than a patient's civil liberties is his "right to treatment." Those courts that have decreed such a right usually mean that a patient may not be confined against his will unless he is given adequate treatment; defining adequacy is not easy, and some courts, perhaps misguidedly, have resorted to measures of staff-to-patient ratios and physical plant. Instead, Dr. Kolb would define adequacy in terms of "the actions to be taken to bring about social re-adaptation." These actions will often include retention of a patient who wishes to flee from a continuing therapeutic relationship. Dr. Kolb's novel reading of "the right to treatment" appears to transform it into society's right to treat a patient until he "re-adapts"--whether or not he is violent. There is every indication that Dr. Kolb's legal analysis and the developing law of involuntary hospitalization are rushing in opposite directions. Looming ominously over the speakers

at the Bar Association symposium and their concern that the law may already have gone too far in protecting patients was the unacknowledged specter of Lessard v. Schmidt, which goes even farther. There, a three-judge Federal court in Wisconsin imposed the full range of criminal safeguards in civil commitment proceedings. (See JLS-19).

Professor Sarbin did not deny that some people may conduct themselves in a way that others find eccentric or dangerous; nor did he fail to acknowledge that security and equality deserved their place alongside personal liberty in our system of values. These three values, of course, often come into conflict and are continually balanced against one another by the courts and legislatures. "But wherever one places individual liberty in his hierarchy of values," Sarbin urged, "....liberty is too precious to be cavalierly manipulated by the outfall of the silent workings of unrecognized ideological premises, especially the ceremonials of civil commitment, and the ritual behavior of doctors performing with their Aesculapian authority."

The fundamental issue dividing Dr. Kolb and Professor Sarbin seems clear enough: granted that society may control a variety of (but not all) behaviors it finds offensive, who is to be its agent? And even if the medical specialty called psychiatry may have acquired this responsibility through historical accident and tenuous analogy, the question remains: does psychiatry carry it out in a way that conforms with the values of society at large? Dr. Kolb assumed, without saying why, both the authority of the physician and the legitimacy of the mental hospital as the agents for maintaining public order. But Professor Sarbin's discussion of the extraneous factors that affect psychiatric diagnosis raises doubts with which readers of these pages may not yet be fully familiar.

At least since the famous 1958 Hollingshead and Redlich study, it has been known that a lower-class patient has a far

greater chance of being diagnosed psychotic than a middle-class patient. (And more recent research purports to show that when you separate out the factors that got a person diagnosed as mentally ill, being poor is the single most important indicator.) Professor Sarbin described in detail the fascinating 1974 study by the Drs. Braginsky into the effect of political attitudes on diagnosis. The researchers videotaped two staged psychiatric interviews, using the same college senior to play the patient in each. The first section of both tapes was the same: the "patient" complained of sleeplessness, irritability, poor appetite, fatigue. After that the tapes diverged. When the patient was asked about his political beliefs, he expressed in the first tape a middle-of-the-road philosophy and decried radical tactics. In the second tape, he expressed a New Left philosophy. At the end of each interview, the patient was asked for his views on the mental health profession. The middle-of-the-road patient criticized the profession for destroying traditional values; the radical criticized it as the handmaiden of a repressive society.

Each tape was played to a different audience of mental health professionals. After each section, the audiences were asked to rate the degree of pathology they observed in the patient. As you'd imagine, the first part of each tape (where the symptoms were the same) produced the same average rating--mild pathology. But as the interviewer delved into politics, the middle-of-the-road patient remained stable while the radical was seen as increasingly disturbed. Then as both patients began to criticize the mental health profession, their mental health took a grave turn for the worse. To test these extraordinary findings, the Braginskys revised the last section of the radical's tape, having him praise the profession. The new tape was shown to a new audience. Up until the end, the pattern established in the first experiment was duplicated--the radical was judged as increasingly disturbed as he expressed his New Left beliefs. But then, when he praised the mental health profession, the raters astonishingly promoted him to

normality.

Evidence like this suggests that institutional psychiatrists may be making the kinds of moral judgments from which society at large is prohibited by the equal protection clause and First Amendment to the Constitution. It strengthens one's belief that the adversary relationship between psychiatrists and patients' lawyers--which Dr. Kolb decries--must be heightened, not compromised. "Bringing these matters into court," Judge David Bazelon wrote in the June 1974 Scientific American, "does not impose an artificial adversary relationship between the patient and his keepers; it reflects an adversity that already exists."

Jeff Steingarten

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