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Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law

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CRAZY BEHAVIOR, MORALS, AND
SCIENCE: AN ANALYSIS OF
MENTAL HEALTH LAW

STEPHEN J. MORSE*

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People . . . . talk about "traumatic experiences" all the time. I wish they would quit it.

When they use that rubbery, nerveless expression, they cheat us out of what our language should make us feel about gruesome events. They should talk about wounding experiences and painful experiences and shocking experiences and crippling experiences and murderous experiences and so on, instead.

I have looked up the meaning of the word "traumatic" in a
For hundreds of years, the Anglo-American legal system has been developing special rules for dealing with problems caused by the inherently perplexing phenomenon of mentally disordered behavior.¹ In almost every area of civil and criminal law, from rules concerning preventive detention to rules concerning criminal responsibility, mentally disordered persons are treated differently from non-mentally disordered persons.

The purpose of this Article is to analyze in detail the social, moral, logical, and scientific bases of mental health law. The goals are to clarify the issues raised by mental health laws and to suggest how they ought to be understood and resolved. The first section introduces mental health law by exploring generally and briefly its nature and assumptions. The second section is the theoretical core of the Article. It examines in detail the three basic questions adjudicated by mental health law: Is the person normal?; Could the person have behaved otherwise?; and How will the person behave in the future? The first and second questions are demonstrated to be primarily social and moral. In addition, the discussion of the second question shows that craziness is only one cause of behavior among many and that it is a

¹. Throughout this Article, the term “behavior” will refer to thoughts, feelings, and actions and will not be limited to externally perceivable actions. The preference for the generic term behavior should not be interpreted to mean that the writer is an adherent exclusively of behavioral psychology.

As explored in greater detail below, mentally disordered behavior refers to thoughts, feelings, and actions that would be described by the word “crazy” or some similar term. The word “crazy” is used because in the author’s opinion it is, for legal purposes, the least question-begging and most accurate word to describe the behavior regulated by mental health laws. No disrespect or flippancy towards disordered persons or those individuals trying to help them is implied. See text accompanying notes 26-57 infra.

Legal problems created by mental retardation are related to those created by mental illness, but they are distinct and will not be considered in this Article.
much less powerful cause of legally relevant behavior than other factors, such as poverty, which are not usually considered legally relevant. The discussion of the third question, which concerns the prediction of future behavior, points out that data does not itself decide legal and moral questions and that, in any case, there is very little data or expertise with which to predict accurately future behavior.

The third section applies the theoretical and empirical arguments of the second section to an analysis of the proper role of expertise in mental health law decisionmaking and substantive mental health laws. It argues first that if the law continues to treat disordered persons specially, the role of experts should be limited. The present use of expertise obfuscates moral issues and promotes the mistaken view that the issues that concern the law are primarily scientific in nature. These issues in fact are primarily social and moral, and mental health professionals have little expertise in resolving social and moral questions. The third section then suggests that the law should not treat mentally disordered persons significantly differently from nondisordered ones because there is little persuasive scientific evidence that the former have significantly less control over their legally relevant behavior or are more predictable than the latter.

I. THE NATURE OF MENTAL HEALTH LAW

The legal system and mental health science are both concerned with understanding and controlling human behavior. In polar terms, the legal system approaches human behavior in terms of moral evaluation and the imposition of values, whereas mental health science approaches human behavior in terms of scientific, value-neutral, empirical investigation. Further, the legal model of behavior holds that persons have free will: persons choose their behavior and are thus morally and legally responsible for it. By contrast, the scientific model is deterministic: behavior, like all phenomena, is caused by its antecedents, and questions of moral and legal responsibility are irrelevant.2

In most instances, the differing approaches of the legal system and mental health science cause few difficulties. It is generally believed that the fundamental assumptions of the legal system adequately interpret and deal with the problems of normal behavior. The problems associated with mental disorder, however, cause a very different reaction. Society and the legal system have always been confused and often frightened by mental disorder.3

2. See notes 58-70 and accompanying text infra.
3. Rabkin, Opinions About Mental Illness: A Review of the Literature, 77 PSYCHOLOGICAL BULL. 153 (1972) and sources cited therein; Sarbin & Mancuso, Failure of a Moral Enterprise: Attitudes of the Public Toward Mental Illness, 35 J. CONSULTING & CLINICAL
Special legal rules seem compelled in response to problems created by disordered behavior because it intuitively seems that disordered persons are significantly different from most persons in fundamental ways. Most persons assume that almost everybody in their culture plays by the same behavioral and social rules they do, but that mentally ill persons do not. When the behavior of a normal individual causes a legal problem, it is believed that the same legal rules applicable to everyone else can be fairly applied to that person. Because the rules of disordered persons are not understood, however, society assumes that they must be different. While society assumes that most persons have free choice concerning their behavior, disordered persons are viewed as having little or no choice. Observers believe that persons who are normal would not freely choose to behave in a mentally disordered fashion. Consequently, when a disordered person engages in legally relevant behavior, the legal system must decide if it can properly apply the same generally applicable legal rules to persons who appear to be fundamentally different and to lack normal ability to control their behavior. The explanations of disordered behavior have changed over the centuries, but special legal treatment of disordered persons always has been bottomed upon the assumption of their fundamental difference from normal persons.

Applying special rules to the problems created by mental disorder raises fundamental moral and political issues. The special treatment authorized by mental health laws is usually based on the premises that the

Psychology 159 (1970); see Kirk, The Psychiatric Sick Role and Rejection, 161 J. Nervous & Mental Disease 318, 318, 324 (1975) (ascribing of psychiatric sickness to deviant behavior increases social rejection).


5. Gross, Mental Abnormality as a Criminal Excuse, in Philosophy of Law 466-76 (J. Feinberg & H. Gross eds. 1975). For a recent psychiatric opinion to this effect, see Chodoff, The Case for Involuntary Hospitalization of the Mentally Ill, 133 Am. J. Psychiatry 496 (1976). After describing the crazy behavior of some persons, Chodoff notes that "they are incapable by an effort of will of stopping or changing their destructive behavior. . . . [t]he must also be acknowledged that these severely ill people are not capable at a conscious level of deciding what is best for themselves. . . . " Id. at 498 (emphasis added). But see text accompanying notes 58-112 infra (analysis of the assumption that crazy persons have no free choice).
mentally disordered person is abnormal and less responsible causally, and thus legally, for his behavior than other persons. Application of mental health laws to a person, therefore, tends to deprive the actor of some form of liberty, autonomy, or dignity by confining him or by negating the usual legal significance of his actions. For example, mental health laws authorize preventive detention by civil commitment even though the person is not suspected of criminal behavior. Mental health laws also authorize a defense, in some instances, to the enforcement of contracts. The law's decision to treat a mentally disordered person specially, on the basis that there is something uncontrollably wrong with the actor's mind, is thus a decision fraught with social and moral implications.

The law recognizes these implications and generally presumes first, that persons are not mentally disordered and have control over their behavior and second, that persons should not be treated specially unless disorder and lack of control can be affirmatively shown. On the one hand, to treat disordered persons like everyone else seems counterintuitive and morally improper. On the other hand, to treat disordered persons differently, usually to their disadvantage in terms of freedom and autonomy, is equally morally improper unless there is a powerful justification for doing so.

Proponents of mental health laws claim that such laws are humane and that they enhance both the dignity of disordered persons and the moral climate of the society. They argue that it is unjust to treat persons who are incapable of behaving like everyone else as if they were so capable. Critics of these laws, however, believe that they diminish the dignity of

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7. Ortelere v. Teachers' Retirement Bd., 25 N.Y.2d 196, 250 N.E.2d 460, 303 N.Y.S.2d 362 (1969); J. MURRAY, MURRAY ON CONTRACTS § 14 (2d rev. ed. 1974). Of course, mentally disordered persons are not the only group protected from the enforcement of their contracts. Minors too, for example, enjoy special treatment. It is interesting to note that the justification is similar in both cases—members of the protected groups are considered incapable of protecting their rights.

8. 31A C.J.S. Evidence § 147 (1964) ("It is to be presumed that a person is mentally sound . . . ."). For example, the criminal law presumes that all defendants are sane. People v. Silver, 33 N.Y.2d 475, 310 N.E.2d 520, 354 N.Y.S.2d 915 (1974). Modern case law has recognized the social and moral implications of mental health laws; when actors may be legally disabled on the basis of alleged insanity, the burden of persuasion for proving mental health law criteria has been raised in areas such as civil commitment and quasi-criminal confinement from a "preponderance" to "clear and convincing" or "beyond a reasonable doubt." Stachulak v. Coughlin, 520 F.2d 931, 937 (7th Cir. 1975), cert. denied, 424 U.S. 947 (1976); In re Ballay, 482 F.2d 648, 667 (D.C. Cir. 1973); Lynch v. Baxley, 386 F. Supp. 378, 393-94 (M.D. Ala. 1974).

9. See note 5 and accompanying text supra.

10. Chodoff, supra note 5; see A. GOLSTEIN, THE INSANITY DEFENSE 9-22, 211-26 (1967); A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 43-82 (1972); American
Although disordered persons may indeed behave differently from most persons, critics claim that in many and perhaps most cases there is good reason to believe that mentally disordered persons are sufficiently like most people to be treated like all other persons and held responsible for their behavior. Thus, it erodes the moral climate of society and infringes on the rights of mentally disordered persons to subject them to special laws that deny their responsibility and consequently reduce their dignity. The choice between these two alternative views of the relevance of mental disorder to law clearly presents a difficult moral, social, political, and legal dilemma.

The difficulty in part explains the readiness of the legal system to turn to mental health experts—the professionals charged in our culture with the task of understanding, treating, and controlling mentally disordered behavior. Confronted with problems caused by mystifying behavior, the legal


It should be noted that the vast majority of commentary on mental health laws, both pro and con, deals with the insanity defense and civil commitment. Therefore, most examples in this Article will be drawn from or refer to these aspects of mental health law.


2. The professionals who have the most contact with and influence on the mental health legal system are psychiatrists, psychoanalysts, and psychologists. These professionals are believed to have special expertise concerning the description, causes, and treatment of disordered behavior. Because they play such a crucial role in the mental health legal system, it will be useful to have a brief description of their training.

The psychiatrist is a physician who specializes in the treatment of mental and emotional disorders. Although any physician may call himself a psychiatrist, the usual course of psychiatric training is for a new physician to enter postgraduate training, termed a psychiatric “residency.” Residencies are three- or four-year programs in psychiatric settings approved by the Council on Medical Education of the American Medical Association. A psychiatric residency is similar to other medical residencies; residents are trained largely by being responsible for much of the day-to-day patient care in the institution. Psychiatric residency training varies widely in quality, but usually includes experience with patients in various types of treatment settings, supervised training in methods of treatment, and some academic training in the theory and practice of psychiatry. Psychiatric training rarely involves much emphasis on normal psychology, other behavioral sciences, or behavioral science methodology; it is usually more clinical in orientation. After finishing the residency the psychiatrist may receive certification by passing an examination in psychiatry given by the American Board of Psychiatry and Neurology. If he or she is eligible to take the examination but has not passed, the psychiatrist is said to be “Board eligible.” If he or she passes, the psychiatrist is said to be “Board certified.”

A psychoanalyst is a person trained in the theory and practice of psychoanalysis.
system naturally turned to scientific experts for explanations and understanding. Much of the moral difficulty engendered by the issue of special treatment seems to be rendered moot if the question of how to treat disordered persons can be redefined from a legal question to essentially a medical

Psychoanalysis is one theory of human behavior and one form of psychotherapy, first developed by Sigmund Freud and then modified by later writers and practitioners. Psychoanalytic training and certification is usually conducted by private associations of analysts. There is nothing to prevent any psychotherapist from calling himself a psychoanalyst, but the appellation is usually reserved for graduates of psychoanalytic institutes. Although psychoanalysis is only one theory and method, trained psychoanalysts deserve separate attention because in the United States psychoanalysis and psychoanalysts have enjoyed singular influence compared to the other schools and practitioners of mental health science. In this country the psychoanalytic institutes have largely reserved their training for physicians, especially psychiatrists. Recently, increasing numbers of nonphysicians are being trained, and such psychoanalysts are called “lay analysts.” Psychoanalytic training usually involves three phases: First, the candidate undergoes a personal psychoanalysis; second, he engages in academic coursework concerned with the theory and practice of psychoanalysis; and third, he psychoanalyzes a small number of patients under the close supervision of senior members of his institute. Psychoanalytic training does not require the candidate’s full time (at most it requires a few hours a day), but because of the lengthy nature of psychoanalytic treatments (the candidate’s own analysis and those he conducts under supervision), the training usually takes over five years before the candidate is “graduated” as a psychoanalyst.

The psychologist has earned the Ph.D. degree in psychology. (Persons with bachelor’s or master’s degrees in psychology are called psychologists in some contexts, but the psychologists involved with the legal system nearly always have doctorates.) There are many specialty areas of psychology, but most psychologists who work in the mental health field are clinical psychologists, and therefore, this discussion shall focus on these psychologists. Training in psychology usually begins with two years of postgraduate coursework that emphasizes the specialty branch for which the student is training. Clinical psychologists take courses dealing with normal and abnormal psychology, human development, treatment methods, psychodiagnostics (including psychological testing), research methodology, and statistics. After completion of coursework, clinical psychology training requires the student to complete a year-long clinical internship in a program approved by the American Psychological Association. These programs are usually based in psychiatric hospitals (including community mental health centers) and offer the trainee supervised clinical experience in diagnosis, especially psychological diagnostic testing, and psychological treatment methods. Like psychiatric residencies, psychology internships vary widely in their quality. They usually offer the trainee supervised experience with a wide variety of patients, treatment settings, and treatment methods. After completing the internship, the psychologist must write a doctoral dissertation that is typically a major, empirical research effort. After finishing their dissertations and earning their doctorates, many clinical psychologists, especially those who wish to practice as well as to teach and do research, then enter postdoctoral programs of one to two years where they receive further clinical training. The vast majority of states now require that psychologists who practice with patients or consult in the community (as opposed to those who mainly teach and do research) be licensed. Although the licensing requirements vary from state to state, most states require the candidate to have completed one or two years of approved postdoctoral experience, and to pass an examination. In addition to licensing by the various states, psychologists with considerably more experience may qualify for a certification in clinical psychology given by the American Board of Professional Psychology. If the psychologist meets the requirements of the ABPP, he is then said to be a “Diplomate in Clinical Psychology.”

In addition to psychiatrists, psychoanalysts, and psychologists, there are other professionals such as psychiatric social workers and psychiatric nurses whose primary responsibility is
or scientific question.\textsuperscript{13}

The legal system, then, has come to rely primarily on the medical model of mental disorder that teaches, in part, that disordered behavior is a symptom of an underlying illness, a state that is not under the person's control.\textsuperscript{14} This assumption implies that the actor is not causally responsible for his disordered behavior. The situation is analogized to that of a person with an infection who is not held responsible for a consequent fever. If legally relevant behavior is the product of illness or disease rather than of free choice, a special legal response seems justified. Then, rather than having to rely on a discomfiting, intuitive justification for the different legal treatment of disordered persons, the legal system is comforted by the allegedly scientific justification offered by mental health science.

It is therefore not surprising that mental health science has had an enormous influence on mental health law. Much of the legal doctrine and operation of the mental health legal system depends on the assumptions and learning of mental health science. Most lawyers regard mental disorders as arcane and disturbing phenomena that are beyond their comprehension working with mentally disordered persons. Only the first three groups, however, have significant contact with the mental health legal system.

\begin{itemize}
\item Bazelon, \textit{Can Psychiatry Humanize the Law?}, 7 Psychiatric Ann. 292, 295 (1977);
\item Hardisty, \textit{Mental Illness: A Legal Fiction}, 48 Wash. L. Rev. 735 (1973);
\item Horstman, \textit{Protective Services for the Elderly: The Limits of Pares Patriae}, 40 Mo. L. Rev. 215, 225-29 (1975);
\item Suarez, \textit{A Critique of the Psychiatrist's Role as Expert Witness}, 12 J. Forensic Sci. 172 (1967);
\end{itemize}


Although the “medical model” is a complex construct that is often oversimplified and misunderstood, the statement in the text is one fundamental tenet of the model. Generally, the “sick” role in our society includes the assumption that the person’s illness or consequent incapacity is not his voluntary act and he is therefore not responsible for it. T. Parsons, \textit{Definitions of Health and Illness in the Light of American Values and Social Structure}, in \textit{Social Structure and Personality} 257, 274 (1970); Kirk, \textit{supra} note 3, at 318-19, 323-24; Siegler & Osmond, \textit{The 'Sick Role' Revisited}, 1 Hastings Center Stud. 41, 46 (1973).

and are understood by only a few highly trained experts. They view the response to problems created by mental disorder as primarily the concern of mental health professionals. Lawyers therefore tend to defer to mental health experts, and mental health law decisions at all levels, especially if the proceedings are not truly adversary, are often based more on psychiatric reasoning and conclusions than on legal reasoning.

In addition to claiming that there is scientific justification for treating the mentally ill differently, some advocates of this strong influence also argue that decisions about the competence, freedom, and responsibility of mental health professionals. Lawyers therefore tend to defer to mental the mentally ill differently, some advocates of this strong influence also argue that decisions about the competence, freedom, and responsibility of mental health professionals. Lawyers therefore tend to defer to mental health professionals.


For an account of the medical model of psychiatry in law (the following of which is confined largely to the U.S. Court of Appeals for the District of Columbia), see Wales, The Rise, The Fall, and the Resurrection of the Medical Model, 63 GEO. L.J. 87 (1974).

This Article will not attempt to resolve the dispute about whether a medical or illness model of disordered behavior is useful. The position taken here is that the illness model may or may not be useful depending on the context in which one is considering the behavior that might be labeled as ill. Thus, whereas an illness model might be useful for clinical or research purposes, it might not be for legal purposes. It will be argued that uncritical acceptance of all possible implications of a medical or illness model of disordered behavior is mistaken when legal decisionmaking is involved. See note 43 infra.


This point has been demonstrated empirically in numerous studies of civil commitment (proceedings that are rarely truly adversary) in which the legal decisionmaking is almost completely perfunctory and in which the concordance rate between psychiatric opinion and ultimate legal disposition is extraordinarily high. Cohen, supra note 15, at 427-31 (in a sample of 40 commitment cases observed, all defendants were committed in accordance with psychiatric recommendation at perfunctory hearings); Fein & Miller, Legal Processes and Adjudication in Mental Incompetency Proceedings, 20 SOC. PROB. 57, 58, 60 n.2 (1972) (in a sample of 756 commitment cases, there was perfunctory adjudication in concordance with expert recommendation of examining committee composed of two physicians and one layman in all but two cases; in the two cases of court disagreement with the committee recommendation, there were unusual circumstances that indicated that the judge did not necessarily disagree with the experts); Maisel, Decision-Making in Commitment Court, 53 PSYCHIATRY 352 (1970) (in a sample of approximately 50 commitment hearings, no exact figures given, but by implication it seems clear that expert recommendations were perfunctorily followed in all cases, including those in which there was no tangible evidence of mental illness); Miller & Schwartz, County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospit-
Commitment decision; Scheff, The Societal Reaction to Deviance: Descriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State, 11 Soc. Prob. 401, 405 (1964) (in a sample of 116 judicial commitment hearings, psychiatrists recommended commitment in all cases, and all defendants were committed after a perfunctory hearing even though there was no evidence of craziness in some); Scheff, The Societal Reaction to Deviance: Descriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State, 11 Soc. Prob. 401, 405 (1964) (in a sample of 116 judicial commitment hearings, psychiatrists recommended commitment in all cases despite lack of evidence in many; in informal discussions, judges and other court officials noted that they would rarely release a person against the advice of the experts); Wexler, The Effect of Legal Counsel on Admissions to a State Mental Hospital, A Confrontation of Professions, 10 J. Health & Human Behavior 66 (1969) (in a sample of 81 commitment cases, 80% of defendants were committed and 20% released, all in accordance with expert recommendation; legal decisionmaking was largely perfunctory; extremely high statistical association [Q = .942] was noted between representation by attorney and decision not to hospitalize); Wexler, Special Project, The Administration of Psychiatric Justice: Theory and Practice in Arizona, 13 Ariz. L. Rev. 1, 60 & n.193 (1971) (in samples of 196 commitment cases in one county and 367 in another, physicians' recommendations perfunctorily followed in 97.9% and 96.1% of cases, respectively; where physician's recommendation not followed, the judge was usually precluded from doing so because the recommendation was not provided for by statute).

Even under "reformed" procedures in which defendant-patients have greater due process protections, the concordance rate is still extremely high. Hiday, Reformed Commitment Procedures: An Empirical Study in the Courtroom, 11 Law & Soc'y Rev. 551, 660-64 (1977) (77% concordance; in 15.6% of contested cases, judge committed patient in concordance with psychiatric recommendation despite lack of evidence of statutorily required danger; but hearings were longer than those reported in previous studies and decisionmaking was considerably less perfunctory). A recent, fascinating study examined the differential nature of commitment hearings in two counties in Wisconsin, one of which followed the stringent due process requirements of Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), and one of which did not. In the former, trials averaged 13 minutes, decisionmaking was perfunctory, and the court followed psychiatric advice in most cases. In the latter, trials averaged 2 1/2 hours, there was true adjudication of the issues, and the court made an independent determination of whether the statutory criteria were met. Zander, Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt, 1976 Wis. L. Rev. 503, 552.

Numerous appellate decisions, both old and new, also confirm the truth of the statement in the text. E.g., In re Oakes, in 8 The Law Reporter 122 (P. Chandler ed. 1846). "Dr. Fox [the expert witness] testifies that he has no doubt that Mr. Oakes is insane. His opinion must have great weight in this case, from his skill and experience in the treatment of insanity. ... If we cannot rely upon the opinion of those who have charge of the institution, and there is no law to restrain the persons confined, we must set all the insane at large who are confined in the McLean Asylum." Id.; see Sis v. Maryland, 334 F.2d 56, 511 (4th Cir. 1964) (expert findings and conclusions are to be given serious consideration and must be relied on to a considerable degree in defective delinquent proceedings); Logan v. Arafah, 346 F. Supp. 1265, 1267-70 (D. Conn. 1972) (denied due process challenge to length of pretrial hearing on civil commitment; decision based on testimony of expert witnesses), aff'd sub nom. Briggs v. Arafah, 411 U.S. 911 (1973); Commonwealth v. Mutima, 366 Mass. 810, 333 N.E.2d 294, 298 (1975) (defendant convicted by jury of first degree murder; prosecution relied on presumption of sanity and defense introduced psychiatric testimony about defendant's insanity; held, verdict against the weight of the evidence); People ex rel. Rogers v. Stanley, 17 N.Y.2d 256, 260-61, 262-64, 217 N.E.2d 636, 637-39, 270 N.Y.S.2d 573, 574-75, 576-78 (1966) (Bergan, J., dissenting) (right to counsel in civil commitment should be denied because it will interfere with proper medical treatment).
the allegedly disordered person should be made primarily by experts. Mentally disordered persons are allegedly so abnormal that legal decision-making about them is largely irrelevant. The legal factfinders and law-appliers must, of course, "make" the final decision; but, it is argued, the major influence on these decisions should be the experts who understand the behavior. The essential moral and legal nature of questions of freedom, competence, and responsibility then come to be seen as proper questions for largely expert determination. Some proponents of this view believe that

Numerous commentators have also noted the legal abdication to psychiatric experts. See sources in note 13 supra; LAW REFORM COMMISSION OF CANADA, FITNESS TO STAND TRIAL 7 (1973); Bazelon, Institutional Psychiatry—"The Self Inflicted Wound," 23 CATH. U.L. REV. 643 (1974); Dershowitz, supra note 11; Halleck, The Psychiatrist and the Legal Process, PSYCHOLOGY TODAY, Feb., 1969, at 25.

In recent years, there has been increasing judicial recognition of the fact that the issues involved in mental health cases are fundamentally legal and that overreliance on experts is a danger. See Humphrey v. Cady, 405 U.S. 504, 509-10 (1972); United States v. Brawner, 471 F.2d 969, 1006 (D.C. Cir. 1972); Washington v. United States, 390 F.2d at 446; Lessard v. Schmidt, 349 F. Supp. 1078 (D.D. Wis. 1972), vacated and remanded on procedural grounds, 414 U.S. 473, new judgment entered, 379 F. Supp. 1376, 1378 (E.D. Wis. 1974), vacated and remanded, 421 U.S. 957 (1975) (for reconsideration in light of Huffman v. Pursue, Ltd., 420 U.S. 592 (1975)), reaf't'd, 413 F. Supp. 1318 (E.D. Wis. 1976). For an interesting case that upheld allowing a criminal prosecution to go to the jury although expert testimony that the defendant was insane was unanimous and rebutted only by cross-examination and lay evidence, see United States v. Dube, 520 F.2d 250, 251 (1st Cir. 1975).

Of course, where proceedings are truly adversary and each side has psychiatric as well as legal representation, there cannot be simple judicial concordance with one expert. Still, as Washington and Brawner discuss, experts often dominate the proceedings and the issues are defined as scientific. See notes 12-16 and accompanying text supra.


More recently, medically oriented writers have taken note of the changing legal climate exemplified by Lessard, and have argued that significant due process rights must be granted to civilly committed. American Psychiatric Association, supra note 10. A fair reading of many current writers is that the decision still ought to be largely medical even if much due process is granted. Chodoff, supra note 5; Treffert, supra note 10; Psychiatric News, Aug. 5, 1977, at 5, col. 1 (a code of ethical guidelines to be considered for adoption by the World Psychiatric Association).

Whenever there is compulsory treatment or detention of a person on psychiatric grounds, that person must have available an appeal, with legal aid, to a panel of psychiatrists . . . .

Id. at 5 (emphasis added). The draft of ethical guidelines finally adopted in principle by the entire World Psychiatric Association provided:

Whenever there is compulsory treatment or detention there must be an independent and neutral body of appeal for regular inquiry into these cases.

Psychiatric News, Oct. 7, 1977, at 23, col. 1. The American Psychiatric Association criticized the W.P.A. draft because it was "vague" and "subject to broad interpretation," and because it "did not mandate a psychiatrically knowledgeable panel." The A.P.A. continues to prefer appeal, with legal aid, to a panel of psychiatrists. Id. at 22. See generally Blomquist, From the Oath of Hippocrates to the Declaration of Hawaii, 4 ETHICS SCI. & MED. 139 (1977).
these issues are resolved by the legal system only because of an historical precedent based on America’s perhaps overzealous guarding of liberty.18

To explore the tension between legal and scientific decisionmaking further, Section II analyzes the social, moral, logical, and scientific bases of mental health law.

II. MORALS AND SCIENCE IN MENTAL HEALTH LAW

A. INTRODUCTION

The structure of all mental health laws is fundamentally the same; all require findings of (1) a mental disorder; (2) a behavioral component; and (3) a causal connection between the mental disorder and the behavioral component (at least in principle).19 For instance, civil commitment is usually based on findings that the person is: (1) mentally ill; (2) dangerous to self or to others, or gravely disabled; and (3) that the dangerousness or grave disablement is a product or result of the mental disorder or defect.20 A person is incompetent to stand trial if he is mentally ill and therefore unable to understand the charges against him or to assist counsel.21 Guardianship or conservatorship may be imposed upon an individual if he is mentally ill and therefore unable to care for himself or his property.22


19. E.g., Cal. Welf. & Inst. Code § 5250 (West 1972) (“[T]he person is, as a result of mental disorder . . . .”); Weihofen, The Definition of Mental Illness, 21 OHIO ST. L.J. 1 (1960). The causal connection criterion is often not recognized or stated explicitly by commentators (including Weihofen) and mental health statutes. The causal criterion is always implicit, however, and in probably the substantial majority of statutes it is included by terms such as, “as a result of” or “because of.” The causal connection criterion is a reflection of the critical rationale of mental health law—that the legally relevant behavior of mentally disordered persons is a product of their mental disorder and not of their free choice. See text accompanying notes 58-112 infra.


21. Drope v. Missouri, 420 U.S. 162 (1975); Dusky v. United States, 362 U.S. 402 (1960) (per curiam); Cal. Penal Code § 1367 (West Supp. 1977). Although some statutes and cases do not make specific reference to mental disorder as the cause of the incompetence, it is nearly always the case that incompetence will be found only if a mental disorder or defect is present. Stutlen & Tullis, Mental Competency in Criminal Proceedings, 28 HASTINGS L.J. 1053, 1053-54 (1977); see Home Office, Department of Health and Social Security, Report of the Committee on Mentally Abnormal Offenders 143 (1975).

Two points concerning the behavioral component of mental health laws must be noted. First, in all cases the behavioral component of the law is the primary impetus for legal regulation. What disturbs society, for example, is an individual's dangerousness, grave disablement, inability to assist counsel, or inability to manage his financial affairs. In other words, society believes that it must protect itself from dangerous persons, that it must protect disabled persons from themselves, that a criminal trial is unfair unless certain conditions are met, and that it is inhumane to let an incompetent person mismanage his property. Second, the behavioral standards alone, such as dangerousness or various incompetencies, also appear in the conduct of normal persons. The behavior is neither necessarily related to mental health problems nor is it exclusively or especially within the province of mental health science.

Mental illness alone does not warrant special legal intervention: a person who is simply mentally ill is left alone unless he behaves in one of the legally relevant ways described by the behavioral components. But when mentally disordered persons behave in legally relevant ways, such as dangerously or incompetently, special rules apply to these individuals that do not apply to "normal" dangerous or incompetent persons. For example, extremely dangerous but nonmentally disordered persons, even those who might be "reformed," are not preventively confineable by civil commitment upon the basis of dangerousness alone.

It is noteworthy that the special legal treatment of disordered persons is authorized even though the vast majority of mentally disordered persons do not meet the behavioral components of the mental health law standards and many normal persons do meet these behavioral standards. In other words, the mentally ill, as a class, are not especially dangerous or incompetent.

23. This Article will refer to the various behavioral components of the standards as "legally relevant behavior."

But, despite the over- and under-inclusive nature of mental disorder as grounds for furthering the social goals that are explicitly or implicitly identified by the behavioral component of mental health laws, the law is clearly instilled with the idea that mental disorder should authorize special treatment.

Mental health law standards are therefore legal rules that have been created to further the social goals identified above. As discussed in Part I, mentally disordered persons have been singled out for special legal treatment because it is believed that it is morally and socially inappropriate to treat them like everyone else. The moral and legal basis for this special treatment depends on three factual assumptions concerning mentally disordered persons: (1) They are significantly different from most persons because they are ill; (2) their legally relevant behavior is the product of their illness and not of their free, rational choice; and (3) their future behavior is predictable. The validity of these assumptions, especially the first two, is the foundation of mental health law. Only if a person is abnormal, non-responsible, and in some cases predictable should he or she be accorded special legal treatment.

Flowing from the structure and assumptions of mental health law, three general questions must be decided:

1. Is the person normal? That is, is the actor suffering from a mental disease, illness, or disorder?
2. Could the person have behaved otherwise? Is the legally relevant behavior the product of free choice, or is it the product of a disordered mind over which the person has no control? That is, is the person causally responsible for the behavior?
3. How will the person behave in the future? For instance, will the person be a danger to self or to others?

This section analyzes in detail the social, moral, logical, and scientific bases
of mental health law by examining the three questions.\textsuperscript{25}

The thesis of this Article is that these questions are fundamentally social, moral, and legal questions, not scientific ones. Although they appear to call for scientific answers, in fact they can be answered best on the basis of commonsense observations and social, moral, and commonsense evaluations of behavior. Further, many commonly believed assumptions about mentally disordered persons that are used to answer these questions are not scientifically proven. Experts may be useful in providing certain factual information, but the primary issues are not scientific. Hard moral issues raised by mental disorder should not be avoided by relying upon experts and allowing the questions to be “medicalized.”

B. IS THE PERSON NORMAL?

The first question asked by mental health law is whether the actor is normal, \textit{i.e.}, whether he or she suffers from a mental disorder. It must be remembered that the legal system does not ask this question primarily for scientific or clinical reasons. Rather, the law asks this question in order to identify a class of persons who seem so inexplicably different from ordinary people that, on moral and social grounds, generally applicable legal rules cannot apply to them.

\textsuperscript{25} A substantial portion of the argument in this section and the remainder of the Article depends heavily on the findings of mental health science and the writer's assessment of those findings. It is, of course, impossible to know or to cite every study that may be relevant to the broad statements that are made herein about mental disorder. Broad statements will therefore be supported either by reference to authorities who agree or to representative studies that support the position taken. At present, there can be few correct answers—the mental health field is too vast and is beset by too many methodological and substantive ambiguities and uncertainties. Before beginning the analysis, therefore, it will be helpful to set forth a brief statement of why knowledge is so hard to achieve in mental health science.

Research on mental disorder, which involves primarily research on human behavior, is at best difficult to perform—few certain conclusions can be reached. Although there are many reasons for the lack of certainty, two deserve special notice here: the imprecision in defining and categorizing mental disorder, and the difficulty in devising adequate tools for measuring human behavior. Chapman, \textit{Schizomimetic Conditions and Schizophrenia}, 33 J. Consulting & Clinical Psychology 646, 648 (1969); see Spitzer, Endicott, & Robins, \textit{Clinical Criteria for Psychiatric Diagnosis and DSM-III}, 132 Am. J. Psychiatry 1187 (1975). It is indeed difficult to reach firm conclusions about any aspect of mental disorder when there is little agreement about the boundaries of the condition being studied and when there are few reliable and valid tools with which to perform the studies. Progress is being made in these regards, but the essential problems remain. See, e.g., Helzer, Robins, Taiseleson, Woodruff, Reich, & Wish, \textit{Reliability of Psychiatric Diagnosis: I. A Methodological Review}, 34 Archives of General Psychiatry 129 (1977); text accompanying notes 26, 29-30, 54, 161-77 infra.

For discussions of these definitional difficulties in the context of the conditions most relevant to legal issues, see Kendell, \textit{The Classification of Depressions: A Review of Contemporary Confusion}, 129 Brit. J. Psychiatry 15 (1976); van Praag, \textit{About the Impossible Concept of Schizophrenia}, 17 Comprehensive Psychiatry 481 (1976); Treves-Brown, \textit{Who is the
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What, therefore, is mental disorder and how is it to be discerned? This section will demonstrate that mental disorder is crazy behavior, and that its definition is primarily a function of social expectations and context. The section will then argue that for legal purposes determinations of who is crazy can, and should be, viewed as social and moral determinations that generally can be made by anyone.

1. What is Mental Disorder?

Mental disorder is abnormal behavior—abnormal thoughts, feelings, and actions. Although the terms "mental disorder" or "mental illness" connote that something more than abnormal behavior is wrong with the person, it must be emphasized that a diagnosis or label of mental disorder means primarily that a person behaves abnormally. "Mental disorder" does not imply any necessary, scientifically proven findings about recognized underlying causative abnormalities of the person's brain, nervous system, heredity, diet, hormonal balance, past history, sexual conflicts, social envi-


On the difficulties of psychiatric and behavioral classification and measurement, see generally T. Barber, Pitfalls in Human Research (1976); G. Frank, Psychiatric Diagnosis: A Review of Research (1975); R. Kendell, The Role of Diagnosis in Psychiatry (1975); Berman & Kenny, Correlational Bias in Observer Ratings, 34 J. Personality & Soc. Psychology 263 (1976); Blashfield & Draguns, Evaluative Criteria for Psychiatric Classification, 85 J. Abnormal Psychology 140 (1976) [hereinafter cited as Evaluative Criteria]; Blashfield & Draguns, Toward A Taxonomy of Psychopathology: The Purpose of Psychiatric Classification, 129 Brit. J. Psychiatry 574 (1976); Kazdin, Artifact, Bias, and Complexity of Assessment: The ABCs of Reliability, 10 J. Applied Behavior Analysis 141 (1977); note 54 infra. For a penetrating methodological guide to the analysis of behavioral science for purposes of applying it to legal problems, see Meehl, Law and the Fireside Inductions: Reflections of a Clinical Psychologist, 27 J. Soc. Issues 65 (1971). As we have seen, moreover, note 14 supra, there is enormous debate about the entire enterprise of considering abnormal behaviors as illness. Many writers feel that studying abnormal behavior on this basis is theoretically and morally misconceived and that knowledge about disordered behavior will inevitably be flawed.

The two most complete, albeit highly critical, reviews of mental health science literature pertaining to legal questions are J. Ziskin, Coping with Psychiatric and Psychological Testimony (2d ed. 1975) and Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Calif. L. Rev. 693 (1974).

Finally, nearly all references are to the literature of adult mental health science. It should be noted, however, that the conclusions of this Article apply to child and adolescent mental health science as well. Morse, Psychological and Psychiatric Issues, in J. Wilson, The Rights of Adolescents in the Mental Health System 81-122 (1978).


Rather than citing authorities to demonstrate the truth of the statement in the text, however, it is better simply to consult the American Psychiatric Association's Diagnostic and Statistical Manual II (1968) [hereinafter cited as DSM-II]. In DSM-II the criteria for all disorders, including those allegedly associated with physical pathology, are abnormal thoughts.
feelings, and actions. If a physical disorder is not accompanied by behavioral abnormality, mental disorder is not considered present. If the abnormal behavior is present, however, mental disorder is diagnosed whether or not physical pathology is allegedly associated with it. For instance, consider the generic definition of "psychosis," generally the most severe class of mental disorders:

Patients are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. The impairment may result from a serious disturbance in their capacity to recognize reality. Hallucinations and delusions, for example, may distort their perceptions. Alterations of mood may be so profound that the patient's capacity to respond appropriately is grossly impaired. Deficits in perception, language and memory may be so severe that the patient's capacity for mental grasp of his situation is effectively lost.

The only possible exception to the general rule is the class of disorders termed "psychophysiological disorders." These disorders are characterized by physical symptoms and are diagnosed by the presence of such symptoms. They are considered mental disorders because they are "presumably" of psychogenic origin. Id. at 46.

The American Psychiatric Association is currently testing a new diagnostic nomenclature, Diagnostic and Statistical Manual III (Draft of 4/15/77) [hereinafter cited as DSM-III]. Although DSM-III has not yet been adopted, it has met with initial favorable reaction by its preliminary users. Psychiatric News, Sept. 16, 1977, at 1, col. 4. But see Goleman, Who's Mentally Ill?, Psychology Today, Jan., 1978, at 34 (considerable dispute about scientific validity, overinclusiveness and usefulness of DSM-III categories). It appears likely to be adopted in a form substantially similar to the present draft. Like DSM-II, DSM-III includes categories wherein abnormal behavior is associated, for example, with transient or permanent dysfunction of the brain (e.g., "Organic Mental Disorders"), but abnormal behavior is still the touchstone of diagnosis in all categories. For example, consider the DSM-III generic definition of "schizophrenic disorders" (a subset of disorders considered to be psychoses by DSM-II):

A group of disorders characterized by a disorganization of a previous level of functioning involving multiple aspects of psychological functioning... As defined here, at some time during the illness a Schizophrenic Disorder always involves at least one of the following: delusions, hallucinations, or formal thought disorder... (U)usually there are several characteristic disturbances in the form and content of thinking, perceptions, affect, the sense of self, volition, relationship to the external world, and motor behavior.

DSM-III, supra, at C1. As is apparent, "Schizophrenic Disorders" refers to abnormal thoughts, feelings, and actions. DSM-III used the following criteria for characterizing behavior as a mental disorder:

By and large, all of the conditions included in DSM-III as mental disorders share the following features: in their extreme or fully developed form, they are directly associated with either distress, disability, or, in the absence of either of these, disadvantage in coping with unavoidable aspects of the environment. Furthermore, they are not quickly ameliorated by simple nontechnical environmental maneuvers or imperative procedures and do not have widespread social support. Because of these features, there is an implicit assumption that something is wrong with the human organism and that there is a call to the profession to develop and offer preventive or therapeutic measures. (This does not imply exclusive responsibility on the part of the psychiatric profession to deal with these conditions).

Three examples of the application of these principles in defining mental disorder follow. Personality disorders are included in DSM-III as mental disorders and are distinguished from personality traits (which are not included) on the basis of the presence of either subjective distress or impairment in social functioning. Simple bereavement is not considered a mental disorder, even though the clinical features are very similar to those seen in depressive disorders, because it is an expected and socially supported reaction. Finally, antisocial behavior is not by itself considered sufficient evidence for the existence of a mental disorder. The diagnosis of Antisocial Personality Disorder in DSM-III not only requires persistent antisocial behavior but also persistent impairment in social and occupational functioning.

Spitzer, Sheehy, & Endicott, DSM-III: Guiding Principles, in Psychiatric Diagnosis I, 3-4 (V. Rakoff, H. Stancer, & H. Kedward eds. 1977),
tonment, or other variables.\textsuperscript{27} Statements that relate such variables to abnormal behavior properly should be considered hypotheses about which varying amounts of supporting evidence have accumulated and that need further testing.\textsuperscript{28} Eventually, research may establish definite, necessary links between purportedly pathogenic factors and mental illness.\textsuperscript{29}

\textsuperscript{27} The term "necessary" in this sentence means that mentally abnormal behavior can occur in the absence of any demonstrably significant abnormality in any of these factors, either taken alone or in sets. See text accompanying notes 28, 71-83 infra.


We still debate the fundamental basis of the most common psychiatric diagnoses and their relationship to belief systems and the realities of social structure. The contrast with most somatic ills is clear enough; if there are indeed biological mechanisms underlying even the most marked psychiatric syndromes we cannot as yet define them; if there are none, we are equally unable to demonstrate their absence; if their etiology should depend on some particular interaction of constitutional endowment and environmental stress we cannot define that relationship in more than the vaguest of terms. Every aspect of psychiatry, from its most general social conditions to the level of individual interaction between physician and patient, is inevitably shaped by extramedical factors—with comparatively few defining technological boundaries.

\textit{Id.} at 137.

By and large, the research literature on retrospective data for persons who have become mentally ill shows only rather weak (and frequently inconsistent) statistical relations between purportedly pathogenic background factors and mental illness.\textsuperscript{30} Even those antecedent conditions which do show some association are ambiguous concerning causal interpretation.\textsuperscript{31}


Biochemical studies of psychiatric patients have revealed many abnormalities, but have failed to identify specific biochemical changes linked to the pathophysiology of the illnesses.\textsuperscript{32} Unfortunately, the search for a relationship between biochemical abnormalities and mental illness has been disappointing. Many abnormalities have been found in different groups of patients, but almost all of these have occurred in patients with very different clinical syndromes and even in some clinically normal people.


The very multiplicity of these conditions that produce behavior at least superficially akin to schizophrenic symptoms casts doubt on the validity of the argument for any one of them. The following is at least a partial list of these allegedly schizomimetic conditions that have been invoked as evidence for a particular theory of schizophrenia: 1. LSD, mescaline, and other drugs. 2. Sensory deprivation. 3. Sleep deprivation. 4. Hypnosis. 5. Speeded performance. 6. Distraction. 7. Relaxed Attention. 8. Disruption of perception. 9. Anoxia. 10. Brain damage. 11. Childhood. 12. "Primitive" racial development. 13. Dreams and sleep.


More optimistic statements to the contrary can, of course, be found. For examples of optimistic statements by a world-famous researcher concerning the alleged biological causes of some mental disorders, see Kety, The Biological Roots of Schizophrenia, \textit{Harv. Mag.}, May 1976, at 20; Kety, supra note 14. Dr. Kety's optimism stems from a very persuasive program of research performed by himself and others that links schizophrenia to a genetic predisposition. Indeed, this interesting example of the state of the art is probably the strongest evidence in mental health science of a linkage between an organic background factor and psychiatric abnormality. The research demonstrates, however, that a genetic predisposition is neither necessary nor sufficient to produce the abnormal behavior labeled schizophrenia. \textit{See, e.g.}, Wender, Rosenthal, Rainer, Greenhill, & Sarlin, Schizophrenics' Adopting Parents: Psychiatric Status, 34 Archives of General Psychiatry 777, 784 (1977). Further, if schizophrenia
tween some abnormal behavior and given variables, but such findings are not at hand; mental health science does not know yet what the critical causal variables are or how powerfully they operate.

Mental disorder is thus diagnosed by observing the person's behavior. There are no physical tests for the presence or absence of mental disorder. Statements about underlying disease processes, whether based upon interviews, psychological tests (which are simply more or less structured behavior samples), or other observations are theoretical speculations. Behavior is the only data in mental health diagnosis that all diagnosticians would agree is relevant.

Since abnormal behavior is the bedrock of mental health diagnosis, the inquiry in this section must ask what it means to say that behavior is abnormal and what kinds of abnormal or deviant behavior compel the label behavior does have a genetic causal component, the mechanism of transmission is not known nor has an abnormality in the genetic material of schizophrenics been discovered. See generally D. ROSENTHAL, GENETICS OF PSYCHOPATHOLOGY 59-116 (1971). For a critical appraisal of the research linking schizophrenia to a genetic predisposition, see Lidz, Commentary on "A Critical Review of Recent Adoption, Twin, and Family Studies of Schizophrenia: Behavioral Genetics Perspectives," 2 SCHIZOPHRENIA BULL. 402 (1976).

It is often believed that because a particular form of intervention is sometimes successful in changing abnormal behavior, the cause of the abnormal behavior must be related to the treatment method. Thus, for example, if chemical agents or psychological methods are successful, it is believed that the source of abnormal behavior must be biochemical or psychological. This is a common misconception known as the treatment-etiopathology fallacy. A treatment method might very well change behavior without having much or anything to do with the primary cause of the behavior. Durell, Introduction, in BIOLOGICAL PSYCHIATRY 4-5 (J. Mendels ed. 1973). For example, imagine the case of a person who becomes depressed after hearing some very bad news. The cause of the depressed mood is quite clearly the bad news, a primarily psychological event, yet the person might feel much better after ingesting a biochemical agent such as alcohol. The efficacy of the alcohol in improving mood would not indicate that the primary cause of the behavior was biochemical.

For a discussion of some of the reasons why knowledge of etiology is hard to achieve, see note 25 supra.

29. Because the touchstone of diagnoses of disorder is behavior, diagnoses can be made only by observing overt actions including speech, or by making inferences about covert thoughts or feelings derived from observations of overt actions (e.g., speech, posture, facial expressions, and other actions). Mental health diagnoses can be made by observing the person's everyday behavior, behavior in clinical interviews, behavior on various tests, and the like. See R. WOODRUFF, D. GOODWIN, & S. GUZE, PSYCHIATRIC DIAGNOSIS 31 (1974).

30. See, e.g., AMERICAN MEDICAL ASSOCIATION, CURRENT MEDICAL INFORMATION AND TERMINOLOGY 366-67 (4th ed. 1971). Inspection of the listings for the various mental disorders demonstrates that there are no laboratory tests or other physical procedures for identifying mental disorders. See also notes 54, 168-71 and accompanying text infra. Of course, there are such tests for diagnosing the various physical disorders that are associated with some mental disorders. It must be remembered, however, that a diagnosis of mental disorder is made primarily on the basis of observations of abnormal behavior, whether or not physical disorder is also present. See note 26 supra. In general, physical pathology is neither necessary nor sufficient to justify a diagnosis of mental disorder. Where physical disorder must be associated...
"mental disorder" as opposed to some other label. This discussion must consider whether it is possible to determine the normality of behavior without reference to social and moral value preferences and expectations. If it is not possible, then it should be recognized that the determination of normality is largely a moral and social determination, and not primarily a scientific conclusion based on the measurement of objective criteria.

One meaning of abnormal is that the actor's behavior is statistically abnormal: it is behavior that occurs very infrequently. Being an exceptionally fast or slow reader or runner are examples of statistically abnormal behavior. Violent criminal behavior is also statistically abnormal. Of course, deciding how infrequent a behavior must be before it is labeled "abnormal" is not a scientific decision; rather, it is a decision based on value preferences. A social consensus about normality may depend to some extent on accurate knowledge of the frequency with which particular behavior occurs in society. Many actions that might be labeled "abnormal" in the absence of data about frequency might be redefined as "normal" by laypersons if they were aware that a large portion of their friends and neighbors engaged in such behavior. Thus, large-scale studies that investigate the prevalence of particular behavior in a population might be useful.

Data about frequency might influence values and judgments, but the question of whether behavior—whatever its frequency—is abnormal would still be a question of social values, rules, and expectations. Let us take I.Q. as an example. The I.Q. scales were constructed so that a simple calculation can determine how many persons in our society have a given I.Q. or how many have an I.Q. score above or below that point. Suppose society wishes to develop special programs to meet the needs of exceptional children—those who are abnormally bright or abnormally slow (in both a

...with abnormal behavior in order to make a particular diagnosis, e.g., "organic mental disorders" in DSM-III; then, of course, lab tests will be necessary but not sufficient. One may question whether it is useful to consider abnormal behavior clearly caused primarily by physical disease to be mental disorder. See text accompanying notes 74-83 infra. 31. Examples of other common labels for deviant behavior are "sinful," "immoral," and "criminal." See H. Steadman & J. Cocozza, supra note 24, at 140-42; Morality and Mental Health 177-78, 270-75 (O. Mowrer ed. 1967); Aubert & Messinger, The Criminal and the Sick, 1 Inquiry 137, 141 (1958); Shah, Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior, 53 Mental Hygiene 21, 21-25 (1969). 32. Of course, such studies and studies on any other point will only be useful if they are reliable and valid. See sources cited in note 25 supra, and text accompanying notes 161-77 infra. 33. D. Wechsler, The Measurement and Appraisal of Adult Intelligence (4th ed. 1958). This Article is not the appropriate forum to argue the merits of I.Q. testing. The skeptical reader is asked to assume only for the purpose of discussion that I.Q. tests do measure intelligence and that intelligence measured by the tests is related to performance on intellectual tasks.
commonsense and a statistical sense). The issue would be where to put the cutting point for determining who is an abnormally bright or an abnormally slow child.

Drawing this line is a clear example of a social determination with respect to abnormality. The cutting point of abnormality on a frequency distribution is not dictated by scientific data. Where the line will be drawn depends on the social purposes and preferences for which it is being drawn. Objective statistical statements are those that simply state the frequency (or probability of occurrence) of the behavior without evaluating that frequency; the evaluation is a social judgment.

A second meaning of abnormal refers to behavior that is dysfunctional—behavior that seems poorly suited to achieve the goals the person sets for himself or are set for him by social expectations. The professional writer who cannot write because he has writer's cramp is behaving abnormally in this sense, as is the family wage earner who cannot work because he or she feels too “down.” Whether a particular behavior is considered dysfunctional and the extent to which it must be dysfunctional in order to be considered abnormal depends on personal and social expectations and preferences, and not simply on the nature of the behavior itself. A person with an abnormally short attention span, for example, may be unable to function as a radar operator but might do very well at tasks that require less concentration.

A third meaning of abnormal refers to behavior that causes the actor to suffer psychologically. A person who is uncomfortably anxious can be said to behave abnormally in this sense. Whether a person suffers psychologically, however, again is dependent in part on social circumstances. A gay person may suffer a great deal in a society that despises homosexuality, but in a sexually tolerant society the person might feel very comfortable. Similarly, a person who hears voices may suffer terribly in a society that considers such behavior disturbingly aberrant, but in another society where such occurrences are treated as a matter of course, the person may not suffer at all. Whether particular behavior causes a person to suffer and what type and how much suffering is necessary to be considered abnormal, depends in large measure on personal and social expectations and norms.

A fourth meaning of abnormal is that the behavior is irrational, weird, crazy, or the like. Truly believing that one is invisible or waving one's arms

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wildly for no apparent reason are examples in our culture of abnormal behavior in this sense. It is an intuitive or commonsense meaning of abnormal that reflects social evaluations and values. Again, however, behavior is not irrational or weird per se; it is crazy or not depending on its context and on social expectations and evaluations. Suppose, for example, that a man takes to bed during his wife's confinement, and out of sympathy for his wife complains of severe physical pains in his pelvic region. In our culture the person would be considered quite crazy, whereas in some primitive tribes such behavior is ritualized and considered quite normal. Simply observing the behavior would not answer the question of whether the man was crazy; we would have to know the social context.

Any theory of abnormal behavior in the four senses discussed cannot be evaluated without regard to its social context. We are concerned here, however, with the question of whether a person demonstrates a particular type of behavioral abnormality—mental disorder. Which of the above four meanings of abnormal—statistical infrequency, dysfunction, suffering, or craziness—is most useful when asking whether an actor is normal in the mental health sense? It is impossible to delineate a precise, operational definition of mental disorder, but depending on the individual case, it clearly involves varying combinations of all four meanings of abnormality discussed above.

Although the first three meanings cover some of the cases with which mental health science and mental health law are concerned, these meanings are vastly over- and under-inclusive. Much behavior that is statistically infrequent, dysfunctional, or causes suffering has little or nothing to do with anyone's definition of mental disorder. Moreover, much behavior that would be considered mental disorder according to current definitions is frequent, not particularly dysfunctional, and does not cause unusual suffering.


36. P. Meehl, supra note 28, at 245; see Livermore, Malmquist, & Meehl, On the Justifications for Civil Commitment, 117 U. Pa. L. Rev. 75, 78 n.11 & sources cited therein (1968) [hereinafter cited as Justifications]. See generally Spitzer, Sheehy, & Endicott, supra note 26, at 3-4; Spitzer & Wilson, supra note 26, at 827. Note, too, that an assumption of behavioral abnormality does not necessarily mean that there is anything wrong with the actor's brain, nervous system, or other bodily systems.

37. This point is simply a matter of logic and everyday experience, considered in the light of present psychiatric categories. For example, extremely high intelligence is statistically infrequent but not a mental disorder. Swallowing one's words when speaking may be dysfunctional, especially for lawyers, but it is hardly per se mental disorder. Finally, many people suffer because of their theological, moral, or political beliefs; these beliefs have little to do with mental disorder. For definitions of behavior that are associated with particular mental disorders, see DSM-II, supra note 26.

38. Epidemiological studies of mental disorder show rates as high as 80% in the popula-
Careful mapping of the concept of mental disorder, however, will demonstrate that its borders most closely approximate those of inexplicable craziness, making this meaning the crucial one for both mental health scientists and the legal system. This is the only meaning of mental disorder that covers all or nearly all of the cases with which the mental health legal system is, or should be, concerned. To state the definition somewhat differently, mentally disordered persons are those who deviate significantly from a culture’s norms for intrapersonal and interpersonal behavior, in a crazy fashion. Mental disorder is behavior that makes little or no sense, leading to the assumption that there must be something wrong with the person.

Some examples from the behavioral realms of action, feeling, and thought will help clarify this definition. Mutilating oneself for no apparent reason at large and even higher rates in particular age groups within a population. B.P. Dohrenwend & B.S. Dohrenwend, Social Status and Psychological Disorder: A Causal Inquiry 9-31 (1969); D. Mechanic, Mental Health and Social Policy 65-67 (1969). According to some theoretical views, all human beings are suffering from some form of mental disorder to some extent at all times. L. Kubie, Practical and Theoretical Aspects of Psychoanalysis 17-20 (1950). It should be noted, however, that absolute estimates of the prevalence of disorder in a population may be highly unreliable. Mental disorder does not necessarily cause an individual significant living problems. Many of the milder forms of mental disorder do not significantly interfere with a person’s general functioning, and indeed, even severe mental disorder may not do so. See sources cited in note 24 supra. Moreover, it is a matter of common clinical knowledge that many mentally disordered people, including those who behave in ways considered the most abnormal, do not suffer unduly (although many others certainly do). Indeed, some mental disorders seem to relieve suffering, e.g., “la belle indifférence” of a person who claims to be paralyzed in the absence of a physical cause and is said to have a “conversion hysteria.” The degree to which crazy behavior may lead to dysfunction or suffering is quite dependent on social response to the behavior—responses that differ across cultures. See, e.g., Al-Issa, Social and Cultural Aspects of Hallucinations, 84 Psychological Bull. 570, 571-77 (1977); Wexler, Culture and Mental Illness: A Social Labeling Perspective, 159 J. Nervous & Mental Disease 379, 380 (1974); cf. Mechanic, supra note 34, at 82 (dysfunction as a result of physical disorder and related psychological stress is dependent on both psychological status of patient and responses from family, friends, and employers).

For a thoughtful reaction to the arguably overexpansive definitions of mental disorder currently dominating western and especially American psychiatry, see Kendall, supra note 34. Other writers have recognized that craziness is the core of mental disorder; specifically, craziness is associated with individuals who are inexplicably irrational. J. Feinberg, What Is So Special About Mental Illness?, in Doing and Deserving: Essays in the Theory of Responsibility 272, 284-89 (1970); H. Fingarette, The Meaning of Criminal Insanity 174-203 (1972); Fingarette, Disabilities of Mind and Criminal Responsibility—A Unitary Doctrine, 76 Colum. L. Rev. 236, 246-48 (1976); Moore, supra note 14, at 1485-87. For a critique of the irrationality definition, see Morris, Criminal Insanity, 17 Inqury 345 (1974). For an empirical study bearing on the definition of mental disorder as craziness or the like, see Mechanic, supra note 4, at 195-203.

Although few writers attempt to delineate precisely the definition of mental disorder, but see Spitzer, Sheehy, & Endicott, supra note 26, at 4, 15-16, it is widely recognized that the definition of what behavior constitutes disorder is culturally and temporally relative. For

For particular studies, see, e.g., Culture and Mental Health (M. Opler ed. 1959); Alissa, supra note 38; Townsend, Cultural Conceptions and Mental Illness: A Controlled Comparison of Germany and America, 160 J. NERVOUS & MENTAL DISEASE 409 (1975); Waxler, supra note 38. For a recent review of the cultural influences on psychopathology, see Dohrenwend & Dohrenwend, Social and Cultural Influences on Psychopathology, 25 ANN. REV. PSYCHOLOGY 417 (1974).

For a general argument against cultural relativism, see Dixon, Is Cultural Relativism Self-Refuting? 28 Brit. J. Soc. 75 (1977). For a generally negative view of cultural relativism based on a review of empirical studies, see Dunham, Society, Culture, and Mental Disorder, 33 ARCHIVES OF GENERAL PSYCHIATRY 147, 152-56 (1976). A specific argument that a theory of mental disease can and should be as value-free as possible is presented in Boorse, What a Theory of Mental Health Should Be, 6 J. Theory Soc. Behaviour 61 (1976).

In a thoughtful article that reviews the history of the disease concept, Kendell, supra note 34, at 309-10. Dr. Kendell offers a limiting and universal set of criteria for mental disorder that are based on a biological teleology. These criteria are decreased fertility and increased mortality, both of which are arguably associated with some mental disorders. In any case, the data cited in support of his argument is admittedly inconclusive. See, e.g., Rimmer & Jacobsen, Differential Fertility of Adopted Schizophrenics and their Half-Siblings, 54 ACTA PSIHYATRICA SCANDINAVICA 161 (1976); Singer, Garfinkel, Cohen, & Strole, Mortality and Mental Health: Evidence from the Midtown Manhattan Restudy, 10 Soc. Sci. Med. 517, 523 (1976).


Perhaps claims about the cultural definitions of normality and craziness should be qualified. First, there is a body of cross-cultural evidence that would suggest that in all cultures there are persons who evidence similarly disorganized behavioral processes that, in their society, render them exceptionally incompetent and that cause them to be labeled crazy or the equivalent. The substance or content of the crazy behavior of such persons might differ from culture to culture, but the form of the abnormal behavioral process seems to be similar. Murphy, Psychiatric Labeling in Cross-Cultural Perspective, 191 Sci. 1019 (1976). But see Stilling, Letter to the Editor, 196 Sci. 481 (1976); Townsend, Letter to the Editor, 196 Sci. 480 (1976). See also Torrey, Is Schizophrenia Universal? An Open Question, 7 SCHIZOPHRENIA BULL. 53 (1973). No one knows the cause of extreme craziness. The significance of its existence, however, is that there may be a type of behavior that is simply incompatible with being considered a normal human being in any culture at any time. The class of persons who display such behavior is extremely small, however, and persons in it tend to be the craziest persons in their society, readily identifiable by laypersons and experts (e.g., psychiatrists, medicine men) alike.

Second, there are enough cross-cultural similarities in the forms of behavior, if not the
reason is a classic example. We assume there must be something wrong with someone who does such a thing. Another example has to do with mood. Most persons recognize that some shift in a person's mood is quite normal in our society; sometimes one feels "up" and at other times "down." We learn, however, that there are normal limits (albeit the normal range is wide) regarding how fast the moods ought to shift, or how extreme the moods "ought" to be. Most persons take it for granted that feeling depressed some of the time is normal. If the feeling of depression, however, becomes so extreme that one loses all his energy and capacity for experiencing pleasure and can barely function, we recognize that the rule of how much depression is normal has been violated. We then think that there is something wrong with the individual; his behavior (i.e., mood) is crazy.

A final example deals primarily with thoughts, rather than with actions or feelings. Nearly everyone fantasizes or daydreams on occasion. Often these fantasies or daydreams are quite unrealistic and pleasurable wish fulfillments. If asked, however, the daydreamer would admit that his fantasy about being invisible, for example, is indeed a fantasy. In our culture we take it for granted that persons will fantasize unrealistic things and also that they will recognize that the fantasy is a fantasy. But suppose a person truly believed that he could become invisible by chanting a magic incantation. We should then say that there is something crazy about this person because he has violated the rules that govern the extent to which persons usually maintain contact with reality.

An extremely important aspect of mental disorder or crazy behavior is that it is inexplicable and unsettling. Mentally disordered persons are perceived as different and, often, frightening. This reaction is quite understandable content, so that western diagnostic categories may be applicable in doing cross-cultural research. Dohrenwend & Dohrenwend, supra at 431. Of course, this only means that similar behavior exists crossculturally—not that such behavior bears the same evaluation in all cultures. Davis, Disease and its Treatment: Values in Medicine and Psychiatry, 18 COMPREHENSIVE PSYCHIATRY 231, 232 (1977); Murphy, supra at 1027. Further, the usefulness of those categories, especially in the context of legal proceedings, is doubtful. For a discussion of the inadequacies of psychiatric diagnostic categories, see notes 161-77 and accompanying text infra.

41. Another example is provided by Professor Scheff, who considers mental disorder to be primarily the violation of "residual rules"—implicit behavioral norms that are generally taken for granted. Scheff suggests that his readers try the experiment of staring fixedly at a conversational partner's ear while engaging in a conversation. Of course, in our culture we generally look at a person's eyes or mouth while conversing with him. We do not look fixedly at his ear because to do so would violate an implicit norm of social interaction. The partner probably would become quite uncomfortable and would feel that there is something odd or wrong with the person who fixedly looks at his ear. Rarely are we expressly taught not to stare at a person's ear, but most of us know not to do it and abide by this behavioral norm or residual rule. If a person persisted in looking at his partner's ear, the partner might very well believe his companion was acting crazily. T. SCHEFF, LABELING MADNESS 5-8 (1975).
able. The functioning of any society or subculture requires general adherence to an understood and shared set of rules or expectations of behavior. Naturally, there is a distribution of behavior around the norm for all behavioral rules, but reasonable deviation is itself normal and makes few persons unduly uncomfortable. Most behavior seems based on the shared rules and expectations that most persons accept and adhere to. Crazy behavior makes most people uncomfortable because it seems baseless or based on inexplicable rules or premises.

It is not clear how crazily one must behave before earning the label "mentally disordered." At some point along the crazy behavior continuum, however, we are likely to say, "he's crazy," rather than "that's crazy" or "what a crazy thing to do (way to behave)." This point may be reached if a person is mildly crazy in many ways or if the crazy behaviors are few but extremely crazy. At some point, we stop feeling that the actor is an essentially normal person who has done some crazy things. Rather, we feel that he or she is a crazy person—a person who seems to have little choice about whether or not to behave crazily.

In summary, to define mental disorder for the purposes of mental health law, the best one can do is to state definitionally and tautologically that abnormal persons in the mental health sense are those who behave inordinately crazily. These are the people for whom special legal rules seem appropriate. If the definition of mental disorder as crazy behavior seems ambiguous, this is quite proper because there is no scientifically agreed on definition of mental disorder. Attempts at more specific definitions are only theoretical. Experts agree only on the observation that in (probably) every society there are persons who behave in ways that society labels mentally ill, mentally disordered, crazy, or some equivalent term.

42. Generally, a person will be considered truly crazy only if it is believed that the actor has had little or no choice about whether to behave crazily. Even if an actor seems to behave very crazily, he is unlikely to be considered crazy in the mental health sense if a rational motive for the craziness can be discerned or if it is believed that the person really is choosing freely, even if inexplicably, to behave crazily. There is an intuition that true craziness is uncontrollable craziness. This Article discusses the question of whether craziness is uncontrollable at text accompanying notes 58-112 infra.

43. Spitzer & Wilson, supra note 26, at 827. See also note 14 supra (sources concerning the medical model in psychiatry).

Unlike Szasz and others, this author has no major theoretical objections to the use of illness language in general in discussion of crazy behavior. If it is useful for clinicians, researchers, and others, there is no harm in employing it. Whatever conceptual models are useful for different purposes should be employed. The major difficulty, however, is that illness language carries with it many unproven assumptions about crazy behavior that may have profound implications in non-mental health contexts such as legal decisionmaking. See note 14 supra. For instance, it is assumed that mentally ill persons lack control over their crazy behavior and its consequences much in the same way that physically ill persons are assumed to
Of course, in our society crazy behavior is usually considered medically abnormal rather than, for example, morally abnormal. But the medical analogy is presently little more than an analogy; all that is known is that some people behave very crazily, and it is these people who are considered to be mentally disordered. Hereafter, the terms mental disorder, mental illness, and crazy behavior will be used interchangeably to ensure that the essential nature of the phenomenon in question is not lost.\(^{44}\)

2. Who is Crazy?

The previous section examined in some detail the nature of the question, "Is the person normal in the mental health sense?" It should now be recognized that for mental health law this question really should mean, in operational terms, "Does this person behave sufficiently crazily to warrant special legal treatment on moral and social grounds?" Once the nature of the question is clear, one can analyze how it should properly be answered. The major thesis of this section is that the question, "Who is sufficiently crazy?" is a social question, and that for legal purposes it can and should be answered by laypersons.

The number of persons who may be labeled "mentally disordered" according to current diagnostic categories is much larger than the number of persons who are clearly crazy\(^{45}\) and thus arguably warrant special legal treatment on both moral and social grounds. Because there is no underlying,

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44. Jargon terms have question-begging connotations about the causes or nature of the phenomenon. Thus, this Article uses a nonjargon term interchangeably with the dominant jargon terms. It is difficult, however, to find a nonjargon term that both describes the behavior considered mental disorder and avoids unwanted connotations. No term is perfect, but "crazy" seems to avoid both legal and mental health science connotations while preserving a sense of serious abnormality. The author owes his preference for the term "crazy" to his former teacher, Professor Alan Stone of Harvard Law School. In Professor Stone's courses on mental health law, it was a term often used and this writer has had an affection for it ever since. It is also widely used by mental health professionals, in discussion both among themselves and with patients. For a similar attempt to find a proper word, see Rosenhan, The Contextual Nature of Psychiatric Diagnosis, 84 J. Abnormal Psychology 462, 465 n.2 (1975).

independently verifiable criterion other than behavior with which to determine if an actor is mentally disordered, it is especially hard to determine if the actor is "normal" in those cases where most observers would not agree that the actor is crazy. Mental health professionals can make such determinations by fiat, but these are not scientific decisions. At the farthest extremes, it is relatively easy for anyone to differentiate a very crazy individual from a normal person, and we are not made uncomfortable by terming the person "crazy" although the conclusion of craziness in even the clearest cases is culturally relative to some degree. But the dividing line, near which most cases fall, is elusive.

Let us consider some examples to analyze further the question of "who is crazy?" and how it should be answered. Suppose an adult walks down the street, accosting passersby and loudly uttering strange epithets. Asked why he is engaging in this behavior, he sincerely replies that electrochemical rays shot at him by supernatural beings are forcing him to behave in this way. This person clearly has a mental disorder according to the American Psychiatric Association, but do we need an expert to tell us that he is crazy? Clearly not. Nor can an expert or anyone else tell us with any degree of certainty why this person behaves this way. All that is known, and this is clear to anyone in our culture—experts and laypersons alike—is that the actor is very crazy.

Let us now consider a much harder example: a man who is extremely neat, punctual, and precise. Indeed, he spends so much time ensuring that he is neat, punctual, and precise that he often accomplishes considerably less in his love life and work life than he might like, a fact that makes him unhappy. Despite his discontent, he finds that for some reason he feels that he just has to be that way, and in any case, he gets along all right with his family and his job. This person suffers from a mental disorder according to

46. Of course, mental health professionals can define for their own purposes whatever behavior they wish as abnormal, but unless the behavior so categorized is crazy or arguably so, society and the legal system would not accept special treatment of the persons so categorized—they would not seem sufficiently abnormal and different.

47. Edgerton, supra note 4, at 51. When mental health professionals attempt to break crazy behavior into "disease" categories or clusters, agreement that the person fits into a category is not high, even for those categories that map the craziest behavior. See Helzer, Clayton, Pambakian, Reich, Woodruff, & Reveley, Reliability of Psychiatric Diagnosis: II. The Test/Retest Reliability of Diagnostic Classification, 34 ARCHIVES OF GENERAL PSYCHIATRY 136 (1977); Spitzer & Fleiss, A Re-analysis of the Reliability of Psychiatric Diagnosis, 125 BRIT. J. PSYCHIATRY 341 (1974). In the seven studies reported by these two articles, the interrater reliability for schizophrenia was .57. For the reasons why diagnostic agreement is difficult to achieve, see notes 25 supra and 161-71 and accompanying text infra.

48. The diagnosis would probably be "Schizophrenia, Paranoid Type," according to DSM-II, supra note 26, at 34, or DSM-III, supra note 26, at C:10.
the currently dominant diagnostic scheme. Indeed, excessive concern with neatness, punctuality, or anything else is a little crazy in the loosest colloquial sense. On the other hand, many persons would probably be inclined to say about this person, “Oh, so and so has some quirks like all of us, but that’s just the way he is.” Most persons would probably agree that his “quirks” are somewhat maladaptive, though others might admire an unusually neat, punctual, and precise person. Is this person normal? Again, does the ability to answer this question require medical expertise or merely common sense based on social rules and expectations?

Mental health experts are a bit more inclined than the average person to declare that particular behaviors are abnormal and evidence mental disorder. Even so, most experts and laypersons would agree in their assessment of our second example. He is a person with some personality quirks (or in “psychiatrese,” characterological symptoms) that interfere to some extent with his successful functioning. Thus, the final question of normality in this borderline case is simply, “How quirky must a person be before he or she will be labeled abnormal?” There is no scientific answer to this question. There exists no objectively identifiable underlying abnormal condition that distinguishes this person from those with fewer, different, or no quirks. Even if there were an identifiable underlying condition, for legal purposes the answer depends on social tolerance for quirkiness or on social value preferences concerning how much a person can “normally” hinder his own functioning by quirkiness before we consider him crazy.

49. The diagnosis would probably be “Obsessive compulsive personality” according to DSM-II, supra note 26, at 43, or “Compulsive personality disorder” according to DSM-III, supra note 26, at K:15.

50. G. Newman, Comparative Deviance: Perception and Law in Six Cultures 39-40 (1976); D’Arcy & Brockman, Changing Public Recognition of Psychiatric Symptoms? Blackfoot Revisited, 17 J. HEALTH & SOC. BEHAV. 303 (1976); Sarbin & Mancuso, supra note 3. See generally Scheff, Decision Rules, Types of Error, and their Consequences in Medical Diagnosis, 8 BEHAVIORAL SCI. 97 (1963); note 38 supra; see also Coe, Costanzo & Cox, Behavioral Determinants of Mental Illness Concerns: A Comparison of “Gatekeeper” Professions, 43 J. CONSULTING & CLINICAL PSYCHOLOGY 626, 635 (1975). On occasion, this tendency can assume outrageous proportions. See Cleary, The Writ Writer, 130 AM. J. PSYCHIATRY 319 (1973) (behavior of patient-prisoners in forensic psychiatry units who petitioned in order to secure their release interpreted as possibly “the expression of omnipotent fantasies, the idea that oppressive external forces can be routed by a stroke of the pen. The magic is not only in the written communication itself but also in the arcane, stylized phraseology so peculiar to legal documents.” Id. at 320); Rosenhan, On Being Sane in Insane Places, 179 SCI. 250, 253 (1973) (pseudopatients who were admitted to mental hospitals as part of an experiment took notes of their experiences while on the ward; the note-taking was seen as evidence of psychopathology according to nursing records in three cases).

There is also evidence that, compared to laypersons, psychiatrists consistently place lower social value on behaviors labeled psychiatric symptoms. B.P. DOHRENWEND & B.S. DOHRENWEND, supra note 38, at 81-88.
A final example is a person whose sexual orientation is exclusively homosexual but who maintains adequate interpersonal relations, whose work life is generally unimpaired, and who has no significantly maladaptive personality quirks. This case illustrates the difficulty in answering the question "who is crazy?" and exemplifies the processes by which professionals sometimes decide such questions.

Our example is a person who would be regarded as quite normal by both experts and laypersons except for his homosexuality. But is this person normal in the mental health sense? If jargon is deleted from scientific definitions, experts and laypersons define homosexuality similarly: the occurrence of a (more or less) persistent sexual preference for members of the same sex. There is no test other than homosexual behavior itself with which to "diagnose" homosexuality. Until 1973, the American Psychiatric Association, the organization responsible for the promulgation of the currently dominant diagnostic scheme of mental disorders, considered homosexuality per se a mental disorder. In that year, by a vote of its membership, the Association decided that homosexuality was not a mental disorder. The nature of homosexuality did not change, nor were there any startling breakthroughs in the scientific understanding of homosexual behavior. No one is sure why the sexual orientation of some persons is homosexual; all that was known to a certainty prior to and after the 1973 vote was that some persons behave homosexually.

What changed were the values of a professional group empowered to affix labels of deviancy. Historically, many societies considered homosexuality sinful. The ascendancy of the medical model of deviant behavior led to a redefinition of this deviant behavior as sick. The majority of mental health experts, although by no means all, now view homosexuality per se as neither sick nor bad; rather, it is viewed as one possible form of human sexual orientation. A homosexual may still be considered mentally disordered, but not on the basis of the homosexuality per se.

For many reasons, homosexual behavior raises particularly difficult questions of defining behavioral normality. Homosexuals are not necessarily dysfunctional in ways important to them or, except for sexual orientation, to the rest of society. Nor is homosexual behavior particularly irrational, weird, or inexplicable; that is, it does not seem crazy. Yet, the unproven notion remains deeply rooted among professionals and laypersons that

51. DSM-II, supra note 26, at 44.
homosexuality is somewhat per se biologically and/or socially abnormal and/or maladaptive. Homosexuals are no longer officially considered sick not because of a scientific finding, but because a majority of professionals with the power to affix the "sick" label changed their minds. If the decision of whether homosexual behavior is abnormal really reduces to a statement of value preferences, however, the assistance professionals can give to laypersons to discern such abnormalities is negligible.

Mental health experts are neither moral experts nor social value experts, nor even experts on any mental health issue about which there is little scientific data or agreement; and mental health is a field of little agreement. For the most part, the experts do not have tests or instruments that reliably and validly demonstrate the presence or absence of abnormal conditions. Certainly, no responsible expert would diagnose mental disorder on the basis of a test result if the person otherwise behaved normally. Any data that experts might use to determine whether a subject meets the legal test of craziness is perfectly accessible to lay observers as well.

53. Cf. Ripper, Commonsense Beliefs About Depression and Antidepressive Behavior: A Study of Social Consensus, 15 Behaviour Research & Therapy 465, 466-67, 471-73 (1977) (subjects who were psychologists were tested on their degree of consensus about beliefs concerning depression and antidepressive behavior; subjects agreed on commonsense propositions verifiable by first hand experience or observation, but disagreed on abstract matters debated by experts; support for validity of lay beliefs about psychopathology). For an interesting series of articles by mental health professionals that deal with the appropriate ethical and professional responses that professionals should make when they are consulted by gay persons, see Bieber, A Discussion of "Homosexuality: The Ethical Challenge," 44 J. Consulting & Clinical Psychology 163 (1976); Davison, Homosexuality: The Ethical Challenge, 44 J. Consulting & Clinical Psychology 157 (1976); Halleck, Another Response to "Homosexuality: The Ethical Challenge," 44 J. Consulting & Clinical Psychology 167 (1976). These articles evidence substantial disagreement among professionals.

54. A possible exception to the statement in the text would occur if experts used psychological test results. There are, of course, numerous tests that measure the supposed presence or absence of mental disorders. See generally M. Maloney & M. Ward, Psychological Assessment, A Conceptual Approach 311-408 (1976); Clinical Methods in Psychology 61-279 (I. Weiner ed. 1976). For legal purposes, however, there are two major difficulties with these tests. First, there is considerable reason to doubt their usefulness in general; tests may not produce reliable and valid information about the person tested. Second, in addition to possible general reliability and validity problems, present psychological tests do not define those persons who are crazy enough to meet the legal standard of mental illness. For the law, it is not the person's behavior on a test that is at issue, but his behavior in the real world. If the tests accurately predicted who behaved sufficiently crazily in the real world, then they might help determine whether the legal standard of mental illness is met. To date, however, there is no indication that tests can do this. See, e.g., M. Maloney & M. Ward, supra at 336-43, 363-70; W. Mischel, Personality and Assessment 39-70, 110-13 (1968); J. Ziskin, Coping with Psychiatric and Psychological Testimony 144-80 (2d ed. 1975); Blatt, The Validity of Projective Techniques and Their Research and Clinical Contribution, 39 J. Personality Assessment 327 (1975); Cleveland, Reflections on the Rise and Fall of Psychodiagnosis, 7 Professional Psychology 309 (1976); Lewandowski & Saccuzzo, The Decline of Psychological Testing, 7 Professional Psychology 177 (1976).
In sum, laypersons and experts both form judgments based largely on their observations of behavior. In commonsense language, their observations are likely to be remarkably similar. In cases where mental health experts readily agree that an actor suffers from a severe mental disorder, laypersons would agree that the actor is crazy. Where persons are less crazy but still arguably irrationally quirky (as in our earlier case of the extremely neat, precise, and punctual man), laypersons and experts would agree on the description although experts would be more likely to diagnose mental disorder than laypersons would be likely to “diagnose” craziness. Yet there would be no scientific reason to call our second person “mentally disordered” as opposed to “quirky” or even normal. “Mental disorder” and “quirky” are both labels affixed to the same behavior. Any extra meaning connoted by “mental disorder,” such as neurological dysfunction or underlying psychological forces, is currently unverified.

The best measuring instrument for determining if a person is crazy is to find out as much as possible about the actor from those persons who have had an opportunity to observe him directly in a wide variety of circumstances. When much is learned about how the actor has behaved at many different times and in many different circumstances, or at a particular time and in particular circumstances, then all members of society will be competent to judge if the person is crazy in general or if he was crazy at the particular time in question. The current deference the law accords mental health experts is misplaced. For legal purposes, the question of who is crazy is not suggested here that critics of testing in general are correct about the uselessness of the enterprise. Cf. Wade & Baker, Opinions and Uses of Psychological Tests: A Survey of Clinical Psychologists, 32 AM. PSYCHOLOGIST 874, 879-881 (1977) (despite criticism of tests, they are still widely used by clinicians of all therapeutic orientations; clinicians recognize the psychometric flaws of tests, but question the reliability and validity of the negative studies; clinicians are probably unaffected by negative results concerning tests because of the need to assess, the lack of weight given to experimental evidence, and the lack of practical alternatives). This writer believes that testing is worthwhile and that some tests are very useful for some purposes. It is claimed here, however, that present tests do not offer data that answer legal questions about normality. By and large, tests of psychopathology track present psychiatric categories that themselves are of little value in legal decisionmaking. See notes 161-77 and accompanying text infra.

55. See note 47 and accompanying text supra.
56. See note 50 and accompanying text supra.
57. Hall, supra note 16, at 1049; see note 47 and accompanying text supra. See also Vestre & Zimmermann, Validity of Informants’ Ratings of the Behavior and Symptoms of Psychiatric Patients, 53 J. CONSULTING & CLINICAL PSYCHOLOGY 175 (1969). It is sometimes suggested that psychiatric categories help limit the number of cases of deviant behavior where mental health law intervention would be justified. Shapiro, Therapeutic Justifications for Intervention into Mentation and Behavior, 13 DUQ. L. REV. 673, 772-73 (1975). Perhaps so, but why should mental health professionals be delegated the power to decide for society and the law the social and moral question of which persons ought to be subject to special legal treatment?
must be recognized as a social and moral judgment that must be decided as such.

3. **Summary**

Mental disorder fundamentally refers to crazy behavior. Theories about abnormal underlying causes of the behavior are yet unproven. Further, what behavior is considered crazy depends largely on social and cultural norms and expectations and on the particular situational context in which the behavior occurs. Except in the clearest cases, determinations of who is crazy are difficult to make because the criteria of craziness are very imprecise. Because determinations of craziness depend on observations of behavior and social norms, such determinations can be made by laypersons and experts alike.

When the legal system must decide if a person is crazy enough to warrant special legal treatment, it should recognize the social and moral nature and significance of the decision. Consequently, the question of who is crazy should be decided by society's representatives—judges and juries of laypersons.

**C. COULD THE PERSON HAVE BEHAVED OTHERWISE?**

Once an initial determination is made that a person has behaved sufficiently crazily to justify labeling him "mentally disordered," *i.e.*, a crazy person, the next important question for the legal system is whether the person could have behaved otherwise. In other words, were the crazy behavior and related legally relevant behavior products of free choice or were they the product of a disordered mind? Was the person a free agent and causally responsible for the behavior? Being different enough to be clearly crazy seems to be a necessary but not sufficient reason for special legal treatment. A further factual assumption appears morally and legally compelled—that the legally relevant behavior was the result of uncontrollable illness.58 In such instances, the crazy actor, unlike most persons, is not regarded as a free agent and special legal treatment does not seem to infringe unduly the actor's dignity and autonomy.

This section first briefly explores the differing views of personal responsibility held by the law and mental health scientists. It then examines in general the degree to which crazy persons have less control over their behavior than normal persons. Finally, the section considers the two crucial

58. See, e.g., Development, supra note 6, at 1212-19, 1228-35 (analysis of the relevance to civil commitment decisions of various forms of legally relevant incapacity caused by mental illness; contention that the policies behind special treatment and due process are both satisfied only if the person treated specially is incapacitated as a result of mental illness).
questions for the law: whether crazy persons are responsible for their legally relevant behavior and how this question can be determined. These questions are analyzed by first examining the threshold issue of the relationship between craziness and other legally relevant behavior. It is concluded that whether a relationship exists is a commonsense determination. Then, on the assumption that there is a clear relationship between craziness and legally relevant behavior, the section explores whether and when the legally relevant behavior was a product of the actor’s free choice. It is argued that crazy persons do have a good deal of choice about the consequences of their craziness, and again, the question of responsibility is to be answered on moral and commonsense grounds.

1. Scientific and Legal Models of Personal Responsibility
The concepts of free will or personal responsibility have little meaning to mental health scientists, as scientists. Simplistically put, the scientific model is deterministic: all phenomena, including behavior, are allegedly the effects of their multiple interacting antecedent causes. According to this model, human thoughts, feelings, and actions are not the products of free will directed by the actor; rather, human behavior is the probabilistic outcome of the many biological, psychological, and social antecedent variables that have operated on the person.59 Responsibility is thus a moral term that is allegedly scientifically irrelevant.60 The various models of behavior assume that different causes are crucial for explaining behavior and that causality is extremely complex. All deterministic scientific models, however, view all behavior as phenomena subject to the same probabilistic laws as the rest of the phenomena of the universe.

Scientists who are strict determinists are aware that at present they are not able to specify all the antecedent causes that would allow them to state


perfectly the probabilities that particular behavior will occur, but they believe that this is a result of lack of knowledge, not a flaw in principle in the scientific model. They believe that when behavior can be perfectly predicted and controlled, notions of responsibility will then wither away.61

The legal system takes a quite different view of personal responsibility. Law is a normative enterprise that treats nearly all persons in all situations as responsible for their acts and often for the natural and probable consequences of those acts.62 In most cases, the law adheres to the commonsense and subjectively experienced view that behavior is a matter of choice; it is the actor's act.63 Nevertheless, the law acknowledges that all persons are subjected to various biological, psychological, and sociocultural factors or pressures that affect their choices of action. All such factors affect choices, making some choices easy and some hard. As a result, the law recognizes that some behavioral choices may be too hard to serve as the basis for the imposition of legal responsibility.64 For instance, in cases of duress the law

61. For the most strikingly optimistic and perhaps frightening example of this view, see B. F. Skinner, supra note 60. Some determinists react to the present incomplete state of knowledge by believing that the orderly functioning of society requires that persons be treated as if they were responsible for their behavior, even if such treatment is based on an allegedly incorrect view of reality. A. Flew, supra note 40, at 95-96; Katz, supra note 60, at 398-99. See generally Waelder, Psychiatry and the Problem of Criminal Responsibility, 101 U. Pa. L. Rev. 378 (1952). In any case, the determinist does not believe that lack of knowledge or a rejection of the behaviorist approach means behavior is free; behavior is still determined, but by unplanned and unknown determinants. M. Feldman, supra note 60, at 272.


64. Morse, supra note 63, at 1251-54. See also H. L. A. Hart, Punishment and Responsibility 13 (1968).

The special features of Mitigation are that a good reason for administering a less severe penalty is made out if the situation or mental state of the convicted criminal is such that he was exposed to an unusual or specially great temptation, or his ability to control his actions is thought to have been impaired or weakened otherwise than by his own actions, so that conformity to the law which he has broken was a matter of special difficulty for him as compared with normal persons normally placed. Id. Presumably, if the actor's ability to conform to law is weakened sufficiently, the law would consider the actor completely nonresponsible. Id. at 14.

It is recognized that philosophers consider substantive determinism to be an all-or-none proposition. Determinism and indeterminism, however, are both unprovable. J. Mackie, supra note 59, at 216. The law cannot proceed on the assumption of either. The law is a moral-evaluative institution that must make decisions concerning real world problems of human interaction. Thus, the law cannot afford to be philosophically pure, but must adopt a commonsense cosmology, congruent with ordinary experience and useful for making decisions. That various factors or pressures make some choices harder and others easier and that such factors bear on the moral and legal responsibility of actors is certainly a commonsense view of the world that accords with ordinary experience. See generally Katz, supra note 60.
excuses otherwise criminally culpable behavior not because the actor absolutely lacked choice in a causal sense, but because society feels the actor's choice to obey the law was too difficult to consider him culpable. In other instances, such as cases of automatism, the law reflects the view that the actor was not causally responsible for his behavior; the act was not his and, therefore, the actor cannot be morally and legally responsible for his behavior. 65

While acknowledging that some choices are so hard that it is inappropriate for society to ascribe responsibility for them to the actor, the legal system allows few exceptions to the rule that persons are causally and legally responsible for their behavior. But which choices are too hard? In another article, the author has analyzed this question as follows:

There is no bright line between free and unfree choices. Harder and easier choices are arranged along a continuum of choice: there is no scientifically dictated cutting point where legal and moral responsibility begins or ends. Nor is there a higher moral authority which can tell society where to draw the line. All society can do is to determine the cutting point that comports with our collective sense of morality. The real issue is where society ought to draw the line of responsibility—and by whom it should be drawn. 66

The central question for our inquiry, then, is whether the choice to behave in legally relevant ways is too hard a choice for society fairly to ascribe moral and legal responsibility to actors whose legally relevant behavior seems caused by craziness. Throughout the analysis, this Article will adopt this commonsense model of harder and easier choices. 67 Scientific data will be relied on, but its relevance to legal determinations will be assessed in the light of this model.

Although the legal system does not generally adopt a deterministic model of behavior, if an actor's behavior is apparently and inexplicably


66. Morse, supra note 63, at 1253.

67. This Article will not attempt to resolve either the philosophical dispute about free will and determinism or the philosophical and scientific quagmire of causation. Interested readers are referred to the following works, which have furnished the general background for much of the argument in this section. H. Blalock, Causal Inferences in Nonexperimental Research (1964); H.L.A. Hart, supra note 64; A. Kaplan, supra note 59; E. Nagel, supra note 59; D. O'Connor, Free Will (1971); K. Popper, Of Clouds and Clocks, in Objective Knowledge 206 (1972); A. Ross, On Guilt, Responsibility and Punishment (1975); M. Sussner, Causal Thinking in the Health Sciences (1973); Determinism and Freedom (S. Hook ed. 1958); Determinism, Free Will, and Moral Responsibility (G. Dworkin ed. 1970); Essays on Freedom of Action (T. Honderich ed. 1973); Freedom & Responsibility 1-51, 262-342 (H. Morris ed. 1961); Free Will and Determinism (B. Berofsky ed. 1966).
irrational and crazy, the law and also persons in general assume that because of mental disorder the actor was not in control of his behavior—that it was not chosen.\footnote{The causal hypothesis is expressed by locutions such as "result of," "because of," "due to," "incapacity," "unable," and the like. See, e.g., CAL. WELF. & INST. CODE § 5150 (West Supp. 1978).} After all, the generally rational model of behavior held by most persons and the law is unable to explain how and why an actor would choose to behave inexplicably crazily. When the law adopts the intuitive and perhaps correct view that the crazy person has great difficulty controlling his behavior, the law comports with and is reinforced in its view by mental health science, even if the correspondence in view only extends to the class of persons considered crazy.\footnote{See M. Feldman, supra note 60, at 270.} Where there is such a correspondence of views, the legal system calls upon mental health experts to help resolve and legitimize the decision as to whether a crazy actor’s legally relevant behavior was caused by his mental disorder rather than by his free choice.

It must be remembered, however, that although determinations of legal causation and responsibility rest in part on factual scientific notions of causation and responsibility, legal and scientific determinations are separable and serve different purposes. Scientists may provide information about pressures and probabilities, but the legal system must determine for its own purposes when those pressures and probabilities are too great to hold the actor legally responsible for his behavior.\footnote{See generally Waelder, supra note 60; notes 62-67 and accompanying text supra.} Although crazy behavior should perhaps be considered an illness for some purposes, doing so when the actor’s moral and legal responsibility is in issue begs the question and prematurely ends the analysis. Are legally relevant behaviors simply uncontrollable symptoms? As noted, mental health laws assume that mental illness is such a powerful cause in fact that it robs actors of their free choice and thus renders them legally nonresponsible. Rather than accepting the validity of this assumption, this Article will examine in the succeeding sections the degree to which the law’s assumption is founded in scientific fact and the extent to which mental health science provides assistance in deciding questions of both factual and legal responsibility.

2. Craziness and the Causes and Control of Behavior

Before we explore further the validity of the assumption that the behavior of crazy persons is more caused by uncontrollable antecedents than the behavior of normals, let us examine the nature of causes in general. Causes are antecedent variables that increase the probability that a later event will occur. Briefly, there are four types of causes: necessary and

68. The causal hypothesis is expressed by locutions such as "result of," "because of," "due to," "incapacity," "unable," and the like. See, e.g., CAL. WELF. & INST. CODE § 5150 (West Supp. 1978).
69. See M. Feldman, supra note 60, at 270.
70. See generally Waelder, supra note 60; notes 62-67 and accompanying text supra.
sufficient, necessary, sufficient, and predisposing. A necessary and sufficient cause is one that, by itself, invariably produces an effect. A necessary cause is one that must be present in order for the effect to be produced, even though the effect may not occur unless other factors are also present. A sufficient cause is one that, when present, will always produce the effect, but that is not necessarily present in order for the effect to be produced. A predisposing cause is one that is neither invariably necessary to produce the effect nor capable of producing the effect by itself. The predisposing cause can be present without producing the effect, and the effect can occur in the absence of the predisposing cause. If the predisposing cause does occur, however, the likelihood that the effect will also occur is increased in proportion to the strength of the predisposing cause.

Nearly all causes identified in the medical and behavioral sciences are of the predisposing variety. There are almost no known necessary, or necessary and sufficient causes, and few sufficient biological, psychological, or sociological causes that produce the occurrence of any behavior—normal or abnormal—including behavior that is legally relevant for mental health law. It is known only that there are predisposing causes that seem to increase the likelihood that an actor will behave crazily. The central


73. See note 28 and accompanying text supra. The majority of known causes are only weakly predisposing. Low socioeconomic status and genetic predisposition are good examples. Epidemiological studies have consistently demonstrated that there are higher rates of severe mental disorder (and of violent behavior) in the lower socioeconomic classes of society. B.P. DOHRENWEND & B.S. DOHRENWEND, supra note 38, at 1-2, 174-75. See also Dunham, supra note 40, at 151. On the higher rates of violent criminal behavior in the lower socioeconomic classes, see, e.g., Bazelon, The Morality of the Criminal Law, 49 S. Cal. L. Rev. 385, 402-03 (1976). The class difference is greater than that predicted by chance. Yet, many crazy and violent persons are from higher classes, and most lower class persons are neither crazy nor violent. There is something about lower class membership that seems to increase the probability that a person will behave crazily or violently, but lower class membership is neither necessary nor sufficient to produce either type of behavior. It is possible that the same variable or variables that account for craziness also account for a drift into the lower class. See Dohrenwend, Sociocultural and Social-Psychological Factors in the Genesis of Mental Disorders, 16 J. Health & Soc. Behavior 356, 370-73 (1975) [hereinafter cited as Sociocultural Factors]. Definitive interpretation of the correlation between social class and mental disorder is difficult, but one reasonable interpretation of the evidence is that lower class membership is itself a partial cause of psychological disorder. B.P. DOHRENWEND & B.S. DOHRENWEND, supra note 38, at 174-75; Sociocultural Factors, supra at 365, 382-87. But see Dunham, supra note 40, at 155. See generally Sociocultural Factors, supra.

Another example of a predisposing factor is genetic predisposition to schizophrenia. See Gottesman & Shields, A Critical Review of Recent Adoption, Twin, and Family Studies of Schizophrenia: Behavioral Genetics Perspectives, 2 Schizophrenia Bull. 360 (1976) (the most
question for the legal system is which predisposing causes of what strength render an actor's choice too hard to ascribe responsibility to him.

a. The causes of behavior—crazy and noncrazy: The legal rationale for the assumption that the choice to behave normally is too hard for crazy persons is based on the medical model of crazy behavior. This model distinguishes between crazy behavior itself (the symptom) and underlying conditions (the disorder or defect) that are assumed inexorably to cause the behavior. The medical model's explanation of unfree crazy behavior is that a person is unable to prevent the crazy behavior and its consequences caused by underlying mental disorder in the same way that he is unable to prevent the fever and its consequences caused by an underlying infection. The crazy person is believed unable to choose to behave normally and the infected person is believed unable to choose to lower his body temperature. Thus, if the legally relevant behavior is caused primarily by mental disorder, it must not have been freely chosen; the actor could not have done otherwise and is not legally responsible.


Holding environmental factors constant, there is a greater probability that an actor will behave schizophrenically crazily if he has a genetic predisposition to that behavior. There is evidently some genetic factor that increases the probability that an actor will behave crazily. Yet, many crazy persons seemingly do not have the genetic predisposition, and most persons who have the predisposition are not crazy. Genetic predisposition to craziness is neither necessary nor sufficient to produce crazy behavior. Wender, Rosenthal, Rainer, Greenhill, & Sarlin, supra note 28, at 784.

74. It is also believed that people cannot voluntarily expose themselves to mental illness in the same way that they can voluntarily expose themselves to physical illness.
A major difficulty with this teaching of the medical model is that nearly always the presence or absence of proven underlying disorders cannot be demonstrated. Again, nearly always the only proven fact is that the person has behaved crazily. Further, there is little or no evidence to demonstrate that the predisposing causes of crazy behavior are any stronger than the predisposing causes of any other kind of behavior. Virtually no sufficient uncontrollable biological, psychological, or sociological causes of any behavior have been discovered.

No matter how quantitatively and qualitatively predisposing to particular behavior a variable may be, not all persons subject to that variable will behave in that way and many persons who do behave that way will not be subject to the variable. Indeed, the majority of persons subject to even the most predisposing variables now recognized do not behave crazily. We do not know why people behave as they do. Both crazy behavior and normal behavior are presumably the probabilistic outcome of their antecedents, including motives and reasons of the actor, and there is no scientific

75. There are exceptions, of course. In a very small fraction of cases (e.g., brain tumors, tertiary syphilis), an underlying physical disorder may be present and possibly casually related to the crazy behavior. In fact, it is alleged that such pathology is present in a large proportion of disordered older persons. In these cases the mental disorder, that is, the crazy behavior, is said to be “Caused by or Associated With Impairment of Brain Tissue Function.” DSM-II, supra note 26, at 5. DSM-II also requires that the physical disorders should be diagnosed separately. Id. at 4. Thus, such cases are not considered primarily as mental disorders, but as physical disorders with behavioral correlates.

Organic brain syndrome is often diagnosed on the basis of behavioral evidence without hard physical evidence of brain pathology. That is, it is assumed that people who behave like confirmed brain-damaged persons must themselves have brain pathology. Without hard evidence it is difficult to know, however, whether brain pathology is present or not. Rates of diagnosis of organic brain syndrome (in similar populations) vary widely across cultures, and within our culture the reliability of the diagnosis is not as high as might be supposed. Alexander, On Being Imposed Upon by Artful or Designing Persons—the California Experience with the Involuntary Placement of the Aged, 14 SAN DIEGO L. REV. 1083, 1096-97 (1977); Helzer, Clayton, Pambakian, Reich, Woodruff, & Reveley, supra note 47, at 136-39 (using highly explicit research criteria, reliability of diagnosis of organic brain syndrome was determined to be only .29, a very low figure in itself and much lower than that found in previous studies using less careful criteria). But see Seltzer & Sherwin, “Organic Brain Syndromes”: An Empirical Study and Critical Review, 135 AM. J. PSYCHIATRY 13, 18-20 (1978) (general discussion; high diagnostic reliability using behavioral criteria only).

DSM-III counsels that the behavior assumed to be caused by organic mental disorder is only presumptive evidence of underlying brain pathology that should be confirmed by laboratory testing. DSM-III, supra note 26, at A:1.

It is worth noting here that discovery of a physical correlate of crazy behavior does not mean that the physical correlate is invariably a cause or the only cause of such disorder or that the disordered behavior is uncontrollable. See notes 79-83 and accompanying text infra.

76. See notes 71-73 and accompanying text supra.

77. It is quite natural and common to ascribe causal efficacy to intentions, desires, reasons, motives, and other such mental states. Davidson, Symposium: Action: Actions,
reason to believe that either type is "more caused" in a physically uncontrollable sense.\textsuperscript{78}

It is often argued that a biochemical or other uncontrollable cause of crazy behavior will be found. This discovery, it is supposed, will finally answer the questions of whether crazy behavior is a disease and whether crazy people are responsible for their disordered behavior and behavior related to it. Even if such causes of crazy behavior are discovered, however, the discovery should not itself compel the conclusion that crazy people are diseased and not responsible for their behavior. An example may better demonstrate the point.

Each year mental health scientists report that a new substance has been discovered that is present in significantly different amounts in the brains, blood, urine, or nervous systems of crazy people and normals.\textsuperscript{79} Let us assume that this year's findings, or those of next year or the year thereafter,

\begin{quote}
Reasons, and Causes, 60 J. PHILOSOPHY 685 (1963); see J. MACKIE, supra note 59, at 216. It is also assumed that persons have control over their intentions or, at least, that they have control over actions that might be predicated on such intentions. When an actor behaves crazily, however, it is assumed that he had little or no control over the formation of his crazy beliefs, reasons, impulses, or motives and that he has little or no control over actions that seem logically to be produced by those crazy beliefs, reasons, impulses, or motives. Many, if not most, writers write as if the point were self-evident and needed no proof that the actor is unable, as opposed to unwilling, to control his behavior. See note 5 supra. Determining the validity of these assumptions is the task of this section of this Article.
\end{quote}

\textsuperscript{78} The strength of this conclusion is bolstered by evidence concerning the ability of so-called "alcoholics" and "addicts" to resist their craving for alcohol or drugs. It is widely believed that such persons cannot prevent themselves from taking the substances. Even though the habitual use of such substances may create a great dependence on them, it seems quite clear that users can stop if they choose to, albeit at the cost of some emotional and physical discomfort. See Fingarette, Addiction and Criminal Responsibility, 84 YALE L.J. 413 (1975); Fingarette, The Perils of Powell: In Search of a Factual Foundation for the Disease Concept of Alcoholism, 83 HARV. L. REV. 793 (1970). Alcohol and drugs do not deprive their habitual users of all choice in regard to those substances, even if they make the choice to stop or cut down a very difficult one. Even if physical causes for behavior are discovered, there is little reason to believe that, compared to other determinants of behavior, they are especially powerful or uncontrollable. Cf. Mostofsky & Balaschak, Psychobiological Control of Seizures, 84 PSYCHOLOGICAL BULL. 723, 723 (1977) (epileptic seizures can be controlled to some degree by psychological methods); Schachter, The Interaction of Cognitive and Physiological Determinants of Emotional State, in 1 ADVANCES IN EXPERIMENTAL SOCIAL PSYCHOLOGY 49, 64 (L. Berkowitz ed. 1964) (behavioral responses to biochemical interventions affected by sociopsychological context and expectations).

\textsuperscript{79} Schmeck, Opiate-Like Substances in Brain May Hold Clue to Pain and Mood, N.Y. Times, Oct. 2, 1977, § A, at 1, col. 3; L.A. Times, Nov. 9, 1977, pt. 1, at 1, col. 1. See also L.A. Times, Nov. 18, 1977, pt. 1, at 1, col. 1. Often it is also discovered that when the substance is injected into laboratory animals, the creatures behave crazily, become physically ill, or even die. But subsequent replication attempts in other laboratories nearly always fail, or an artifact is discovered that explains the results of the original study. The search continues, however, encouraged by persuasive evidence that there is a biological substrate for schizophrenia and affective disorder.
can be replicated and are valid. Suppose that Biochemical Blip X (hereinafter BBX) is found in the brains of schizophrenics statistically significantly more often than in the brains of normals or other types of crazy people. Suppose also that it is established that the presence of BBX in the brain precedes crazy behavior rather than the reverse. What would such findings look like and what would they mean?

If the prior history of medical and behavioral science is a guide, we may safely predict that BBX will not be found to be either a necessary or sufficient cause of schizophrenia. That is, some people who behave just like schizophrenics with BBX will not have BBX present in their brains, and some people with BBX will not behave schizophrenically. Of course, a non-BBX schizophrenic will still be considered mentally ill because he behaves schizophrenically, and a BBX person who behaves normally will probably not be considered ill (although he may be considered predisposed to illness) unless BBX has pathological effects other than producing schizophrenia. In sum, it will be found that BBX is a predisposing or facilitating cause of schizophrenic behavior. When present, it significantly increases the probability that the person will behave schizophrenically.

But would discovery of BBX answer the question of whether schizophrenia was a disease or any of the legal questions raised when schizophrenia appears related to legally relevant behavior? Does finding a biochemical predisposing cause of crazy behavior necessitate the conclusion that the behavior is an illness or disease or that other behavior related to it is an uncontrollable symptom? Whether or not a biochemical cause for crazy behavior is found does not yield a definitive answer as to whether to call that behavior an illness or disease or to call its related behavioral consequences symptoms. All behavior—crazy and noncrazy—presumably has biochemical (as well as psychological and sociological) predisposing causes. We

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80. See notes 72-73 and accompanying text supra.
81. Whether or not schizophrenia was considered a disease, the discovery of BBX would be enormously useful for all those who wish to prevent or ameliorate schizophrenic behavior. Another antidotal chemical could be created, Anti-BBX (ABBX) that blocks the effects of BBX. Of course, the results of the use of ABBX, as of all chemical treatments, would probably be mixed. Some percentage of BBX schizophrenics would be cured, some would not. Indeed, it would then seem that the schizophrenia of uncured BBX schizophrenics was not caused by BBX but by something else. Further, some BBX normals who were taking ABBX prophylactically would begin to behave schizophrenically regardless. Although these BBX normals might be predisposed to schizophrenia, when they became so despite taking ABBX, their schizophrenia would seem to be caused by something other than BBX. In addition, it might be so expensive to test all schizophrenics and their relatives for BBX, that ABBX would be given indiscriminately to all schizophrenics and their relatives even though ABBX would not work with non-BBX individuals. Finally, the use of ABBX surely would cause side effects in some users. Still, discovery of BBX and subsequent creation of ABBX would be a great boon to the accurate and efficient treatment of some persons who behave schizophrenically, whether or not schizophrenia was considered a disease.
search mainly for the biological causes of crazy behavior, however, because we have chosen on other, social grounds to consider crazy behavior illness, and illness is expected to have organic causes.

Let us take another example. Great analytic ability (GAA) and mental disorder are both extreme forms of behavior found generally in the population, but of the two, only mental disorder is considered an illness (largely because it is unsettling, inexplicable, and often dysfunctional and productive of suffering). We search hard for the biochemical causes of craziness, but we do not search for the biological causes of GAA because it is not considered an illness. But if researchers spent a century and enormous resources looking for the biochemical cause, Biochemical Blip Y (hereinafter BBY), that produces GAA, they would surely find it or some promising leads to it. Of course, if BBY were found, we would not begin to consider GAA an illness or its consequences uncontrollable symptoms. Considering any behavior to be an illness depends on social evaluation of the behavior and analogizing it to physical dysfunction, suffering, mortality, and the like. Nor would BBY “soft-thinkers” be considered to have GAA. With or without BBY, a person would be considered to have GAA only if his behavior demonstrated it by evidence of hard thinking. Schizophrenia is considered an illness not because it has a biochemical cause or because all of those who behave that way show biological defects. It is considered an illness because schizophrenic behavior tends to be interpersonally dysfunctional and to cause schizophrenics and others to suffer psychologically.

Now, would discovery of BBX mean that persons with BBX are not responsible for their schizophrenic behavior and its consequences? Even if we do consider certain behavior a disease and find some biochemical causes for it, does this mean that persons behaving that way specially lack control over their behavior? While the answer to the question is unknown, it seems clear that discovery of BBX is not dispositive. Some proportion of BBX individuals are normal: BBX is only predisposing to schizophrenia and is not necessary or sufficient. Still, we might decide as a moral matter that if Q% of BBX individuals are also schizophrenic, BBX schizophrenics should not be considered responsible for their schizophrenic behavior and its consequences. This is fine so long as we are also willing to admit that if Q% of BBY individuals are also GAA, BBY GAA’s should not be considered responsible for their great analytic ability and its consequences. Thus, if we do not wish to condemn BBX schizophrenics for the legally relevant consequences of their schizophrenic behavior, neither should we praise BBY GAA’s for the products of their great analytic ability. Each has equally predisposing biochemical causes and calling one an illness does not answer

the question of responsibility.

Who is to be considered responsible, for both positively and negatively valued behavior, does not depend on proof of some degree of biochemical or other causation. It depends on social evaluation of how predisposing the causes are. Finding biochemical or other causes for behavior does not dispose of the millenial problem of free will and responsibility although it may provide data helpful in deciding moral and legal questions. Society can draw the line of responsibility wherever it chooses, but however we choose to evaluate the relationship between various causes and responsibility, the evaluation of predisposing causes logically should apply equally to both crazy and noncrazy behavior.

In sum, in terms of our knowledge of the strength of predisposing uncontrollable causes, at present, there is little reason to believe that any behavior, noncrazy or crazy, is irresistible. Indeed, most of the alleged causes of crazy behavior are only weakly predisposing and craziness is only weakly predisposing to legally relevant behavior. Few causes are as strong-

83. See notes 24, 28, 71-73 and accompanying text supra and note 98 infra. A pertinent question is often raised about cases where craziness and consequent legally relevant behavior appear closely related to physical disease. These cases are rare and probably are best viewed as instances of physical disorder with behavioral correlates rather than cases primarily of mental disorder. Such cases deserve discussion here, however, because they are one powerful paradigm of mental disorder. An understandable first impulse in such cases is to assume that the actor could not have behaved otherwise. This may be true in some instances, but rarely is it clearly so; the issue is more complex.

Let us take an apparently clear example: suppose a previously normal person begins to act unusually hostile and strangely suspicious and finally commits a violent act stemming from the hostility. It is discovered that the person has a brain tumor and neurologists agree that the tumor probably became large enough to exert significant pressure on his brain at about the time he started to behave strangely. When the tumor is surgically removed, the defendant behaves like his old self once again.

How should one analyze the questions of the defendant’s ability to behave otherwise and his legal responsibility? An immediately relevant question would be what percentage of people with tumors of the same type behave as this defendant did. Suppose nearly all people with such tumors act strangely, but most behave harmlessly strangely. Or to make the case harder, suppose the vast majority of such persons experience an uncharacteristic increase in hostility, but most of them control it or express it in trying but not legally relevant ways. Or to make the case easier, suppose few tumor sufferers of this sort experience serious personality changes and almost none behave in legally relevant ways. In all three cases, the tumor seems to be a predisposing cause of some personality changes, and, indeed, in the first two cases it seems to be almost a sufficient cause of the uncharacteristic strangeness or hostility, yet not a sufficient cause of legally relevant behavior.

In all three cases, the tumor is only a predisposing cause (of varying strength) of legally relevant behavior. Clearly other causes seem to be operating, including, perhaps, the actor’s characteristic self-control that is being sorely tested by unusual feelings he cannot account for. If the tumor-suffering actor does behave criminally, the law might decide that his choice to conform his behavior to law was too difficult to ascribe moral and legal responsibility to him. In the absence of perfect correlation between physical disease and resultant legally relevant
ly predisposing as poverty is to criminal behavior, yet we do not excuse the
criminal behavior of poor offenders. If a specific variable over which an
actor had no control, such as a brain lesion, or a specific interacting set of
variables was found to be antecedently present in every or nearly every case
of a particular type of crazy or legally relevant behavior, then we might be
inclined to say that the behavior was the uncontrollable result of the lesion—
that the lesion was a sufficient or near-sufficient cause of the behavior. But
almost no such invariant or near-invariant relationship has been discovered
between behavior and any causal factor. In any case, it will be necessary for
society to make the moral decision as to whether the cause, no matter how
predisposing, should excuse the actor from responsibility for his behavior.

In thinking about the responsibility of persons for their behavior, we
are left with a moral and commonsense determination of whether we
believe the actor's choice was too hard to ascribe responsibility to him. To
the extent that there is scientific data about the causes of behavior, this may
be helpful but it is not dispositive. And, at present, too little is known in
most cases about the causes of behavior for science to be of much help. Still,
we believe that the choices of crazy persons to behave normally must be
harder than the choices of normals because we believe that no one would
freely choose to behave crazily. We shall therefore next examine some
further evidence bearing on the ability of crazy people to behave normally
and rationally.

b. Is the behavior of crazy people and normal people significantly
different?: Another approach to thinking about whether crazy persons have
control over their behavior is to consider the total range of behavior emitted
by crazy persons and then to compare this behavior broadly to that of
supposedly normal persons. Three types of evidence are relevant here: (1)
clinical observation of crazy people; (2) empirical research comparing crazy
people to normals; and (3) empirical research bearing directly on the
rationality and normality of crazy persons. If the differences between crazy
people and normals are not as great as one might suppose and if crazy
persons have significant capacity for normal, rational behavior, then doubt
must be cast on the hypothesis that crazy persons are vastly out of control of
their behavior.

behavior, scientific evidence would not support the inference that the defendant lacked all
ability to control himself and to act within the law. See Virkkunen, Nuutila, & Huusko, Brain

Finally, if among all actors who commit the defendant's act, more have a background of
broken homes than have a tumor, one may wonder why the law would consider a tumor but not
a broken home relevant to responsibility. See Bazelon, supra note 73, at 394, 401-05.
It is a striking clinical commonplace that crazy persons behave normally a great deal of the time and in many ways. Even when they are in the midst of a period of crazy behavior, much of their behavior will be normal. Further, between crazy periods crazy people are not reliably distinguishable from normal persons. As a general matter, then, crazy people are by no means constantly crazy and they are capable, even when behaving crazily, of also behaving normally and rationally.

Most of the empirical research concerning craziness has attempted to demonstrate the difference between crazy persons and normals in a variety of behavioral tasks. Two well-respected researchers recently reviewed 300 such published studies of schizophrenia that appeared between 1959 and 1973 in two particularly prestigious and rigorous journals. The objective of the review was to determine if the enormous amount of research during the period covered had identified any stable, objective behavioral correlates of schizophrenia.

If I had to make a general statement about the results of the 300 studies, I would say that most of the investigations show small differences that favor the normal sample. That is, normals on the average get “better” scores. A few studies report no differences, and at least one reports a difference where the normals do worse. The statistical operations are designed only to show that the small differences between averages of the samples are probably not related to chance factors.

So long as there is a statistically reliable difference between the means of the two samples (no matter how small), the investigator implies or asserts a claim for the validity of his model and then makes the logically inappropriate inference that schizophrenics function differently from normals. From inspection of the data it is clear that most schizophrenics function no differently on these experimental tests from most normals. It would be the height of folly to try to identify a person as schizophrenic or normal by his score on any known experimental variable. This is an alternative way of saying that every study contains a high proportion of cases that are counter-instances to the predictions of the particular hypothesis.

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85. The reviewers were T.R. Sarbin and J.C. Maneuso. The results of the review are reported in T. Sarbin, Ideological Restraints on the Science of Deviant Conduct 14-15 (Apr. 19, 1975) (unpublished ms.) (on file with the Southern California Law Review). The journals reviewed were the Journal of Abnormal Psychology and its predecessor, the Journal of Abnormal and Social Psychology.

86. T. Sarbin, supra note 85, at 15-16 (emphasis in original).

The statistical tests are not designed to locate the subjects precisely as belonging to
Similar findings have been made with respect to affective disorders.\footnote{87}

In sum, those behavioral deficits that are hypothesized to be characteristic of the most common severe disorders are ranged along a continuum of severity and are ubiquitously present in the normal population. The inability to think straight, pay attention, process information, perform social tasks competently, and the like is hardly unique to crazy people. Few, if any, formal, measurable behavioral deficits seem uniquely and inexorably to lead to craziness or to consequent legally relevant behavior.

Another type of empirical evidence bearing on the capability of crazy persons to behave normally and rationally is found in two programs of research done on hospitalized crazy persons—those who are usually the most crazy. The first deals with “impression management,”\footnote{88} the ability of

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\footnote{87. See, e.g., A. Beck, supra note 84, at 228 (conclusion from the studies reviewed disputed on the basis of one study performed by the author, but this study is too flawed methodologically to count as significant contrary evidence); Andreasen, \textit{Do Depressed Patients Show Thought Disorder?}, 163 J. NERVOUS & MENTAL DISEASE 186 (1976) (limited definition of thought disorder; nonpsychotic sample although some subjects had endogenous phenomenology). \textit{But see} Braff & Beck, \textit{Thinking Disorder in Depression}, 31 ARCHIVES OF GENERAL PSYCHIATRY 456, 458-59 (1974) (rather limited definition of thought disorder; depressives showed greater abstract thought deficit than normals, but less than schizophrenics; but depression in depressives positively correlated with abstract thought). Fewer empirical studies have compared normals to persons with affective disorders than have compared normals to persons with schizophrenia. Even if persons with affective disorders have cognitive deficits such as thought disorder, however, it is clear that normals have such deficits as well. \textit{See} note 86 and accompanying text \textit{supra}.}

\footnote{88. See generally E. GOFFMAN, \textit{The Presentation of Self in Everyday Life} 208-37 (1959).}
hospitalized patients to manipulate the craziness of their own behavior in order to maneuver hospital personnel so that the patients will attain their goals. For example, many patients, even quite crazy ones, are able to convince their hospitals that they are crazy or not in order to remain in hospital or gain release. 89

Some patients are arguably unaware of their manipulations, a possibility that has led some commentators to claim with some justification that such unself-conscious behavior is not evidence of the patients’ ability to cope rationally with their environment.90 This argument, however, proves too much. The inability to identify correctly and be aware of one’s “real” reasons for action is hardly evidence of irrationality or abnormality; if it were, the class of persons considered abnormal would expand considerably. Indeed, some researchers claim that correct identification and awareness of the reasons for one’s action are the exception rather than the rule.91 Further, it is not certain that some patients are totally unaware of what they are doing; many are so aware.

The second research program bearing on the rationality of crazy persons involves “token economies,” behavior modification regimens wherein institutionalized mental patients are rewarded for approved behavior by being given tokens such as points or poker chips. The tokens can then be used to purchase desired goods or increased privileges.92 Token economies

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90. See, e.g., Moore, supra note 14, at 1485-87.


are often effective; patients do change their behavior in the desired ways.\footnote{93} Although cast in the theoretical terms of operant psychology, the programs can also be characterized as positing a rational, economic theory of human behavior. Patients respond to changes in relative prices and wages as economic theory predicts normal persons will respond;\footnote{94} that is, patients act to maximize their expected utilities. The effectiveness of token economies and their conformity to "rational person" economic models is further evidence that crazy persons are capable of behaving as rational beings when they are offered the incentives to do so.

Thus, a great deal of evidence indicates that crazy persons are capable of behaving normally and rationally, and that they are not very different from normals in terms of behavioral deficits or background variables. This evidence suggests that many crazy people can behave normally or control themselves when they choose to do so. At the least, one can infer that the behavioral control of crazy persons is not an all-or-nothing phenomenon and that it is ranged along a continuum. Very few, if any, crazy people seem to have no control and most appear to have a great deal.

This Article does not contend that people who are considered crazy are no different from people who are considered normal. Some crazy persons do seem totally or near totally different from most people. It is simply unbelievable to most persons that people who are hallucinatory or delusional have substantial control over their crazy behavior, or over behavior that is directly related to the crazy behavior. For some crazy people, behaving normally or controlling behavior related to their craziness may be extremely difficult. Little hard evidence indicates, however, that crazy persons cannot control much of their craziness, or at least other behavior related to their craziness.

Claiming that crazy persons could not do otherwise is little more than an intuitive hunch, a post hoc moral justification employed to reach the result of differential legal treatment. The widely held hunch that the choice of crazy persons to behave normally or that to control behavior related to

\footnote{93} See Gripp & Magaro, The Token Economy Program in the Psychiatric Hospital: A Review and Analysis, 12 BEHAVIOR RESEARCH & THERAPY 205 (1974); note 92 supra. For a less positive analysis of token economies, see Hersen, Token Economies in Institutional Settings: Historical, Political, Deprivation, Ethical and Generalization Issues, 162 J. NERVOUS & MENTAL DISEASE 206 (1976).

craziness is a very hard choice may be correct, but behavioral science has not furnished persuasive proof of this. Even in the seemingly easiest cases of extreme disorder, no one can be sure that the actor could not have behaved otherwise (although it might have taken great effort to do so). With this in mind, let us turn to the question of the causal relationship between craziness and legally relevant behavior.

3. **Is Craziness the Cause of Legally Relevant Behavior?**

The behaviors referred to in the second component of mental health law standards such as dangerousness, inability to appreciate the nature of one's actions, inability to assist one's criminal defense counsel, or lack of ability to manage one's property are all maladaptive behaviors. In these instances, respectively, civil commitment, a defense to criminal responsibility, incompetence to stand trial, or conservatorship can result if the behaviors were related to and legally caused by mental illness; the behavior must be so clearly caused by the mental disorder that society and the law can no longer ascribe causal responsibility to the actor's free choice.

It must be shown that the actor could not do otherwise. Persons who are capable of controlling their behavior are considered fully responsible and, within the usual legal limits, are allowed to behave as irrationally or irresponsibly as they wish; the law does not treat such people specially. Unless there is a causal nexus between the mental disorder and the other criteria, mental health laws should not apply because it is assumed that there is something legally special only about behavior that is primarily caused by mental disorder and not by autonomous choice. The questions, then, are how can the relational and causal nexuses be demonstrated and who should make such determinations.

The threshold issue for deciding if the actor could do otherwise is whether there is a relationship between the actor's mental disorder and the other legally relevant behavioral criterion. If the relationship exists, the case may be appropriate for mental health law adjudication because the legally relevant behavior may be a product of the mental illness and therefore not freely chosen.

Although a person has acted crazily in some ways on some occasions, all his behavior is not necessarily the product of craziness. If we were to conclude otherwise, we should also have to assume that a crazy person's normal behavior is the result of the person's craziness. The actor may be crazy, but if his legally relevant behavior is not the product of or at least affected by craziness, there is little reason to believe that the other behavior was not freely chosen. If the actor freely chose his legally relevant behavior, the usual legal rules, not special mental health rules, should be applied to the
This Article has argued that mental disorder is really crazy behavior of usually unknown origin. Thus, when one asks if mental illness is the cause of or is related to legally relevant behavior, one is really asking when behavior causes or is related to other behavior. That is, when are crazy thoughts, feelings, or actions the cause of legally relevant thoughts, feelings, and actions? Stated this way, three types of relationships between mental disorder and legally relevant behavior may be distinguished.

1. Clear relationship—e.g., a paranoid attacks someone who is not an enemy but who is part of the paranoid’s delusional system.
2. No relationship—e.g., a paranoid who self-defensively strikes a person who has attacked the paranoid without provocation. Even paranoids have real enemies.
3. Unapparent but assumed relationship—i.e., where the legally relevant behavior itself seems crazy but where there is no other independent and significant evidence of craziness, e.g., cases of alleged impulse disorder such as inexplicable violent outbursts.

Before we can consider whether legally relevant behavior is caused by craziness, we must first make the threshold determination that there is a relationship of some type between craziness and the legally relevant behavior. How is the presence or absence of the relationship determined? Are mental health experts needed to help make this determination?

a. Crazy behavior clearly related to legally relevant behavior: A clear case is presented where crazy behavior, such as a belief in hostile enemy agents, is the obvious precursor to legally relevant behavior, such as killing a victim sincerely believed to be an agent. If the defendant is not lying about his beliefs, he is clearly crazy and his particular crazy behavior is beyond doubt related to the legally relevant behavior, the killing.

Do we need an expert to help us determine that a relationship exists in this case? No test will demonstrate the presence or absence of a mental disorder other than the behavior—the crazy belief itself. We clearly do not need an expert to tell us that this particular belief is crazy or that it is related to the legally relevant behavior. We might question the person’s sincerity with respect to his beliefs, but sincerity and truthfulness are not the special province of mental health experts. There is no underlying disorder whose presence or absence tells them or judges and juries if this crazy belief is “for real.” We should probably be inclined to trust the defendant’s sincerity if, for example, he had also entertained other crazy beliefs or had consistently
demonstrated this belief. Again, there are no tests; we observe the behavior or hear evidence about it, and then decide if it is crazy and related to the legally relevant behavior.

b. Crazy behavior seemingly unrelated to legally relevant behavior:
The second case is where there seems to be no relationship between the actor's crazy behavior and other behavior that satisfies the behavioral component of the mental health laws. Behaviors that satisfy the behavioral component of mental health laws are usually maladaptive, but they are not necessarily crazy behaviors. The behavioral standard of "dangerous to others" is an example of behavior that need not be crazy in the sense that we are using the term "crazy." For instance, an organized crime "hit man" is not necessarily crazy, nor is his dangerous behavior seemingly crazy in itself.

Now consider the case of a generally nondangerous paranoid who gets into a fight with a person he considers an enemy for reasons totally unrelated to his paranoia. It would strain plausibility to assume that the fight was a result of the paranoia.

Consider the harder case of an actor who is both crazy and generally dangerous in a noncrazy way. For instance, a person may have very crazy beliefs and also be temperamentally hostile, becoming quite assaultive when crossed, including when crossed about matters unrelated to his crazy beliefs. If this person did not have queer beliefs, he would be considered difficult, dangerous, and perhaps rather evil. Because of the queer beliefs, however, it will often be claimed that he is dangerous because he is crazy. Such a claim could only be proved by establishing the existence of an underlying mental disorder that allegedly causes both the craziness and the temperamental hostility. We have seen, however, that claims about the existence of such underlying states are, in nearly all cases, unprovable speculations.

Finding the link between craziness and legally relevant behavior in either of the examples just described would necessitate relying on the assumption that when a person exhibits any crazy behavior, all of his socially deviant behavior must also be related to his craziness. Such assumptions are often made in order to reach a particular result such as commitment of the dangerous person. But no scientific evidence presently demonstrates the existence of relationships between underlying mental dis-

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95. This assumption is especially unlikely in view of the fact that even the craziest persons behave normally in a great number of ways and a great amount of the time. Indeed, in many if not most respects, crazy persons are more like normals than unlike them. See notes 84-94 and accompanying text supra.
orders and two seemingly unrelated behaviors, one of which is crazy. Thus, there is no scientifically based rationale for applying the mental health law in such cases and no need for experts to theorize about the presence of allegedly underlying connections.

c. Crazy legally relevant behavior: The third case arises when the behavioral criterion of a mental health law is satisfied by behavior that is arguably crazy, but where there is no other significant, independent evidence of craziness. Inexplicable or seemingly random assaultive behavior is a good example. Consider the case of a person who attacks others only when he feels like it or when he has inexplicable rages and for no other rational reason. Or, consider a person who mutilates himself for no apparent reason. Such behavior is dangerous, deviant, disturbing, and may be deemed crazy by some persons. If, however, the actor gives no other evidence of crazy thoughts, feelings, or actions, is the actor crazy, and if so, is the craziness related to his violent behavior? In this case, as usual, an expert cannot tell us whether the person suffers from an underlying mental disorder that causes the violence, and without the assaultive behavior there is no other evidence of craziness. In order for the mental health law to be applied here, laypersons must simply decide that the person is or must be crazy because the behavior that satisfies the “dangerousness” standard is so crazy in itself.

Absent independent evidence of craziness, however, a tautological conclusion must be reached to apply the mental health law. For instance, we decide that the actor is crazy because he is randomly assaultive. Why is he assaultive? Because he must be crazy. The relationship is found on the basis of circular reasoning. Such an outcome is possible and occurs regularly because a vast number of persons, including many, if not most, mental health professionals, probably feel that such behavior is evidence of mental disorder. 96 That is, most people believe that no rational person would choose randomly to hurt others or himself because he feels like it. Rather, they believe that the person must be crazy. The relationship of craziness to legally relevant behavior is not apparent here, but many assume it is present.

96. This author knows of no empirical study bearing directly on this point, but it follows logically from the definition of craziness itself and from the general attitudes of psychiatrists and the public to such behavior. See note 3 supra. Such behavior will be considered queer or odd or as evidence that something is wrong unless a coherent explanation can be given for it. See J. Feenberg, supra note 39, at 285-89; Mechanic, supra note 4, at 22; Moore, supra note 14, at 1485.

The hypothetical in the text rules out the possibility of a coherent explanation. The notion that something is wrong in this case would be reinforced by the stereotype that crazy persons are dangerous and unpredictable. See sources cited in note 3 supra. The lack of a coherent explanation together with the stereotypes will almost certainly lead both laypersons and experts
Now, whether or not random violence or any other behavior is crazy in itself plainly is not a scientific matter; it is a matter of cultural expectations, and thus can be assessed by any member of society. In all cases, the determination of whether the legally relevant behavior is crazy per se or is related to craziness is a commonsense determination. There are no scientific tests to demonstrate underlying connections; observable relationships can be evaluated by anyone.\(^\text{97}\)

4. *Is Craziness the Uncontrollable Cause of Legally Relevant Behavior?*

As we have seen, craziness is not invariably related to legally relevant behavior. Most crazy persons do not behave in legally relevant ways such as dangerously or incompetently.\(^\text{98}\) Further, many people who are not crazy do behave in those ways. The conclusion that an actor is crazy does not compel the further conclusions that his legally relevant behavior was uncontrollably caused by his craziness, or, even, that the behavior was related to the craziness. If all or nearly all crazy persons were found to behave in a particular legally relevant manner and such behavior never or rarely occurred in the absence of craziness, then we might be inclined to say that in general the behavior was perhaps caused by the craziness, especially if the

to the conclusion that such behavior is crazy and evidence of illness. Of course, some people might also consider it evil.

\(^{97}\) An interesting example that may seem to disprove some aspects of the thesis of this section is presented by Dr. Bernard Diamond. The crazy behavior he discussed was the killing of an 8-week-old infant by its mother who felt that she was unable to care properly for the baby and thus thought it better off dead. The woman did not seem mentally ill at the time of her psychiatric examinations and evidently she had been in contact with reality at the time of the killing. All the doctors assumed, however, that she must have been crazy because she had behaved crazily in similar circumstances in the past: immediately after the birth of her first child, she had behaved in a terribly depressed and disorganized fashion. Further, psychological tests (we are not told which) supported the alleged presence of a residual schizophrenic disorder. Thus, it may seem that experts were necessary to demonstrate the relationship of an underlying mental disorder to the killing where no relationship was otherwise evident. Diamond, *Criminal Responsibility of the Mentally Ill*, 14 Stan. L. Rev. 59, 61-62 (1961).

This Article contends, however, that no experts were needed. Even if the woman had behaved crazily in the past, there is no evidence that she was still behaving crazily at the time of the killing—except, perhaps, for the killing itself. The evidence from the psychological tests is almost certainly inconclusive because of general reliability and validity problems. Assume, however, that she was able to demonstrate independently of the killing that she was under terrible stress following the birth of the second infant. Putting all the facts together, one might reasonably infer and conclude that after the second birth she was under enormous stress and not herself even though she was not behaving crazily. Under such circumstances, it might seem just to mitigate her culpability or perhaps excuse her actions altogether. There is no persuasive evidence, however, that the killing, crazy as it may seem compared to the usual maternal response, was related to an underlying mental disorder. Notice too that no expertise was necessary to collect the crucial data or to draw the critical inferences. The conclusions of the experts about underlying diseases were unproved speculations and added very little to the commonsense moral evaluation that needed to be made.

\(^{98}\) See Buchsbaum, Haier, & Murphy, *Suicide Attempts, Platelet Monoamine Oxidase*
relationship between the craziness and the legally relevant behavior was clear. But no such invariant or near invariant relationship has been discovered between craziness and legally relevant behavior. As a general matter, then, craziness is perhaps predisposing to legally relevant behaviors, such as incompetence and dangerousness, but not more predisposing than many variables affecting normal persons who behave in the same way.

Still, the law is concerned with specific cases where an actor may be clearly crazy and where the craziness is clearly related to legally relevant behavior. Even if, as a general rule, craziness is only predisposing to legally relevant behavior, in specific cases where craziness is clearly related to legally relevant behavior how does one decide if the actor could have behaved otherwise? In terms of responsibility, how should one conceptualize the individual case of clear relationship between craziness and legally relevant behavior (e.g., killing someone because it is believed that the victim is a hostile enemy agent)? Is the paranoid capable of attending to and weighing information contra to the delusional belief, or at least controlling overt action based on the belief? These questions may seem strange, but their answers are at the theoretical base of why such persons are treated specially. The questions seem strange, especially to mental health clinicians, largely because mental health scientists and laypersons alike assume they know the answers despite the lack of what most would consider acceptable scientific proof.

Individual cases of clear relationship may be separated into two types: crazy urges and crazy reasons. In each case, this section considers the particular factors that help one decide whether the actor could have behaved otherwise. Even assuming that the craziness was a causal variable, the critical question remains: Was the crazy urge uncontrollable or was the crazy reason and the legally relevant behavior based on it the inexorable result of a disturbed mind?99

99. Crazy urges (i.e., impulses, feelings) and crazy reasons are the phrases used in this

and the Average Evoked Response, 56 Acta Psychiatrica Scandinavica 69, 70 (1977) (suicide not a specific symptom of a particular mental disorder, including affective disorders, or of mental disorder in general; rates of suicide considerably higher among mental patients than among normals, but only small percentage of patients attempt or succeed in suicide); Lagos, Perlmutter, & Saexinger, Fear of the Mentally Ill: Empirical Support for the Common Man's Response, 134 Am. J. Psychiatry 1134 (1977) (literature review and discussion; original empirical study too flawed to allow any significant conclusions to be drawn therefrom); Virkkunen, Nuutila, & Huusko, Effect of Brain Injury on Social Adaptability, 53 Acta Psychiatrica Scandinavica 168 (1976) (certain brain injuries do not lead to reliable conclusions about how a previously healthy person will be affected in the long run or whether such injuries lead to criminal behavior); sources cited in note 24 supra. Mental illness is so weakly correlated with most legally relevant behavior that knowing a subject is crazy does not help predict with substantial accuracy his future legally relevant behavior. See generally notes 116-44 infra.
a. Crazy urges: The case of crazy urges refers to what is usually termed an "irresistible impulse." The actor may be perfectly rational cognitively, but he feels as if he must carry out a particular behavior and that he cannot prevent himself from doing so. He may be quite aware that the action he feels compelled to perform is weird, deviant, immoral, maladaptive, or the like. Still, he feels incapable of behaving otherwise. If the behavior felt to be compelled is weird, deviant, or immoral, we are inclined to believe that the urge is crazy, because no one would desire to behave in those ways when he comprehends how those behaviors were assessed. The prototypical case of a crazy urge is the sexual deviant, e.g., a child molester, who knows that his actions are viewed as sick or evil (or both) by most persons, and yet who feels an overwhelming desire to molest children.

Is the child molester’s behavior the irresistible effect of his crazy urge? To analyze this question we must first ask the threshold question of whether the actor’s crazy urge is related to mental illness. This case is a clear example of the situation where craziness is diagnosed because the legally relevant behavior seems crazy itself and where no other significant evidence of mental disorder may exist. We assume that there must be some underlying abnormality because no rational person would choose to molest children unless he was "forced to" by circumstances beyond his control. We have already seen that there is no evidence of underlying abnormality in such cases, but let us accept arguments that it is reasonable to call this person crazy because he experiences a perhaps inexplicable and crazy urge.

Is the urge irresistible? For at least two reasons, most persons would assume that the urge must be very strong. First, the molester reports that the urge is overwhelming. Second, it seems intuitively obvious that most

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Article to map the commonsense and long recognized observation that there are two major classes of variables that undercut responsibility—compulsion and ignorance or mistake. ARISTOTLE, Nicomachean Ethics, in 2 THE WORKS OF ARISTOTLE 339 (R. Hutchins ed. 1952). Modern insanity defense tests, for instance, have recognized this classification by allowing two different sorts of insanity excuses: those based on volitional incapacity and those based on cognitive-affective incapacity. MODEL PENAL CODE § 4.01, Comments, 156-60 (Tent. Draft No. 4, 1955). See also J. FEINBERG, supra note 39, at 285-92 (crazy reasons are what is so special).

The common assumption about crazy people is that crazy urges and crazy reasons are themselves beyond the actor's control and that actions based on those urges and reasons are likewise beyond the actor's control.


101. See notes 96, 99 and accompanying text supra.
persons would not "give in" to such an urge unless it was overpowering. Let us assume that, indeed, the urge is powerful and perhaps even tormenting to our molester. But could it have been resisted, albeit at the cost of frustration and discomfort? Do all persons who feel such urges give in to them, or are there some who resist?

Although there exists little systematic epidemiological study of such questions, it is clear from clinical practice that many persons report extremely strong "deviant" urges that are often a source of misery to them.\textsuperscript{102} Yet most persons do not engage in the urged behavior; indeed, many seek assistance from clergymen, doctors, counselors, and psychotherapists in order to defeat the urge. Holding that the urge is not overwhelming in such cases, but that it is overwhelming in the cases of those who give in, is tautological reasoning: the urge must be overwhelming because the person gave in. In terms more familiar to lawyers, we are faced with the difficulty of distinguishing between the irresistible impulse and the impulse not resisted.

There is no scientific measure of the strength of urges. Nor is there evidence of what percentage of people who experience various urges of various strengths act on those urges. Even if such measures and data were available, as they may be someday, the measured strength of the urge would not answer the question of whether the urge was irresistible.\textsuperscript{103} Such data may help us to identify how predisposing, in a statistical sense, the urge might be, but they would not answer the question of moral and legal responsibility. Where to draw the cutting point would clearly be a moral and legal determination. In the future, behavioral science may provide more precise information to help draw the line, but science alone cannot draw the line of legal responsibility.

At present, then, the determination of the irresistibility of crazy urges must rest on commonsense assessments of the craziness and strength of the urge. The data to be evaluated would be first, the report of the urged actor,


\textsuperscript{103} A behavioral view would characterize the matter differently, however, and might claim that one can measure the strength of urges by reciprocally measuring the strength of self-control. Briefly, this could be done by estimating quantitatively the actor’s knowledge of and control over the situational variables that seem functionally related to the crazy urge. \textit{See} C. Thoreson \& M. Mahoney, \textit{supra} note 102, at 8-10.
and second, the craziness of the urged action. Whether certain urges are crazy is not a scientific question that needs expert answers. And whether the urge is sufficiently strong or crazy is a question that is answered by assessing the reported feelings of the actor and the sincerity of his report. There is simply no test for knowing when an urge is irresistible, and indeed, there is no reason to believe that there is any urge that is not, to some degree, resistible. Deciding whether an urge is irresistible is not a scientific decision.

b. Crazy reasons: It may also be believed that an actor had no free choice about whether to engage in certain behavior if the actor reports crazy reasons for his behavior. If an actor kills someone because he sincerely believes the victim was a hostile agent, we believe that the killing not only is related to the crazy belief as was seen above, but that it is the compelled result of the crazy belief. After all, no one would hold and act on such beliefs unless there were something uncontrollably wrong with him that caused him to have those beliefs.

Before we can determine whether an actor had control over his crazy reasons and consequent actions, we must first analyze the nature of a crazy reason. Following from our definition of craziness itself, we may define a crazy reason as one that is irrational and inexplicable. Of course, the degree of craziness of a reason varies along a lengthy continuum. Consider three variations of an example: a person refuses to take a lifesaving drug, even though the drug is minimally risky in itself. In variation one, the person refuses because he sincerely believes the prescribing physician is an enemy agent who intends to poison him. In variation two, the actor expresses fear of the drug even though he recognizes that it is quite irrational to refuse to take it. In variation three, the person refuses to take the drug because he is a firm believer in a religion that accepts only natural healing.

Most persons would agree that the reason in variation one is crazy and that the reason in variation three is not. There would probably be a great deal of disagreement about variation two, however. Expectedly, decisions about the unclear cases seem difficult because they are contextually and culturally relative.

It is difficult to conceive of any reason for behavior that is per se crazy; whether a reason is crazy is a function of cultural expectations. In all three variations of the example above, the actor is operationally suicidal. Yet in our culture, religious reasons are considered valid and therefore noncrazy. A completely "techno-scientific" society might find the religious reason in variation three quite crazy. Variation two is particularly hard in our society.
because there is no general cultural valuing of such inchoate fears; in
general, however, the person seems quite normal. Ultimately, the touch-
stone for decision in variation two would probably be whether or not the
person was capable of reasoning normally and of reaching a different
decision. Indeed, this capacity is probably the heart of the issue. In variation
one, we assume the person was not capable of reasoning normally. In
variation three we are fairly sure the person is so capable. In variation two
we are simply not sure.

Once it is determined that the reason given for legally relevant behavior
is or may be crazy, the crucial issue becomes whether the crazy reason was
an irresistible product or result of mental disorder. We ascribe personal and
legal responsibility to the actor who gives a crazy reason for his behavior so
long as we believe that he was capable of reasoning noncrazily. Thus, we
must delineate the criteria for deciding whether a person is capable of
reasoning noncrazily.

A crazy reason may be considered the compelled product of a disor-
dered mind if either (or both) of two criteria are met: First, the actor's
behavior seems to demonstrate a significant perceptual and attentional
deficit, that is, the actor seems incapable of attending to the factors relevant
to his decision to act; or second, the actor is incapable of weighing the
factors relevant to his decision. These criteria explicitly focus on the
reasoning process itself rather than on the outcome of the reasoning process
(i.e., the crazy reason itself or the behavior chosen). The law should and
often does focus on the process because the nonresponsibility argument
holds that the person is incapable of reasoning noncrazily, not that the
person finally gives reasons that may seem crazy. By focusing on the
person's reasoning capability rather than the reasons he gives (although the
two are intertwined in practice), the law preserves the person's autonomy,

104. See H. FINGARETTE, supra note 39, at 175-203; Murphy, Incompetence and Paternal-
ism, 60 ARCHIVES PHILOSOPHY L. & SOC. PHILOSOPHY 465, 473-78 (1974). Most authors
assume that if the actor consistently attends and weighs data irrationally, it must be because he
is incapable of doing so rationally. This is a fine, commonsensical approach; if the person
shows no counter-instances of rational weighing or attending, it is perhaps a fair conclu-
sion that the person was incapable of behaving otherwise. Of course, this conclusion follows
not from the discovery of a defect in the person, but from observations of his interactions in the
world. If, however, there are counter-instances of rational weighing and attending, it seems
reasonable to conclude that this actor does have some capability for rationally weighing and
attending. See Lehrer, An Empirical Disproof of Determinism?, in DETERMINISM, FREE WiLL,
AND MORAL RESPONSIBILITY, supra note 67, at 173-82; notes 84-94 and accompanying text
supra. A possible response to counter-instances would be to show that a person always gives
crazy reasons under certain conditions even though he attends and weighs rationally under
others. We might then assume that under specific conditions he is incapable of behaving
rationally.
dignity, and liberty; the actor is allowed, within the usual legal limits, to live his life as he pleases and to act irrationally if he chooses.105

To analyze further the question of whether a crazy reason is the inexorable result of a disordered mind, let us return to variation one, the case of the person who refuses to take a drug because he believes that his physician is an enemy agent who intends to poison him. Assume that the actor is reasonably intelligent and that he has been fully informed of the known benefits and risks of the medication. The actor who believes the doctor is a hostile agent who intends to poison him is clearly mistaken and crazy. Almost certainly, enormous amounts of data are available that would contradict his belief, and we may expect that much of this data has been brought to his attention by those concerned for the actor's health. Assuming he is totally convinced and has no reservations about the crazy belief,106 either the actor is not attending to this data or he is not weighing it in any rational or explicable manner. But is he incapable of attending to or weighing the relevant considerations? Unfortunately, there is no scientific means by which to test such capability. Nor does the fact that the reason given is crazy decide the question in a scientific sense.

It is clear in variation one that the person has given a crazy reason and that the crazy reason is related to the refusal to take the drug. We may conclude that a person who sincerely believes that his physician is a hostile agent must be incapable of attending to and weighing the data that might lead him to a contrary conclusion, particularly because the consequences to the actor are so great. The grounds for such a conclusion, however, are moral and social. Indeed, the decision must be based on the belief, unsupported by scientific evidence, that it is simply impossible for someone to maintain and act on such a crazy belief unless he is incapable of doing otherwise.

We do not and cannot know in a scientific sense whether the actor was incapable. There is, after all, an alternative to the intuitive hunch that he must be incapable. It may be that the actor has great difficulty in thinking straight, in perceiving consensual reality in a more or less normal manner. He may be and probably is aware to some degree that his perceptions are "out of line," but he may also be unwilling to exert himself to pay attention to or to give any weight to the data that might help him better align his

105. Friedman, supra note 92, at 77-80; Developments, supra note 6, at 1212-17; Note, Mental Health: A Model Statute to Regulate the Administration of Therapy Within Mental Health Facilities, 61 MINN. L. REV. 841, 879-80 (1977).

106. There is no scientific way to prove this. It is a commonsense evaluation that must be based on an assessment of all the relevant circumstances. See text accompanying note 57 supra and notes 181-85 and accompanying text infra.
perceptions and beliefs with consensual reality. Or, given his crazy reasons, he may be unwilling to exert himself not to act on the basis of those crazy reasons or beliefs.\textsuperscript{107}

It may be very hard for a person to think straight; in some cases, crazy beliefs may powerfully compel the crazy person to act on them. But there is no certainty that an actor cannot control his crazy beliefs or, at least, control actions based on them. Indeed, even the craziest persons seem to behave quite normally or rationally a great deal of the time, especially if there is good reason to do so. On at least some occasions, including some instances when they are behaving crazily, crazy persons are clearly capable of playing by the usual rules.\textsuperscript{108} Nor do they always act on the basis of their crazy reasons. Moreover, the defects and disordered thinking that supposedly distinguish crazy persons from normal ones are very prevalent in the general population.\textsuperscript{109} The actor in variation one may finally be declared incompetent and forced to take the drug, but the decision will be based on the strongest sort of commonsense or intuitive basis and not on any scientific knowledge. Even if it is found that the person typically seems out of touch with reality, reasons crazily, and gives mostly crazy reasons for his behavior, scientific evidence cannot demonstrate that such behavior is the result of mental disorder and that related legally relevant behavior is sufficiently unfree to ascribe nonresponsibility to the actor. At most it can be urged that a person who typically does not think “straight” is more or less predisposed to give crazy reasons and to act on them. Whether Daniel M’Naghten could have countered his crazy belief about Peel or could have controlled his behavior based on the belief is simply not capable of scientific determination.\textsuperscript{110}

In summary, no test can determine whether the crazy reason given in a particular case was the product of an underlying abnormal condition or whether the actor could have controlled his behavior based on the reason. Indeed, there is no scientific standard of how a person should “normally” attend to and weigh factors relevant to a particular matter. All we have are culturally determined standards. Behavioral scientists arguably possess the expertise to determine and describe in precise detail how a specific actor’s

\textsuperscript{107} It is well recognized that delusional people do not always act on the basis of their crazy beliefs. \textit{See, e.g.}, DSM-III, supra note 26, at C:11 (“The impairment in functioning [of a paranoid schizophrenic] may be minimal if the delusional material is not acted upon...”).

\textsuperscript{108} \textit{See} notes 84-94 and accompanying text supra. \textit{See also} note 104 supra.

\textsuperscript{109} \textit{See} notes 85-87 and accompanying text supra.

\textsuperscript{110} \textit{See} M’Naghten’s Case, 8 Eng. Rep. 718 (House of Lords 1843); N. Walker, \textbf{1 Crime and Insanity in England} 84-103 (1968) (an account of the case and its background); Moran, \textit{Awaiting the Crown’s Pleasure: The Case of Daniel M’Naghten}, 15 \textbf{Criminology} 7 (1977) (argument that the exculpation of M’Naghten on medical grounds helped the Tory government to minimize the considerable political problems that were then plaguing it).
mind functions in general or in relation to a specific matter, but whether the described type of functioning is compelled or ought to be considered compelled is not a matter for scientific determination. Deciding whether the person could have attended to or weighed the factors differently is a moral, social, and legal determination that must be based on commonsense observations and evaluations of the actor's behavior. Some choices may be too hard, but identifying which ones are too difficult is not a matter of scientific judgment.

5. Summary

Whether craziness is related to and seems to be a causal variable that produces legally relevant behavior is a commonsense and moral determination. A commonsense and intuitive view would hold that although all of us choose our behavior, we are all subject to various factors that affect our behavior. The many variables operating on an actor affect choice, making some choices harder and some choices easier. The choice to behave crazily or to behave in ways related to the craziness seems not to be an exception. No mental health-related factor makes certain the occurrence of crazy behavior, nor does craziness make certain the occurrence of legally relevant behavior. It is possible, however, that some of these factors so predispose an actor to crazy behavior and its legally relevant consequences that it is unjust not to respond differently to the crazy actor.

There is no bright line, however, between free and unfree choices. Whether persons are to be held responsible for their crazy behavior is not a scientific matter to be determined by experts. It is a moral, social, and legal matter to be determined by legislatures and courts, the political and legal representatives of society. Moreover, the line drawn reflects a moral judgment that is not compelled by scientific findings. We simply do not and cannot have a scientifically proven answer to the question of whether crazy persons or normal persons have free will. Behavioral scientists and laypersons both have intuitive hunches: observers simply decide whether in their judgment it was too hard for the crazy person in question to behave otherwise, e.g., to counter the crazy reason or to resist the crazy urge. Even if it could be demonstrated that people who act crazily often have underlying mental disorders, this finding would not require the conclusion that the disordered person's legally relevant behavior was compelled.

Like a gun held at one's head or a particular type of upbringing, an underlying mental disorder (if such exists) might be a predisposing factor to

111. See text accompanying notes 178-79, 186, 189-90 infra.
112. See Murphy, supra note 104, at 476-79.
certain types of behavior, but there is little reason to believe that crazy persons do not choose their behavior or are incapable of behaving otherwise, even if the reasons for their behavior are inexplicable to normal persons. It may be extremely difficult for crazy persons to control their crazy behavior and related legally relevant conduct, but we simply do not know that they cannot.

D. HOW WILL THE PERSON BEHAVE IN THE FUTURE?

Once the legal system has determined that a person is abnormal and that his legally relevant behavior was uncontrollably caused by craziness, the next question that is asked by mental health law is, "How will this person behave in the future?" Although predictions about future behavior are not relevant to all mental health or mental health-related laws, in many important areas such as civil commitment or child custody disputes, predictions are a crucial focus of legal inquiry. Indeed, predictions about the actor's future behavior often will be central to decisions about what to do with or to an individual.113

The accuracy of predictions of human behavior is an empirical issue. The law has long assumed that predictions by psychiatrists and other mental health experts were largely accurate, and that interventions such as civil commitment, which are based in part on those predictions, were justified. Nevertheless, because predictions about future behavior are often pivotal in mental health law decisionmaking, it is necessary to explore the accuracy in fact of behavioral prediction in order to assess properly the fairness and efficiency of mental health law. This section briefly analyzes the nature of legal questions about future behavior and then examines the art and science of behavioral prediction.

1. Legal Questions About Future Behavior

Behavioral predictions are statements that describe the quantitative probability that a given behavior will occur in the future. A law that includes a prediction as a criterion for decisionmaking should comprise two distinct standards: First, it should specify the behavior to be predicted; and second, it should specify the degree of probability of occurrence that warrants legal intervention.114 For example, the behavioral component of civil commitment statutes typically provides that the alleged crazy person is "likely to


harm himself or others." It is readily apparent that in this standard the behavior to be predicted and the degree of probability are both quite imprecise.\textsuperscript{115} What quantitative probability is meant by "likely"? What kind of behavior or result is meant by "harm"? Most mental health law prediction criteria are drafted in the vague form given in the example.

Mental health law intervention based on prediction usually involves some deprivation of liberty or the right to avoid involuntary treatment. Because important rights depend on the prediction, the probability of occurrence of a particular behavior that should justify legal intervention should be specified on moral and social grounds. This truism becomes especially clear when one considers the nonscientific nature and vagueness of the legal prediction criteria. Terms such as "likely" or "harm" do not have an agreed on scientific meaning. A scientist, as a scientist, might be able to state the quantitative probability that precisely defined behavior such as suicide was going to occur. If a scientist says "harm is likely," however, he is behaving as an ordinary layperson, assigning his own private, unscientific meaning to the terms "harm" and "likely." This determination, however, is not part of the scientist's proper role in the courtroom. Rather, the judge or jury should consider the empirical data and then decide the social, moral, and legal question of whether the legal standard is met.

Of course, if utterly explicit prediction standards were drafted, it might be clear in specific cases whether the empirical data met the legal test. For example, instead of using the standard, "likely to harm self," the following standard might be substituted: "75% likelihood to attempt suicide by a means 50% likely to cause death." If such a statute were adopted and its terms were all operationalized, the primary issue in a particular case would be whether the standard is met, surely a "question of fact." Statutes are rarely so written, however, because of the inevitable complexity of human behavior and the wide range of need for legal intervention. Thus, criteria such as "likely to be dangerous" are written and enacted. The task then is to give content to the standard and to decide if it is met—issues of both law and fact that must be answered by reference to common notions of morality and probability. Thus again, the decisions should be made by laypersons. Broad statutes will leave judges and juries some room to maneuver to fulfill the social and moral weighing function of applying the law to the case at hand. And, as we shall see, this conclusion is strengthened when the accuracy of predictive judgments is considered.

Legal decisions may be based in part on empirical data, but whether a given probability warrants legal intervention is a social, moral, and legal

\textsuperscript{115} Goldstein & Katz, supra note 114, at 235-37; Justifications, supra note 36, at 79-84.
question. Moreover, when mental health law relies on predictive criteria, it ought to do so in light of an honest and rigorous assessment of the accuracy of behavioral predictions. Therefore, this section next turns to an analysis of the art and science of behavioral prediction.

2. The Art and Science of Behavioral Prediction

Two meanings of behavioral prediction or prognosis should initially be distinguished: First, rather general prediction based on the “natural history” or course of a “behavioral condition”; and second, prediction of specific future behavior. Although the two meanings are related, the second meaning is far more important for legal, as opposed to clinical, purposes.

There is much clinical wisdom about the course of various mental disorders but precious little hard, reliable data. It is extremely difficult to perform good retrospective or prospective longitudinal studies that examine the course of various disorders. Yet some facts do seem relatively established. For instance, persons who are depressed, even severely, feel better after some amount of time whether or not they are treated, and many persons who seem chronically crazy throughout childhood and adolescence will tend to remain chronically crazy throughout life. Although there are some suggestive prognostic indicators, most prognoses are very imprecise and general. The data are often soft, and seemingly good predictors are often invalid.

Although general and soft prognostic data may be useful to clinicians who treat patients, the mental health legal system should require more
accurate predictions of specific legally relevant behavior. After all, mental
health law predictions do involve important rights. What is adequate predic-
tive science for the clinic, laboratory, or classroom is not necessarily
adequate when legal rights are involved. The important prognosis for the
legal system is whether legally relevant behavior (e.g., dangerousness or
inability to manage in the community) will occur or continue if there is no
intervention.

Most behaviors that concern mental health law (and behavior in gener-
al) are particularly hard to predict accurately.122 First, these behaviors occur
very infrequently, and infrequent behavior is especially hard to predict.123
Second, it is virtually impossible to obtain all the data necessary to make an
accurate prediction. Put simplistically, behavior is a product of the interac-
tion between the individual's biological and psychological predispositions
or characteristics and the environmental variables that act on him. Indeed,
some theorists claim that environmental variables have the vast share of
causal efficacy.124 Even if everything is known about the individual, the
specific future environmental influences that will act on him cannot be
known. And of course, behavioral scientists do not approach having perfect
knowledge of the individual either. Taken together, the lack of knowledge
about the individual, the unpredictability of the environment, and the infre-
quency of the behavior to be predicted render future legally relevant behav-

122. Megargee, The Prediction of Dangerous Behavior, 3 CRIM. JUST. & BEHAV. 3
(1976).
123. P. Meehl, Antecedent Probability and the Efficiency of Psychometric Signs, Patterns,
or Cutting Scores, in PSYCHODIAGNOSIS: SELECTED PAPERS 32-62 (written with A. Rosen);
see Justifications, supra note 36, at 84-85.
124. B.F. SKINNER, supra note 61 (the most extreme behaviorist statement); see A.
Bandura, SOCIAL LEARNING THEORY (1971) (a more balanced behavioral view); B.F. SKINNER,
SCIENCE AND HUMAN BEHAVIOR (1953). The debate over the relative weight of personal
and situational variables in causing human behavior has a long and intense history. See generally
W. Mischel, supra note 54; Alston, Traits, Consistency and Conceptual Alternatives for
Personality Theory, 5 J. THEORY SOC. BEHAV. 17 (1975); Beem & Allen, On Predicting Some
of the People Some of the Time: The Search for Cross-Situational Consistencies in Behavior, 81
PSYCHOLOGICAL REV. 506 (1974); Bowers, Situationism in Psychology: An Analysis and a Critique, 80
PSYCHOLOGICAL REV. 307 (1973); Mischel, Toward a Cognitive Social Learning Conceptualization of Personality,

This Article cannot resolve the person-versus-situation debate, but the existence of the
debate might cast some light on why mental health-based predictions may be difficult. If
madness is not a "trait" inherent in the person, but like other behavior is situation specific,
then predictions based on mental health diagnoses would necessarily be quite inaccurate
unless the situational variables could be predicted with great accuracy. If madness is a
condition in the person, it can be the basis for accurate prediction only if there is good, specific
data about the behavioral course of the condition and how it affects other behavior. As we have
seen, such hard, specific data is usually lacking. Notes 116-21 supra.
ior hard to predict with any reasonable degree of accuracy. Mental health law is concerned with predictions about relatively specific behavior, and the specificity of predictions of future behavior is inversely related to their accuracy.

Predictions generally can be based on two types of processes—statistical and clinical. In statistical prediction, the prediction of behavior is based on the known actuarial probability that persons similar in relevant ways to the individual to be predicted will behave in the predicted manner. The predictor need not have any theories about behavior in general or the individual to be predicted. The prediction depends on a mechanical “cookbook” approach that compares data about the person to actuarial data about the class of persons to which he belongs. For instance, if one wishes to know the probability that a young paranoid male will behave violently, one makes the prediction by simply determining what percentage of young male paranoids in general behave violently. No attention is paid to factors or hunches that seem relevant to this case, but that are extraneous to the actuarial data.

By contrast, clinical prediction is based on the clinician’s assessment of the individual case. Even if the clinical predictor knows the hard actuarial data collected on the prediction question in point, he changes the weight of actuarial predictive factors based on his intensive study of the particular individual in question. Often, the weight will be changed on the basis of the clinician’s own untested actuarial impressions, his clinical hunches, and his theoretical preferences. For instance, although the clinician may know that $X\%$ of young paranoid males behave violently, he might decide that a particular young paranoid male has a higher or lower probability depending on the clinician’s clinical assessment of the individual case before him.

The comparative accuracy of statistical and clinical prediction is one of the most well-studied topics in behavioral science and one of the few in which there is near unanimity in the outcome of the studies. Statistical prediction is nearly always more accurate. Prediction based on clinical

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126. The most famous treatment of this issue is P. Meehl, CLINICAL vs. STATISTICAL PREDICTION: A THEORETICAL ANALYSIS AND A REVIEW OF THE EVIDENCE (1954). Both types of prediction are complex processes. The discussion following in the text will attempt only to outline their general nature and differences.


128. P. Meehl, When Shall We Use Our Heads instead of the Formula, in PSYCHODIAGNOSIS: SELECTED PAPERS 83-89 (1973); Justifications, supra note 36, at 75 n.4; Meehl, Psychologic
judgment may seem more "human," but it is simply not as good as mechanical application of actuarial data to the case at hand.

The law should thus be extremely skeptical about pure clinical prediction. Although statistical prediction also is generally not highly accurate, it is the best tool for making legal predictions. At the least, if clinical prediction is to be used, the law should be concerned with how accurately clinicians predict such behavior.

Unfortunately, there are few methodologically sound studies that examine the accuracy of predictions, by any method, of legally relevant behavior. Most studies that have assessed the accuracy of predictions about specific legally relevant behavior have focused on predictions by behavior scientists of violence to others or to the self. Reviewers agree that the ability to predict violence to others is extremely limited.129 At best, such predictions are accurate only about one-third of the time, and even one-third accuracy is obtained only under ideal conditions. In most studies the accuracy rates are considerably lower; indeed, the mean accuracy for predictions of violence in seven leading studies is approximately 19%.130 That is, when experts predict future violence, on the average they overpredict by incorrectly predicting violence in four cases for every one case in which they are correct. And, because mental illness is not highly correlated with legally relevant behavior, knowledge that a subject is mentally ill does not substantially increase the accuracy of predictions of his legally relevant behavior.131

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131. See Dix, Administration of the Texas Death Penalty Statutes: Constitutional Infirmities Related to the Prediction of Dangerousness, 55 TEX. L. REV. 1343, 1398 (1977); notes 24, 98 supra. But see Martin, Cloninger, & Guze, Female Criminality and the Prediction of Recidivism, 35 ARCHIVES OF GENERAL PSYCHIATRY 207, 212-13 (1978) (diagnoses of antisocial personality and drug dependence were significant predictors of female recidivism; but note that these diagnoses are among those that are most questionably considered mental disorders).
Predictions concerning suicide or capacity to manage in the open community are similarly unsuccessful. Predictions of suicide, a very infrequent event, are even less accurate than predictions of violence to others. At best, suicide prediction is unlikely to be more than 20% accurate.\footnote{Mackinnon & Farberow, An Assessment of the Utility of Suicide Prevention, 6 SUICIDE & LIFE THREATENING BEHAVIOR 86 (1976). See generally Greenberg, Involuntary Psychiatric Commitments to Prevent Suicide, 49 N.Y.U. L. REV. 227, 249-50, 259-63 (1974); Rosen, Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events, 18 J. CONSULTING PSYCHOLOGY 397 (1954).} There is less clear data concerning predictions about whether persons can manage their lives or "get along" without professional intervention and hospitalization, but in such instances, as in predictions of violence, mental health professionals tend to be highly inaccurate.\footnote{Martin, Friedmeyer, & Sterne, Absconders, Elopers, Escapists, and other Irregular Patients: A Review, in 1 RESEARCH COMM. PSYCHOLOGY, PSYCHIATRY & BEHAVIOR 435 (1976); Barret, Kuriansky, & Garland, Community Tenure Following Emergency Discharge, 128 AM. J. PSYCHIATRY 72 (1972) (among a large group of chronic, long-institutionalized patients, a group with an extremely low probability of making a satisfactory community adjustment, 29% were able to remain in the community six months after being released because of a general staff strike in the hospital; there were no differences in pathology between those able to remain out and those who returned to the hospital; available community roles for the patients accounted for community adjustment differences); Ennis & Litwak, supra note 25, at 717-18; Scheer & Barton, A Comparison of Patients Discharged Against Medical Advice with a Matched Control Group, 13 AM. J. PSYCHIATRY 1217 (1974) (review of literature and original empirical study both demonstrate that patients discharged against medical advice have same posthospital adjustments as patients discharged with medical advice). Because there are few direct studies of predictions of community adjustments, it is difficult to estimate precisely how inaccurate such predictions are, but they are clearly quite inaccurate.}

Mental health laws also are often concerned with predictions about the outcome of various mental health treatments or interventions. For legal purposes, the critical questions about mental health treatment outcome are whether and in what way the intervention will change the actor's behavior, especially legally relevant behavior. If effective, mental health treatments change behaviors (i.e., the alleged symptoms); they do not "cure" underlying diseases in the way that a fever is lowered by treating an underlying...
infection with antibiotics. Many treatments have been studied to determine their efficacy in changing behavior, and there is now an enormous amount of data to help predict treatment outcome. The vast majority of the data, however, do not refer to changes in legally relevant behavior. Instead, the data refer, often in rather global terms such as “improved,” to diminution of crazy behavior. Consequently, there is much data on the reduction of anxiety, depression, crazy thinking, and the like, but there is less data on the ability of clinicians to “treat” such behaviors as violence, financial incompetence, social isolation, or an inability to assist counsel.


If predictions of community adjustment are tested by observing the behavior of institutionalized patients who professionals believed should not be released, the likelihood of correct prediction of nonadjustment is increased greatly by a phenomenon known as “institutionalism”—the patient’s socialization into dependence on hospital life and the sick role. See R. Stuart, Trick or Treatment 21-42 (1970); Townsend, Self-Concept and the Institutionalization of Mental Patients: An Overview and Critique, 17 J. Health & Soc. Behavior 262 (1976); Wing, Institutionalism in Mental Hospitals, 1 Brit. J. Soc. & Clinical Psychology 38 (1962). The results of the study reported in Barrett, Kuriansky, & Garland, supra, are particularly striking in light of this phenomenon.

134. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, PHARMACOTHERAPY AND PSYCHOTHERAPY: PARADOXES, PROBLEMS AND PROGRESS 279-81 (1975); May, When, What, and Why? Psychopharmacotherapy and Other Treatments in Schizophrenia, 17 Comprehensive Psychiatry 683, 688 (1976) (antipsychotic drugs do relieve “primary” symptoms, however); Scheff, Medical Dominance: Psychoactive Drugs and Mental Health Policy, 19 Am. Behavioral Scientist 299, 300 (1976) [hereinafter cited as Medical Dominance]; see Price v. Sheppard, 307 Minn. 230, 239 N.W.2d 905, 913 (1976). Of course, if a person continues to take drugs, the unwanted behavior may be constantly suppressed. For example, there is evidence that taking lithium salts will help prevent recurrent mania, but the lithium must be taken constantly.

See Fieve, Lithium Therapy, in Comprehensive Textbook of Psychiatry-II, supra note 26, at 1982, 1985. This is not the same as curing the underlying pathology. Further, long-term maintenance psychiatric drug treatment has serious risks of side effects.


136. See, e.g., A. Stone, supra note 10, at 36-37 (lack of effective treatment for danger-
Nearly always, professionals err in the direction of overpredicting the occurrence of legally relevant behavior, of overproducing false positives.\textsuperscript{137} Thus, they tend to err in favor of legal intervention. Although there are many reasons for professional overprediction of legally relevant behavior such as violence,\textsuperscript{138} two particular reasons should be emphasized here: illusory correlation and professional treatment bias. An illusory correlation is a systematic error of observation or prediction based on an assumed

ousness). Hospitalization involves mainly drug treatment, but drug treatment is effective mainly to reduce cognitive and affective symptoms—it does not socially rehabilitate a person. See sources cited in note 134 supra. Community care programs are more successful for social rehabilitation. See sources cited in note 133 supra.

Treatment methods developed by mental health science are usually directly aimed at craziness. Except for behavior therapists, less work has been undertaken on developing treatments for specific social disabilities. See J. Krumboltz & C. Thoresen, COUNSELING METHODS (1976) (case studies wherein specific behavioral techniques are applied to specific behavioral problems). It appears logical to assume that if crazy behavior is ameliorated, consequent legally relevant behavior will also change. This is a commonsense prediction based on the observational knowledge that particular craziness is sometimes directly related to particular legally relevant behavior. If the craziness is affected, the resultant legally relevant behavior should also be. But this is often not the case. Craziness is usually only a part of the reason for legally relevant behavior and ameliorating craziness will not necessarily significantly change legally relevant behavior even if it is clearly related to the craziness. One noted researcher has cogently and eloquently stated the problem in the context of a discussion of the limitations of drug therapy for crazy behavior that is termed schizophrenia:

Treatment of the schizophrenic person will always need people and the kind of things that only persons can do. Drugs may be helpful in promoting restitution and restoring perceptual control. But, quite apart from unwanted side effects, they do not enlighten the patient about his problems, inform him how to adapt, help him to take advantage of opportunities, or accept his limitations. They do not repair self-esteem, nor do they repair the damage that he has done to his friends and family. They cannot get him a job, they cannot make mothers or mothers-in-law change their minds, they don't handle traffic violations and ... they cannot teach him to play the violin if he couldn't do so before. Obviously, therefore, treatment must include someone who has a relationship with the schizophrenic person and who tries to help him with the practical affairs of everyday living.

May, supra note 134, at 689. The costs of providing such treatments for all those persons with legally relevant social disabilities would be prohibitive; these treatments are labor intensive and therapists are very expensive. See, e.g., G. Paul & R. Lentz, PSYCHOSOCIAL TREATMENT OF CHRONIC MENTAL PATIENTS (1977). Moreover, there is yet no persuasive evidence that such treatments would be reasonably effective given their costs. See Miller, The "Right to Treatment": Can the Courts Rehabilitate and Cure?, PUB. INTEREST, Winter 1977, at 96-107. But see G. Paul & R. Lentz, supra (successful psychosocial treatment of chronic patients).

Treatment outcomes predictions are completely relevant to mental health law only under a "need for treatment" behavioral component standard, a standard that is increasingly in question as an appropriate basis for involuntary legal intervention in the actor's life. See notes 215-18 and accompanying text infra. But see A. Stone, supra note 10, at 66-70 (explicit treatment-based standard for civil commitment).

137. Two other important terms: When a prediction is made that an actor will behave a certain way and then he does not do so, the case is termed a "false positive." Similarly, an incorrect prediction that a particular behavior will not occur is termed a "false negative." When experts or laypersons predict future behavior, both types of false predictions will far outnumber correct ones.

138. Monahan, supra note 130, at 13, 22-25; Shah, supra note 125, at 227-30. Other reasons given are (1) lack of corrective feedback to the predictor; (2) differential consequences to the predictor (i.e., it is safer for the predictor to overpredict violence and incarcerate too many
relationship between two variables that does not exist in fact. For instance, a clinician may predict that a mentally disordered person will be violent because the clinician erroneously believes that as a rule mentally disordered persons behave significantly more violently or incompetently than noncrazy persons. But the stereotypes are incorrect; crazy persons are probably not considerably more violent, criminal, or incompetent than normal persons.

Treatment bias refers to the professional attitude that incorrect failure to treat is a greater error than treating unnecessarily. Mental health professionals are well-meaning clinicians whose whole training orients them to find problems and remedy them. Thus, they tend to overdiagnose and overpredict. This is perhaps especially true in the mental health field where there are fewer objective criteria of illness and less prognostic knowledge than in physical medicine.

In the absence of good probability data, the best data to use for predicting future specific behavior is past behavior in similar situations. Such data, if available at all, is of course available to all persons. In such cases, predictions can and should be based on commonsense lay judgment. Everybody makes predictions about the future behavior of his fellows and often relies on those predictions. If an employee decides on Sunday to wait until Tuesday to ask his boss for a raise because the boss is always grumpy on Monday, he is making and relying on a (probably quite accurate) prediction of the boss's behavior. Neither a diagnosis nor a "dynamic people than to underpredict and release someone who may cause harm and thus cast doubt on the accuracy and wisdom of the predictor); (3) differential consequences to the subject (i.e., using the prediction of dangerousness in order to achieve other goals such as their retribution in the case of indefinite confinement of a "mentally disordered sex offender"); (4) unreliability of the criterion (e.g., the vague definition of the behavior to be predicted, or the fact that the prediction itself may influence the later labeling of an actor as within the predicted class); (5) low base rates (discussed at note 123 supra); and (6) powerlessness of the subject (i.e., those about whom predictions are made, e.g., prisoners and mental patients, may be unable to challenge incorrect predictions).

139. Chapman & Chapman, Illusory Correlation as an Obstacle to the Use of Valid Psychodiagnostic Signs, 74 J. ABNORMAL PSYCHOLOGY 271, 272 (1969); see note 138 supra.
140. See notes 24, 98 and accompanying text supra.
142. W. Mischel, supra note 54, at 135. Indeed, past behavior is a key variable used in creating actuarial predictive data and typically it is the best predictor. See, e.g., H. Steadman & J. Cocozza, supra note 24, at 107, 152-53 (only age and a legal dangerousness scale based on past behavior distinguished returnees originally released pursuant to Baxstrom v. Herold, 398 U.S. 107 (1966), from nonreturnees); Monahan, supra note 130, at 3, 16-22.
143. For interesting and useful analyses of such predictions, see generally Ajzen, Intuitive Theories of Events and the Effects of Base-Rate Information on Prediction, 35 J. PERSONALITY & SOC. PSYCHOLOGY 303 (1977); Tversky & Kahanman, Judgment Under Uncertainty: Heuristics and Biases, 185 Sci. 1124 (1974).
formulation" of the boss or anyone else seems to increase substantially the accuracy of predictions of a person's specific future behavior. If there is no good, directly relevant data, lay prediction is thus likely to be as accurate as expert prediction.

3. Summary

In general, mental health professionals (and laypersons) are more likely to be wrong than right when they predict legally relevant behavior. When predicting violence, dangerousness, and suicide, they are far more likely to be wrong than right. Although statistical prediction is nearly always more accurate than clinical prediction, it remains highly inaccurate.

How the mental health legal system should respond to scientific data about behavioral prediction is hardly a scientific matter. Analysis of the costs and benefits of interventions based on predictions should rely on scientific evidence, but that evidence is not dispositive per se. To decide how much unwarranted infringement on liberty, autonomy, and dignity based on false prediction is acceptable compared to the benefits conferred by special treatment of crazy persons requires social, moral, political, and legal weighing of interests; the degree of successful prediction necessary to authorize intervention is not a scientific determination. The mental health legal system need not abandon rules that require predictions. But when legislatures make such rules or when factfinders make predictions, whether or not based on expert testimony, they should be aware of how inaccurate those predictions are likely to be.

III. APPLICATION AND RECOMMENDATIONS

In light of the analyses presented in the preceding section, this section will first explore the relevance of expertise and its proper role in legal decision-making. It will then turn to an examination of substantive mental health laws.

A. THE RELEVANCE OF EXPERTS

This Article has examined the nature of the questions asked by mental health laws when crazy behavior causes a legal problem. It has argued that these issues are primarily social and legal questions that call for common-sense social and moral determinations, and that answering them requires considerably less scientific expertise than is commonly supposed. Further, a clear implication of much of the previous argument that will be explored in

144. Ennis & Litwak, supra note 25, at 700-11. Indeed, a diagnosis does not describe with accurate specificity the person's abnormal behavior. Id.; see notes 168-77 and accompanying text infra.
Section III.B is that there is less reason than is usually believed to give special consideration to craziness as a variable that may affect legally relevant behavior.

Still, society will probably continue to consider craziness a special factor for some time. Craziness will probably continue to be a focus of legal decision making when it seems related to legally relevant behavior, and the law is likely to turn to mental health experts for assistance in explaining and dealing with it. Crazy people simply appear too different to be treated like everyone else, and mental health laws do authorize, albeit inefficiently and often unfairly, seemingly desirable results (e.g., preventive detention of dangerous persons) that might not be easily reached by other means.

It is important, however, that the law continues to distinguish legal criteria from mental health science criteria because the goals of each are different. Mental health science is concerned mainly with clinical and research purposes. The law is concerned with crazy behavior for social and moral purposes. This distinction suggests that mental health experts should play a much more limited role in mental health law decisions than present practice permits. 145 It will be argued that mental health experts should be limited to testifying about behavior they observe and in limited cases about relevant reasonably hard scientific data. They should not be allowed to testify about theoretical matters that are in dispute or to state conclusions that are not based on firm scientific evidence. The thrust of the argument is that very little mental health knowledge meets the standards for expertise required by law.

It is a matter of hornbook law that experts are qualified to draw inferences from facts that jurors are not competent to draw. Thus, expert testimony is appropriate when the subject of the inference is “so distinctively related to some science, profession . . . as to be beyond the ken of the average layman.” 146 It is also a matter of hornbook law that expert test-


Although this Article’s conclusions agree substantially with many of these writers, the present emphasis is often different and the author is somewhat more optimistic about the possible role of mental health expertise.

timony will not be allowed if the state of the relevant scientific discipline does not allow for reasonable opinions even by an expert.\textsuperscript{147} It is, of course, widely believed that inferences about mental disorder and its consequences fall within the criteria of the proper scope of expert testimony.\textsuperscript{148} As Section II of this Article demonstrated, however, much of the science of mental health is uncertain and expertise is extremely limited, especially when legal standards must be applied. Although the law has given mental experts considerable responsibility for helping decide legal questions raised by crazy behavior, experts have less competence to assist in these decisions than is commonly believed. Moreover, much of the factual knowledge necessary for legal decisionmaking is accessible to lay observers as well as experts.

The use of experts encourages courts, legislatures, and legal decision-makers to avoid the hard social, moral, and legal questions posed by mental health laws by responding as if there were scientific answers to them. This tendency is exacerbated when mental health questions are often conflated with ultimate legal questions and experts are allowed to draw conclusions about legal issues. For instance, in United States v. Brawner,\textsuperscript{149} the United States Court of Appeals for the District of Columbia adopted the Model Penal Code test for the insanity defense,\textsuperscript{150} and specifically allowed experts to testify whether, in the expert’s opinion, the defendant met the test as a result of mental disease.\textsuperscript{151} Whether a person lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to law is not, however, a scientific question.\textsuperscript{152} As the court recognized, the insanity defense test requires an ethical and legal judgment and not a scientific conclusion.\textsuperscript{153} When experts testify on ultimate legal issues, they

\textsuperscript{147} Id. at 31.

\textsuperscript{148} For a listing of the numerous legal standards to which psychiatric testimony is relevant, see Mezer & Rheingold, \textit{Mental Capacity and Incompetency: A Psycho-Legal Problem}, 118 AM. J. PSYCHIATRY 827-28 (1962).

\textsuperscript{149} 471 F.2d 969 (D.C. Cir. 1972).

\textsuperscript{150} Id. at 973. The ALI standard adopted by the Brawner court reads as follows:

1. 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.

2. As used in this Article, the terms “mental disease or defect” do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct. MODEL PENAL CODE § 4.01 (Proposed Official Draft, 1962).

\textsuperscript{151} United States v. Brawner, 471 F.2d 969, 1006 & n.82 (D.C. Cir. 1972). This is the so-called “causality” or “productivity” requirement.

\textsuperscript{152} If an expert testifies that a particular state of mind is a result of mental disease, he is implicitly testifying that there is an objective, scientifically measurable state of mind produced by a similarly objectively identifiable disease and that he has special knowledge about such a state of mind and disease. As we have seen in Section II and will see further in this section, there is considerable reason to believe that such special knowledge is lacking.

are offering unscientific value judgments that are no more reliable or entitled to weight than lay judgments.

The difficulty of the questions presented and the confusion of legal and mental health issues often lead to three results: courts abdicate responsibility for deciding legal issues independently, or become confused about the issues, or both. In nonadversary proceedings, legal decisionmakers tend to treat the decision as a scientific matter and to ratify the conclusions of the experts. If the proceedings are truly adversary, with each side represented by competent counsel and competent psychiatrists, the social and moral issues tend to be obscured by the confusion and conflict over what appear to be scientific matters.

Responsibility for deciding legal questions concerning crazy behavior must be accepted by legal decisionmakers. If crazy persons are to be deprived of liberty, "fixed" against their wills, or are to have the usual legal significance of their actions negated, such decisions should be made with the full realization that they are extremely difficult social and moral decisions and not simply legal ratifications of scientific judgments. This Article contends that laypersons are perfectly competent both to provide most of the observational data necessary for mental health decisions and to make such decisions. Despite the general competence of laypersons and the dangers of reliance on experts, it is also argued that for limited purposes experts will be able to furnish helpful data. They should not, however, be allowed to

154. See notes 13, 16 and accompanying text supra.
155. See note 16 supra. Even if one side is represented by an adversary expert, judges and juries tend to defer to an "impartial expert" appointed by the court.

A mental health proceeding is truly adversarial only if both sides are represented by attorneys and psychiatrists. At the least, the party disputing the allegations of craziness should be represented by a zealous attorney who understands mental health law and science and who is able effectively to cross-examine mental health experts. Where the attorney disputing allegations of craziness performs only perfunctorily, the proceeding cannot be considered truly adversarial. See Cohen, supra note 15, at 446-49; Wexler, supra note 16, at 51-60. Even where attorneys are present and effective, however, and where persuasive independent evidence of craziness and legally relevant behavior is absent, judges still defer unduly to psychiatric conclusions. Hidy, supra note 16, at 664.

Of course, the need for effective legal and psychiatric representation is increasingly recognized. See, e.g., State ex rel. Memel v. Mundy, 75 Wis. 2d 276, 249 N.W.2d 573 (1977); 18 U.S.C.A. § 3006A(a) & (e) (West Supp. 1977) (right of criminal defendants to obtain necessary experts); Wash. Rev. Code Ann. § 71.05.470 (1975) (right to independent psychiatrist of one's choice in civil commitment proceeding); Farrell, The Right of an Indigent Civil Commitment Defendant to Psychiatric Assistance of His Own Choice at State Expense, 11 Idaho L. Rev. 141 (1975); Note, The Role of Counsel in the Civil Commitment Process: A Theoretical Framework, 84 Yale L.J. 1540 (1975).
draw conclusions or to state their data in other than commonsense and observational terms. There are no scientific answers to legal questions such as whether the actor’s behavior is normal or whether he could have behaved otherwise. Moreover, the categories and theories of mental health science are at present too imprecise and speculative to help clarify legal questions. When scientific expertise is used, it should be based on direct observations or other hard data. The legal decisionmaker should not be offered unscientific theories or conclusions that are supported mostly by the Aesculapian authority of unproven expertise.

To support these contentions, this section will return to an analysis of the three questions raised by mental health laws and examine the role of expertise in answering them. The analysis will not try to be exhaustive and cover every possible instance where expertise might be relevant. Rather, it will suggest the general areas in which expertise may or may not be helpful and the general form in which expert testimony should be offered.

1. Expertise and Normality

The crucial question for the law is not, or at least should not be, whether the actor allegedly fits one of the mental health diagnostic categories, but whether the actor behaves crazily enough to warrant special legal treatment on moral and social grounds. The law must therefore decide on legal grounds and for legal purposes which cases fit this criterion of sufficient craziness. These decisions should not and cannot be totally dependent on scientific categories that may serve other purposes, and experts should not testify about whether an actor suffers from a mental disorder or even about whether the actor is normal. Conclusions about mental disorder or psychiat-

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157. Justifications, supra note 36, at 80; see notes 161-65 and accompanying text infra.
158. Some commentators have suggested that physicians possess a unique kind of authority that is based on a combination of knowledge and expertness, moral authority, and charisma. This authority is strengthened by the facts that medicine deals with death and was once unified with religion. Siegler & Osmond, Aesculapian Authority, 1 HASTINGS CENTER STUD. 41-43 (1973). This unique authority may be extended, however, to spheres where it is not applicable. Many commentators believe that crazy conduct is not a medical matter and that the psychiatrist’s authority in judicial proceedings is improper and derives solely from the magico-religious background of much of medicine. See generally authorities cited in notes 13-14 supra. Of course, Siegler and Osmond believe that crazy behavior is a sphere where the authority of physicians is appropriate. In either case, the concept is useful for understanding the power of medical experts in the mental health legal system. See generally Bazelon, The Perils of Wizardry, 131 AM. J. PSYCHIATRY 1317 (1974); Starr, Medicine and the Waning of Professional Sovereignty, 107 DAEDALUS 175, 175-76 (1978).
159. The three questions are: Is the person normal?; Could the person have behaved otherwise?; How will the person behave in the future?
ric normality are not particularly and precisely relevant to legal decisions about normality. Rather, for various reasons, experts should be limited to describing behavior to the factfinder that laypersons may not notice but that may be relevant to legal decisionmaking.

The first reason for limiting experts to descriptions of behavior is that their conclusions are based, in part, on mental health diagnostic categories that are generally overinclusive. These categories are much broader than the crazy behaviors that seem to compel special legal treatment. The various disorder categories delineated by both the present and proposed diagnostic manuals of the American Psychiatric Association may be ranged along a quantitative and qualitative continuum of craziness. Some categories seem to describe behavior that would be considered quite crazy, at least in its extreme forms, by anyone. Others describe behavior that would not be considered crazy and, at worst, would be considered normally quirky.

Thus, present definitions of mental disorder cover such a wide range of behavior that vast percentages of the population may be considered disor-

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163. _See_, e.g., Catatonic Schizophrenia:

It is frequently possible and useful to distinguish two subtypes of catatonic schizophrenia. One is marked by excessive and sometimes violent motor activity and excitement and the other by generalized inhibition manifested by stupor, mutism, negativism, or waxy flexibility. In time, some cases deteriorate to a vegetative state.

DSM-II, _supra_ note 26, at 33-34.

The essential feature is a marked psychomotor disturbance which may involve particular forms of stupor, rigidity, excitement or posturing. Sometimes there is a rapid alternation between the extremes of excitement and stupor. Associated features include negativism, stereotypes, mannerisms, and waxy flexibility. Mutism is particularly common. This subtype is not applicable in the presence of the full depressive or manic syndrome, which is suggestive of the Schizo-affective subtypes.

This subtype tends to be associated with two different courses: one with an abrupt onset which is frequently followed by periodic remissions and recurrences (sometimes called periodic catatonia), and the other with a chronic course without remission. During catatonic stupor or excitement the patient needs careful supervision and his illness may constitute a medical emergency because of the risks of starvation, exhaustion, or inflicting injury on himself or others.

DSM-III, _supra_ note 26, at C:10.

164. _See_, e.g., Inadequate Personality:

This behavior pattern is characterized by ineffectual responses to emotional, social, intellectual and physical demands. While the patient seems neither physically nor mentally deficient, he does manifest inadaptability, ineptness, poor judgment, social instability, and lack of physical and emotional stamina.

DSM-II, _supra_ note 26, at 44; or, Avoidant Personality Disorder (Other):

The essential features are excessive social inhibitions and shyness, a tendency to withdraw from opportunities for developing close relationships, and a fearful expectation that they will be belittled and humiliated. Desires for affection and acceptance are strong but they are unwilling to enter relationships unless given unusually strong guarantees that they will be uncritically accepted. Therefore, they have few close relationships and suffer from feelings of loneliness and isolation.

DSM-III, _supra_ note 26, at K:13; or, Compulsive Personality Disorder:
dered, including most persons whom the legal system would not consider crazy or different enough to warrant special treatment. A large proportion of the diagnostic categories simply do not describe behavior that seems very crazy and the inexorable product of a deranged mind. If no conclusions about diagnosis, illness, disease, or abnormality are drawn by experts, the law will avoid the confusion engendered by the metaphysical complexities of the mental health debate about which behaviors ought to be labeled and considered illnesses.165 Further, whether behavior is considered disordered for clinical or research purposes should not be dispositive of legal decision-making where narrower moral and social definitions of craziness are appropriate.

The second reason for limiting experts to descriptions of behavior is that particular diagnoses do not accurately convey legally relevant information concerning the person’s behavior. A diagnosis will not inform the law whether, how, or to what degree an actor behaves crazily. The major related reasons for this fact are that present psychiatric diagnoses are not highly reliable or descriptively precise.166

The essential features are excessive emotional control and concern with conformity and adherence to internalized standards. There is usually a conspicuous concern with matters of order, organization and efficiency. Everyday relationships usually have a conventional, formal and serious quality to them, often precluding personal informality and unstructured relaxation. There often is a perfectionism, a tendency to inappropriate focus on details and to be upset by deviations from the routine. A premium is often placed on work and productivity to the exclusion of pleasure and the value of interpersonal relationships.

DSM-III, supra note 26, at K:15.

165. As we have seen, underlying abnormality has been demonstrated to be a cause of only a tiny fraction of crazy behaviors, and many of the persons who exhibit these behaviors do not suffer unduly nor are they significantly dysfunctional. See notes 26-28, 36-37 and accompanying text supra. Nonetheless, it is easy to see why those people whose behavior places them in the categories that do seem to describe obvious craziness are also considered disordered. In addition to being crazy, such persons often suffer or behave significantly dysfunctional according to dominant social standards. It does not strain common sense or the analogy to physical illness to consider the behavior of such persons disordered or to consider them ill.

It is not apparent, however, why categories that do not describe obvious craziness are considered disorders. There is no scientific or even commonsense answer to this question; rather, the answer is a product of how mental health science developed in this century. Mental health scientists, especially in the United States, came to believe that their province was not only disabled and agonized persons who were “out of their minds,” but also the total range of behavioral maladaptation, the complete sphere of normal unhappiness, quirkiness, suffering, and evil. Kendell, supra note 34. For instance, criminal behavior, homosexuality, and quirky neatness have all been viewed as “symptoms” of mental disorder. See generally A. Flew, supra note 40; sources cited in note 14 supra. There seems little justification for labeling such behavior as diseased or disordered, however, and the term “illness” is used largely because mental health scientists have decided to apply it to such behavior. Indeed, many mental health scientists are now suggesting that their proper domain should be limited to the grosser forms of craziness. Kendell, supra note 34, at 314; Kety, supra note 14, at 962.

166. Mental health scientists often refer to descriptive precision as a matter of validity.
In behavioral science, reliability is a complex construct, but for the purposes of legal decisionmaking about abnormality it can be defined as the accuracy of a diagnosis. The preeminent "measuring tool" used to make diagnoses is a human observer applying the present diagnostic categories to behavior. Unlike much physical disorder that often can be verified by various tests that measure pathology (whether or not the cause of the symptom, syndrome, or condition is known), there is no objective, empirical referent of mental disorder other than crazy behavior itself. Indeed, the only possible verification of the presence of mental disorder is by a consensus of those who have observed the actor's behavior. There is no postmortem pathological examination or other diagnostic procedure to verify conclusively whether or not a person suffered from a particular disorder or any disorder at all. Even if objectively verifiable referents other than behavior itself are present, an actor is not considered mentally disordered unless he behaves crazily.

In a sense, there is no such thing as an independently "correct" or "incorrect" mental health diagnosis; there are only agreed on and disagreed on diagnoses. The crucial issue, then, is the extent of agreement achieved by professional diagnosticians when they apply their categories of disorder to behavior itself. The best evidence of the reliability of present diagnostic categories indicates that if two professionals independently diagnose a person on the basis of the same or similar data, it is rare for them to agree on the diagnosis in more than half the cases. The large amount of disagreement is not narrowed appreciably by limiting the possible diagnoses to broad diagnostic categories. Thus, mental health diagnoses are not terribly reliable; people who do not have mental disorder or a specific disorder will...
be diagnosed as having it, and vice versa. Of course, in clear cases everyone will agree the actor is crazy, but such cases are few.

Mental health diagnoses are unreliable and thus do not accurately convey information for many reasons, but two causes require discussion here: observer variance (differences resulting from characteristics of the diagnostician), and criterion variance (differences resulting from the imprecision of the diagnostic categories). Other reasons given for unreliability are: (1) subject variance—differences resulting from patients having different conditions at different times; (2) occasion variance—differences resulting from patients being in different stages of the same condition at different times; (3) information variance—differences resulting from raters having different information about the patient; (4) observation variance—differences resulting from differing characterizations of the

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Helzer, Clayton, Pamuk, Reich, Woodruff, & Reveley, supra note 47, at 139. Some observations about these figures are necessary. First, these reliability figures are statistically significant, although they are quite low in an absolute sense. Second, the lowest reliability occurs for some of the diagnoses that are especially pertinent to mental health law, e.g., affective disorder and schizophrenia. Third, in the Helzer study, the reliability of the diagnosis of organic brain syndrome, a condition with an allegedly physical etiology, was extremely low.

Diagnosticians hope that by increasing the specificity of the behavioral criteria for specific diagnoses, their reliability will be increased. Indeed, the Helzer group was able to achieve somewhat higher than usual reliability because it used research criteria that are considerably more explicit than those in current use. These criteria are described in Feighner, Robins, Guze, Woodruff, Winokur, & Manos, Diagnostic Criteria for Use in Research, 26 ARCHIVES OF GENERAL PSYCHIATRY 57 (1972). But not only were the criteria used more explicit than those generally in use, they may not comport well with clinical reality, according to other investigators. Kendell, supra note 25; Taylor & Abrams, A Critique of the St. Louis Psychiatric Research Criteria for Schizophrenia, 132 AM. J. PSYCHIATRY 1276 (1975). See generally R. Kendell, supra note 25, at 29-39; Helzer, Robins, Tableson, Woodruff, Reich, & Wish, supra note 25.

It is often pointed out that diagnoses of physical disorders are also quite unreliable. Even so, the consequences of unreliability are considerably different. Physical diagnoses rarely lead to stigmatizing special legal treatment that deprives persons of rights or brands them as lacking in behavioral autonomy and dignity. Simply put, behavioral abnormality implies vastly more negative moral and legal evaluation than does most physical abnormality.

170. Other reasons given for unreliability are: (1) subject variance—differences resulting from patients having different conditions at different times; (2) occasion variance—differences resulting from patients being in different stages of the same condition at different times; (3) information variance—differences resulting from raters having different information about the patient; (4) observation variance—differences resulting from differing characterizations of the
and moral context. Of course, good diagnosticians try to be as socially and morally value-neutral as possible, but the problem cannot be avoided entirely, and it is heightened when the diagnosis has powerful ethical, social, or political implications.

Legal cases involve just such implications; observations, diagnoses, or other conclusions in the context of legal decisionmaking will be consciously or unconsciously affected by the diagnostician's feelings about the issue in question. For instance, a hardnosed forensic psychiatrist might be expected to diagnose much malingering or benign disorder among those seeking to avoid criminal responsibility, whereas a more softhearted

same stimuli; (5) context variance—differences resulting from differing contexts in which the behavior may occur. Ennis & Litwack, supra note 25, at 719-32; Spitzer, Endicott, & Robins, supra note 25, at 1187-88.

A theoretical reason for unreliability that needs no extended discussion here is whether mental disorder is a condition of the person or whether disordered behavior is a product of interactions between the person and the environment. See note 124 supra. If the latter is more nearly correct, then a diagnosis primarily of the person makes little sense. For purposes of this discussion, however, we shall assume that the diagnostic process is conceptually coherent.

171. B. BRAGINSKY & D. BRAGINSKY, MAINSTREAM PSYCHOLOGY: A CRITIQUE 120-32 (1974); Ennis & Litwack, supra note 25, at 726-29; cf. Abramowitz & Dockekl, The Politics of Clinical Judgment: Early Empirical Returns, 84 PSYCHOLOGICAL BULL. 460 (1977) (review of studies examining the effect on examiner judgment of various patient and examiner variables; mixed results found for race, sex, class, values; analysis of political values yields most consistent results—prejudice found against political dissidents). A major bias of mental health professionals is a preference for diagnosing mental disorder. See note 50 and accompanying text supra. Observer variance will of course depend on the context in which the diagnosis is made. See also note 168 and accompanying text supra.


If there is an adversarial presentation, the judge or jury can decide which side has presented better observational data or more persuasive opinions. If, however, there is only one allegedly impartial expert, the jury is likely to believe that the impartial expert is presenting unbiased and scientifically correct testimony. An unbiased and purely objective scientific mental health expert, however, is an illusion. Of course, problems of bias arise in physical medicine as well, but the difficulty is further compounded in the mental health area where there is a much greater lack of objective standards and reliable measuring instruments—especially if only one expert has made the examination. Except in the clearest cases, where no expert will be needed, a mental health professional's observations and judgment will be affected by his own social and political values and preconceptions, even if he tries very hard to be objective and fair.

For an interesting argument that scientists should use a more adversarial method to resolve scientific disputes in some areas, see Levine, Scientific Method and the Adversary Model: Some Preliminary Thoughts, 29 AM. PSYCHOLOGIST 661 (1974).
professional who believes that crime is a symptom of illness and that prisons are abominations might be expected to diagnose many more cases of true and severe disorder.173 Thus, in the legal context, expert observations or conclusions are usually affected by value judgments, and thereby probably tend to be even less reliable than otherwise.

The major cause of diagnostic unreliability—criterion variance—further explains why particular diagnoses do not convey legally relevant information. Criterion variance is both a general cause of unreliability and a bar in specific cases to the ability of a diagnosis to convey precise information, even when observers agree on the diagnosis. The diagnostic categories of mental disorders are descriptions of allegedly recurring clusters of behaviors, that is, of recurring patterns of thoughts, feelings, and actions. It is hypothesized that each category describes a more or less distinguishable disorder.174 The present and proposed diagnostic categories, however, are vague and overlap; each includes a quite heterogeneous range of behavior.175 Some persons who receive the most severe diagnoses that seem to map legal craziness, such as “schizophrenia,” may not be crazy enough to warrant special legal treatment. Vastly different behavior, ranging from only mildly to wildly crazy, may properly fit into the same and most serious diagnostic categories. Thus, even if two psychiatrists do agree on a diagnosis, it is impossible to know whether social and moral purposes will be

173. Dr. Lawrence C. Kolb, former Commissioner of the New York Department of Mental Hygiene has observed: “To believe that a psychiatrist is anything other than a thirteenth juror when he pleads to the right/wrong question . . . is utter nonsense.” Address by Dr. Lawrence C. Kolb, Association of the Bar of the City of New York, at 23 (Sept. 29, 1975) (transcript).

The difficulty of expert bias can arise also in the civil law context. Consider the case of a will contest where the decedent omitted his children from his will and left his money to a young paramour who “befriended” him in his declining years. Assume there is some general evidence that the testator’s mental powers were failing somewhat at the time he made his will; he was not as sharp as he once was, but he was not totally or near totally disoriented. A psychiatrist who believes in general that such amorous behavior is evidence of senile dementia and who feels that the children have been treated unfairly, is likely to conclude that the testator was incompetent and thus to focus on evidence of craziness. Conversely, a psychiatrist who believes that relationships with paramours enhance the golden years and who firmly believes that people should do as they wish with their money, is far more likely to believe that the will was not the product of the testator’s declining faculties and thus to focus on evidence of normality.

174. To be more precise, there has been a long debate about whether each mental disorder is a distinguishable and finite class of homogeneous behavior clusters or whether disordered behaviors are simply extreme forms of behavior that occur on a continuum of craziness in the general population. The former is termed category classification while the latter is termed dimensional classification. Category classification is the more popular, but the dimensional approach has powerful support. See R. Kendell, supra note 25, at 119-36.

served by special legal treatment unless the behavior itself is described to the factfinder.

A particular diagnosis would be a useful shortcut in normality determinations only if it were based on the same or a very similar type of crazy behavior every time the diagnosis was reliably made. It is unfortunate, but for legal purposes, present categories of mental disorder do not meet this test of precise particularity. A diagnosis does not convey information about an actor's behavior with substantial accuracy and specificity. In sum, the banning of diagnostic terms yields no loss in behavioral description for purposes of determining normality, and it avoids the false implications that the person suffers from an objectively identifiable (and perhaps uncontrollable) condition with a well-known cause, history, and course.

This Article has tried to demonstrate that for the law the answer to the question, "Who is normal?" or "Who is crazy?" depends largely on social and moral values and goals, and that the question is best resolved by laypersons. It has also claimed that mental health categories do not convey significant amounts of legally relevant information. There is still a role, however, for expert assistance and expert testimony in deciding whether an actor is crazy.

Because experts interact with all types of crazy persons far more often than laypersons, they may be especially sensitive to or inquire about behavior that would go unnoticed by laypersons. Laypersons may not know to ask, for example, if a person hears voices, entertains crazy beliefs, or has trouble sleeping or staying awake. Because the expert is attuned to crazy behavior, he may help the factfinder attend to a fuller range of the actor's behavior. Nonetheless, the expert need not and should not report conclu-

176. It is not claimed, nor should it be, that current categories are totally lacking in usefulness to clinicians and researchers. Usefulness depends on context, and the focus here is on the categories' precision for legal decisionmaking. See generally R. Kendell, supra note 25, at 40-48; Evaluative Criteria, supra note 25.

177. Another way of stating the point that diagnoses are not very useful for discussing present behavior is to note that they are not valid. In broad terms, this means that the members of any diagnostic class are not generally homogeneous and are not exclusive in relation to any other variables such as etiology, past behavior, or future behavior. See B.P. Dohrenwend & B.S. Dohrenwend, supra note 38, at 95-109; G. Frank, supra note 25; Ennis & Litwak, supra note 25, at 697-99, 708-19; Frank, Psychiatric Diagnosis: A Review of Research, 81 J. General Psychology 157 (1969); sources cited in note 25 supra.

In the future, it is of course possible that diagnostic categories may be more highly refined and will achieve greater reliability and validity. See, e.g., Murphy, Woodruff, Herjanic, & Fischer, Validity of the Diagnosis of Primary Affective Disorder, 30 Archives of General Psychiatry 751 (1974). But see Kendell, supra note 25. It is believed, for example, that the proposed diagnostic criteria in DSM-III will be more reliable and valid.
sions about mental disorder, abnormality, or even craziness; these are legal determinations for the judge or jury. It is far more precise and useful to the judge or jury if the expert simply describes his observations of behavior. For the legal question of normality, then, the relevant expertise of mental health professionals is not their ability to draw inferences from data or to form opinions. Rather, their special skill is observational—to perceive behaviors that nonexperts may fail to notice.\textsuperscript{178} The expert should describe, in as much precise but commonsense detail as possible, his observations of how the person thinks, feels, and acts. The test of relevance for the testimony of experts and laypersons alike should be whether their observations of the actor's behavior shed light on the question of whether the actor is crazy.

For example, experts should not testify that an actor is "hallucinatory and probably schizophrenic." Instead, the expert should testify that the actor told the expert that on some (specified) occasions, the actor heard or hears voices despite the fact that no one was or is talking to him and the voices told or tell him the following (specified) things. For another example, experts should not testify that an actor "suffers from loose associations when questioned on an ego-threatening topic and is therefore probably schizophrenic." Rather, the expert should testify that when the expert asked the actor certain (specified) questions about topics that seem to mean a lot to the actor, the actor responded in the following way (specified by examples).\textsuperscript{179} Of course, if laypersons such as family, friends, coworkers, or neighbors are aware of such behavior, they too can testify about it.

Using lay as well as expert testimony about the actor's behavior, the

\textsuperscript{178} For an explanation of who is an expert for such purposes, see notes 205-07 and accompanying text infra.

\textsuperscript{179} Descriptions and conclusions may be difficult to distinguish in some instances. Ennis & Litwak, supra note 25, at 743-45. Terms such as "depressed" have both commonsense, descriptive connotations and technical connotations. Experts should carefully avoid using technical terms and should put their observations in commonsense language. Because psychiatric terms generally describe behavior, nearly always there will be ordinary language equivalents for jargon. Also, since conclusion terms, whether or not technical, are based on observable referents, the referents should be described. If possible, it would be most useful if the factfinder could hear a tape recording of the interview or see a videotape of it.

It is assumed, too, that the adversary model would ensure, through the use of adversary experts or effective cross-examination, that the person's normal as well as crazy behavior would be described by the experts. Otherwise, it is far too easy to make a person appear crazy by selective testimony. Ennis & Litwak, supra note 25, at 745. The problem of selective testimony would be reduced if the factfinder has access to a tape of the interview.

One difficulty that will arise from the suggested mode of testifying concerns the presentation of psychological test results. The results of such tests are unlike the data of ordinary experience—lay observers have no baseline to measure them against. If there were tests that validly answered legally relevant questions (which at present there are not), the expert would have to describe the validity studies, specifying the probability that a person who achieved a certain test result also behaves sufficiently crazy for legal purposes in real life.
decisionmaker can then decide if the person is sufficiently crazy to be an appropriate candidate for the application of mental health laws. If the factfinder’s response to the behavioral data it hears is “so what,” then the actor probably does not meet the legal criterion of mental disorder; if the response is “that’s crazy” or “he’s crazy,” then the criterion of mental abnormality may be met.

It is sometimes claimed that experts may be useful in differentiating persons who seem to be truly crazy from those who are malingering or faking. Expert assistance on the issue of credibility or malingering is problematical, however. There is little systematic study of the ability of experts to identify mental health malingering, and the evidence available is not very encouraging. Mental health professionals can be quite easily fooled by faking, even when the shamming is rigged to make spotting it easy. It is relatively easy to fake clear craziness, and even crazy persons learn to fake craziness in order to manipulate their environment. Moreover, the

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180. Rosenhan, supra note 50. In this study, psychiatrists at 12 hospitals were unable to determine that pseudopatients were indeed faking craziness when the pseudopatients presented themselves at the hospitals and claimed to be suffering from symptom patterns never described before. Further, although the pseudopatients stopped faking craziness immediately after gaining admission to the hospital, the range of time spent in hospital was from 7 to 52 days. Rosenhan then informed one hospital that he was planning to send more pseudopatients. Of the 193 patients admitted during the “trial” period, 41 were alleged to be pseudopatients by at least one member of the staff. In fact, no pseudopatient from Rosenhan’s study attempted admission during the period in question.

The Rosenhan study is powerful and has enormously strengthened the arguments that diagnoses are unreliable and that ascriptions of mental disorder do not depend on qualities within the person but are largely context-dependent. The most forceful critique of the study is Spitzer, On Pseudoscience in Science, Logic in Remission, and Psychiatric Diagnosis: A Critique of Rosenhan’s “On Being Sane in Insane Places,” 84 J. ABNORMAL PSYCHOLOGY 442 (1975). Rosenhan’s rejoinder is Rosenhan, The Contextual Nature of Psychiatric Diagnosis, 84 J. ABNORMAL PSYCHOLOGY 462 (1975).

For a study that attempts to describe a method for distinguishing true pathology from malingering, see Pankrantz, Fausti, & Peed, A Forced-Choice Technique to Evaluate Deafness in the Hysterical or Malingering Patient, 43 J. CONSULTING & CLINICAL PSYCHOLOGY 421 (1975).

181. See note 180 supra. See also note 89 supra (studies on impression management). A truly telling example comes from a recent news item that is worth quoting almost in full:

**Actors Used for Psychiatric Diagnosis**

Sane actors are being used . . . in producing videotapes to teach medical students and other interested groups how to recognize and deal with various forms of mental illness . . . the scripts for the tapes are drawn from actual interviews with psychiatric patients, first altering any clues that might identify individual patients. Tapes of actual interviews cannot be used because of the need to protect the confidentiality of the doctor-patient relationship.

"Another problem with real tapes," according to Snibbe, "is that they are either too long or too short and that the diagnosis is seldom clearcut. So we hit on the idea of using actors. We found that simulated interviews are almost more believable than the real ones and much better from the technical standpoints of photography and voice reproduction. Our students seldom realize that they are watching simulations, although we do not try to keep it a secret."


182. See notes 88-89 supra.
reliability of a diagnosis of malingering is further compromised because
diagnoses tend to be quite unreliable in general.183 More specifically, where
malingering is a possibility in a legal case, we might expect the expert’s
determination to depend at least in part on his values and how he wishes the
case to be decided.184 Because at present there is no referent other than the
behavior, there is simply no way to demonstrate that the person is truly
disordered except by assertion.185

The detection of psychiatric malingering is a question of credibility,
and on this issue experts are probably not particularly expert. Indeed, to
determine whether an individual is truly crazy and how crazy in a given
case, it would probably be more useful to find out as much as possible about
the events in question and about how the person has behaved in the past.
Common sense should then be applied to the data. If the actor has never or
rarely behaved crazily or if there seem to be motives for behaving crazily at
present, he is more likely to be shamming. If he has behaved crazily in other
ways and at other times, then it is more likely, although not certain, that he
is truly crazy at present.

Another use of experts would be to identify those very few cases in
which there is a previously unrecognized but explicable physical reason for
crazy behavior. For example, various neurological and nonneurological
physical disorders have correlates that mime mental disorder. Further, non-
disease factors such as the ingestion of hallucinogenic drugs can also
produce crazy behavior. Experts are far more likely to be aware of, inquire
about, and recognize the various explicable disease and other physiological
causes of crazy behavior. Although the identification of a cause of possibly
crazy behavior does not answer the question of whether the person is
sufficiently crazy to warrant legal intervention, such identification does help
clarify the question of whether or not the actor is shamming.186 Moreover,
needed medical treatment might then be provided.

183. See notes 25, 47, 166-77 and accompanying text supra.
184. See notes 171-73 and accompanying text supra.
185. In the future, however, if powerful biochemical or other predisposing causes of
craziness are discovered, their identification in an actor who is behaving crazily certainly
increases the likelihood that the actor is not shamming. Also, some psychological tests such as
the Minnesota Multiphasic Personality Inventory (MMPI) may be useful for identifying malingers
when used by a sophisticated tester. Test subjects taking a long and complex instrument
are unlikely to be aware of the proper “sick” responses. Some studies have attempted to assess
the usefulness of the MMPI for distinguishing malingerers, but its validity for this purpose is
186. In the absence of demonstrable physical indica, however, courts should not accept
speculations from experts about whether the actor is “really” suffering from a physical
In conclusion, experts should serve as guides to behavior. In clear cases, laypersons will have noticed the craziness and little expert assistance will be needed. In less clear cases, however, the expert may focus the court’s attention on relevant behavior that would not be noticed by laypersons. Experts may facilitate accurate identification of those persons who are crazy, provided that they simply describe behavior and do not superfluously and prejudicially report conclusions about illness, abnormality, or craziness.\(^{187}\)

2. Expertise and Personal Responsibility

Whether an actor could have behaved other than as he did, and whether disorder with behavioral correlates. Further, experts who do testify about physical disorders or indicators should be highly qualified as to the physical disorder or indicator in question. No physician, for instance, is an expert on all physical medicine and many psychiatrists in particular tend not to be well qualified in physical medicine or even neurology. See notes 205-08 and accompanying text infra. See also Snyder, *Neurology in the Psychiatry Boards*, 134 Am. J. Psychiatry 1267 (1977). For instance, suppose an expert testifies that the actor’s inexplicable assaultive behavior may be a correlate of epilepsy. The questions to be raised are: Is the expert an expert on epilepsy? Has he done all the neurological tests customarily done? How sure is he of the diagnosis and why? If the answer to the first two questions is “no,” then the testimony about epilepsy should be excluded.

Because physicians may be allowed to state conclusions about reasonably verifiable physical disease does not mean that they should be allowed to draw conclusions about unverifiable mental disease or to offer speculative hypotheses about the alleged but unidentified underlying causes of crazy behavior.

187. Although it may be difficult for experts (and other witnesses) to confine themselves to factual observations and to avoid conclusions, this should not be unduly burdensome when the issue is whether or not the actor behaves crazily.

Adoption of the present system would ameliorate many of the problems of reliability presented when psychiatrists present hearsay data or form conclusions about normality that are based on hearsay. A full exploration of the hearsay issue is beyond the scope of this Article, but a few points should be noted. Although mental health professionals can usually base their conclusions on hearsay if it is the type of information customarily relied on in the field, this is an unwise exception to the hearsay rule. In clinical mental health practice little is at stake if a professional relies on sources other than his own observations in forming opinions. In a court of law, however, where liberty or other important rights are in question, hearsay sources are far too unreliable on questions of mental health to accept them as the basis for expert testimony. The objectivity and reliability of primary observers themselves, even professionals, are in grave doubt when sanity is in question; use of hearsay increases the risk of unreliability beyond acceptable levels. All observational data should be descriptive and firsthand.

moral and legal responsibility should be ascribed to him, have been shown to be social, moral, and legal questions. They can and should be decided by judges or juries on the basis of their commonsense conclusions about the actor’s behavior.\textsuperscript{188} This section suggests that mental health experts may be able to produce data that will assist the legal decisionmaker’s determinations about responsibility, but it is urged again that experts should not report conclusions—in this instance about whether an actor could have behaved otherwise or was responsible for his acts.

Expert assistance may be helpful in determining the threshold question of whether there is a relationship between craziness and legally relevant behavior. As was shown above, this question really asks if there is a relationship between crazy thoughts, feelings, and actions and other legally relevant behavior.\textsuperscript{189}

In determinations of the degree to which a crazy actor is able to control his behavior, it is desirable to have some picture of how the actor typically behaves. If an actor consistently demonstrates crazy thinking or consistently gives in to his impulses, it is a fair inference, after all, that this person has more difficulty than most persons in thinking straight or controlling himself. Of course, it takes no particular expertise to determine how an actor usually behaves. The family, friends, and associates of a person typically know his behavioral traits well and could describe them to a judge or a jury.

Mental health professionals, however, are constantly concerned with observing behavioral processes. They may be especially able to identify efficiently and precisely thought processes such as suspiciousness or reaction patterns that seem related to legally relevant behavior. Thus, experts may help determine the ways in which the person does not think straight, or they might help the factfinder receive a fuller impression of the actor’s response to his urges. There seems little reason to exclude expert evidence that efficiently identifies and describes relevant behavior processes or patterns. Here again, experts can function as acute observers of behavior. They can help the factfinder understand an actor by describing in commonsense language his reasoning and control processes.

Another helpful contribution of experts would be to provide probability data that would assist the factfinder’s determination of whether the actor’s choices were too hard to ascribe responsibility to him or her.\textsuperscript{190} For exam-

\textsuperscript{188} See notes 58-112 and accompanying text supra.
\textsuperscript{189} See text at p. 578 supra.
\textsuperscript{190} Rather than being used to make a prediction, this data is only meant to provide a sense of the strength of the factors disposing persons to the legally relevant behavior in question. It is sometimes argued that group probability data should not be applied to individual cases. To
pie, there may be data linking causal variables operating on the actor to the actor's type of craziness. If so, it would be useful to know what percentage of persons subject to those variables behave crazily and what percentage of persons behaving similarly crazily are subject to those variables. Or, if a crazy person behaves violently, it would be useful to know what percentage of similarly crazy persons engage in this type of violence and what percentage of similarly violent persons are crazy. Such data can shed some light on the uncontrollability of the actor's craziness or on the strength of craziness as a predisposing cause of legally relevant behavior, but it cannot be dispositive of the moral and legal questions involved. Society can resolve only on nonscientific grounds the question of how strongly predisposing a cause must be in order to negate moral and legal responsibility.

The use of probability data poses difficulties, however. First, there is limited data linking various variables to craziness and even less data linking craziness to consequent legally relevant behavior. Second, the law may not be willing to consider probability data relevant. For example, in instances not involving craziness where there is much stronger evidence of a link between other predisposing causes and legally relevant behavior (e.g., poverty and criminality), the law does not consider the probability data relevant.

Still, if the law continues to believe that craziness is relevant to responsibility, hard and methodologically reliable probability data bearing on the difficulty of the actor's choice should be heard when it is available. Of course, the data should be directly applicable to the specific case at hand. For instance, if the person in question is a depressed, middle-class woman in her twenties who has shoplifted, the data should be about depressed, middle-class women in their twenties. Speculations by experts about individual cases should be avoided. If there are no reasonable probability data, experts should not be allowed to offer either theoretical views about why the actor behaved as he did or opinions concerning the difficulty
of the actor’s choice. Of course, to the extent that otherwise hard quantitative data relies on questionably reliable and valid diagnoses, this weakness in the data should be made known to the decisionmaker.

Even though expert data may help a judge or jury decide if it would be too hard for the actor to reason or control himself within normal limits, experts should not draw conclusions. Whether an actor could have behaved otherwise and is legally and morally responsible for his legally relevant behavior cannot be determined scientifically. No diagnosis gives the answer to these questions, and there are no scientific tests to measure the strength of crazy urges or the strength of the actor’s self-control. Nor are there tests to distinguish the person who cannot think straight or control himself from the person who will not think straight or control himself. Whether a person cannot or will not think straight or control himself is a moral and commonsense judgment that should be made by the legal decisionmaker.

Let us take an example to examine how experts might help or hinder legal decisions about responsibility. In a famous homicide case, clinicians testified that the defendant killed the victim in order to avoid psychic disintegration and insanity. If this formulation is correct, the defendant was faced with a very hard choice indeed—kill or psychically disintegrate—and the defendant would hardly seem as responsible as most criminal homicide defendants, or perhaps, responsible at all. Some clarifying questions, however, should be asked: (1) Are there hard data behind the theorizing that the killing was the inexorable or nearly inexorable result of threatened ego-disintegration?; and (2) What percentage of persons with such fears kill?

193. See note 158 and accompanying text supra.

A special case is presented where an objectively identifiable physical variable such as a brain tumor is clearly causally related to the actor’s craziness and legally relevant behavior. In principle, such a cause should be treated like any other. The trier of fact should know what percentage of persons with such a tumor behave as the actor did. Although the expert may have some sense of the probabilities, unfortunately, hard data rarely is available. The danger here is that most persons in our society are conditioned to believe that when a physical variable is causally related to behavior, the behavior is uncontrollable. Thus, judges and juries will overweight the uncontrollability of physical causes, even though they should not necessarily do so. Still the data is relevant. To avoid prejudice, the expert should not tell the court that the tumor was the cause of the legally relevant behavior. Rather, the expert should simply describe the usual course of the disease and its peripheral effects. Further, he might describe the temporal coincidences between the presence or absence of the tumor and observable behavior. If the expert is honest, he also will admit that few, if any, physical disorders commonly produce legally relevant behavior. Although judges and juries will probably continue to overweight the uncontrollability of physical variables, where such variables are objectively verifiable and clearly causally related to the legally relevant behavior, the trier of fact should have the data about them. See also note 85 supra.

The answer to question (1) is "no," and the answer to question (2) is that the data are unavailable although the actual percentage is probably quite low. Such fears are not a proven necessary or sufficient cause of homicidal behavior. In this case, as in all cases, the expert's assertion that the person could not have acted otherwise is really a moral guess and not a scientific fact. Justice would be better served if the expert drew no conclusions and simply described in ordinary language the cognitive and affective state of the defendant without intruding terms and theories of unproven accuracy and usefulness.195

In sum, experts should be very careful not to present hypothetical physical, psychological, or social causal variables as necessary and sufficient because there are no data on which to bottom such assertions. Nor should they inject insufficiently tested theory or propound commonsense factual or moral judgments as scientific ones. They should simply present descriptive data that would otherwise be unknown and hard, relevant probability data.196 Then, taking into account the events in question and all other available and relevant data about the actor's behavior, the judge or jury must make the moral and legal judgment about whether the actor could have behaved otherwise.

3. Expertise and Prediction of Behavior

This Article has already described the difficulties attending accurate predic-

195. Of course, an expert who tries to describe the person's past mental state faces grave difficulties. This probably cannot be done with substantial accuracy unless the expert had occasion to know or examine the actor at the past time in question. Thus, experts probably should never testify about an actor's mental state at a time when the expert had no direct knowledge of it. Still, descriptions of a present mental state may help a factfinder draw inferences about a past mental state provided that the time in question is not too remote and that there is some direct evidence of the actor's behavior at the past time.

196. The presentation of scientifically acceptable probability data should not present significant hearsay problems. It is not necessary for the testifying expert to have collected the statistics himself; it is sufficient if the expert has a comprehensive knowledge of the data and is able to discuss its methodology. Experts should be allowed to rely on reasonably performed scientific studies in their field so long as they are able to discuss, if necessary, the deficiencies of the studies and the implications of those deficiencies. Of course, this argument applies also to expert testimony about prediction data. See text accompanying notes 197-204 infra.

To the extent that only hard, methodologically sound quantitative data is deemed relevant, there is a danger that the trial will turn into an academic dispute over the scientific adequacy of data introduced into evidence or the relative scientific respectability of opposing experts. Of course, such an outcome will not be helpful. One can only rely first, on the discretion of trial judges to limit testimony on these points and second, on the common sense of the decisionmaker to determine which studies or experts seem nonreliable. If it should result that assessing scientific adequacy is an impossible task for a court, this author's preference would be to exclude all such testimony rather than to accept as sufficiently scientific all expert testimony that is offered by a "credentialed" witness.
tion of human behavior. It has also noted that for some legally relevant behaviors such as dangerousness or treatment outcome, there are data available, although the predictive accuracy is not likely to be very high or precise. When predictions are necessary, though, such data should be available to the legal decisionmaker.

Before turning to the form in which data should be provided, it is necessary briefly to delineate some cautions. If there is no data bearing directly on the prediction in question, experts should not be allowed to hazard a prediction. Without hard, methodologically sound quantitative data, the guess of an expert is unlikely to be better than the guess of laypersons. An expert without data directly relevant to the prediction at hand is not an expert for purposes of that prediction, and guesses based on generally inaccurate clinical wisdom should be disallowed. There are some occasions when clinical hunches are more trustworthy than a prediction table, but such occasions cannot be specified at present, and the clinical hunches of laypersons are likely to be as accurate as those of experts.

When data is offered to the decisionmaker, it should be quite precisely relevant to the case at hand. Behavioral science is far too imprecise to allow legal rights to hinge on generalizing from a sample population unlike the case in point. For instance, suicide prediction studies performed on older adults should not be used in order to predict the suicidal potential of an adolescent. For another example, diagnoses per se do not lead to accurate predictions. In sum, prediction expertise must rest on the professional’s thorough and precise knowledge of the empirical data (or lack of it) bearing on the type of prediction in question. He must be able to describe to the legal decisionmaker not only the specific data of a study or studies, but also the methodological rigor of the studies on which he is relying.

197. See text accompanying notes 116-144 supra.
198. P. MEEHL, supra note 28, at 234-35; see id. at 81-89, 168-73. Although it may be impossible to specify in advance the proper occasions for clinical prediction, an incredible instance presented itself recently. David Berkowitz, known as “Son of Sam,” who has since pleaded guilty to the ambush slayings of six persons in the year prior to his arrest, was recommended for release on his own recognizance (ROR) by a pretrial service agency. The reason for the recommendation was that Berkowitz’s characteristics (e.g., lack of previous arrests) matched an actuarially developed profile of arrestees who were good ROR risks. The judge used his good sense and held Berkowitz without bail. L.A. Times, Aug. 19, 1977, pt. I, at 1, col. 1. The recommendation for ROR is an example of the use of the actuarial approach without a shred of common sense. Still, it is nearly impossible to identify accurately those cases in which the actuarial approach should be abandoned. It should be noted that in the Berkowitz case the decision to use the clinical approach and the clinical prediction itself was not based on theoretical speculation or strained inferences. The prediction was sensibly based on a course of recent behavior that the accused threatened to continue. Predicting that violence was highly likely seems powerfully justified in such a case.
199. See notes 131, 134 and accompanying text supra. See also notes 174-77 and accompanying text supra.
As discussed above, the law usually asks for predictions by putting questions in vague, general forms. For instance, such questions might be: "How likely is it, Doctor, that this person will improve if he is given 'Thorazine' or is placed in a token economy?" or "Is there a substantial likelihood that this person will commit suicide if he is not hospitalized?" This Article has argued that such general questions do not contain specific quantitative standards. Rather, they set legal standards that allow the decisionmaker some moral and social flexibility. Still, decisions based on predictions rely to some extent on empirical estimates that can be provided by experts when data are available. Thus, experts should testify with all the quantitative precision they possess and should leave the interpretation of legal terms such as "likely" or "improve" to the legal decisionmaker.

For example, the expert should not testify: "If we give this schizophrenic patient 'Thorazine,' he’s likely to improve, all right; most schizophrenics do." Instead the expert should testify in the following form: "When given 'Thorazine,' X% of people who behave as this person does, change in n specific ways, within time period T." Or, rather than unhelpfully testifying: "There’s a very good chance that this depressed man will commit suicide if you leave him free," the expert should testify as follows: "People who behave as this person does are X times more likely than the average person to attempt suicide, but only Y% of persons like him do in fact attempt suicide." Given the numbers, the judge or jury can decide if those numbers satisfy legal tests such as "likely improvement" or "likely suicide" that are applied for social and legal purposes such as deciding whether to detain and treat the person involuntarily.

This approach may seem mechanical, but a uniform finding of behavioral science is that statistical-actuarial prediction of human behavior is more accurate than clinical judgment. When important rights turn on a prediction, the law should require that the best technique be used. If no

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200. See notes 114-15 and accompanying text supra.
201. See text accompanying notes 114-15 supra.
202. Contrary to the suggestion in the text, it is often believed that diagnoses are useful for choosing particular treatments or predicting response to them. Much research, however, shows that treatment prescription based on specific behavioral manifestations is more useful than prescription based on diagnosis. G. Frank, supra note 25, at 57-62; R. Kendell, supra note 25, at 40-44; Bannister, Salmon, & Leiberman, Diagnosis-Treatment Relationship in Psychiatry: A Statistical Analysis, 110 Brit. J. Psychiatry 726 (1964); Goldberg, Frosh, Grossman, Schouler, & Johnson, Prediction of Response to Phenothiazines in Schizophrenia: A Cross-Validation Study, 26 Archives of General Psychiatry 367 (1972); Overall, Henry, & Woodward, Decisions About Drug Therapy—V. Models Derived from Diagnostic Frequency Patterns, 13 J. Psychiatric Research 77 (1976).
203. See note 128 and accompanying text supra.
204. Cf. Shull, supra note 125, at 230 (statistical-actuarial prediction would yield greater
actuarial data is available, the law need not ask the opinion of experts and may safely rely on predictions made by judges or juries; accuracy would not be lost, prejudice would be avoided, and efficiency would be gained.

In sum, when predictions are necessary, experts should be allowed to testify only if their testimony is based on data and presented in a form that leaves the legal issues to be decided by the judge or jury.

4. Who is an Expert?

The professional discipline primarily and traditionally involved in mental health law decisionmaking is medicine, especially the specialty branch of psychiatry. More recently, psychologists, too, have become increasingly involved as courts and legislatures have qualified them as expert witnesses.205 To assess the role that these disciplines and others might play in mental health law decisionmaking, the framework of the three questions adjudicated by mental health law will be used once again. Indeed, it should be recognized that an expert may not be an expert on all three questions, but only on a subset of them. Sometimes, three different experts might be needed to obtain truly expert opinions on all three questions, and at other times no expertise may be available or needed.

In determinations of normality, almost any person with extensive clinical experience with crazy persons should qualify as an expert. The ability to be attuned to crazy behavior is not primarily a function of the discipline in which the clinician was trained; rather, it is dependent on the clinician’s clinical training and sensitivity. Professionals without extensive, recent, and relevant mental health clinical experience, whatever their formal consistency and uniformity as well as equity). If a proceeding is nonadversarial, the Aesculapian authority of the clinical predictor will tend to carry prejudicial weight, even if the expert is vigorously cross-examined in an attempt to cast doubt on the accuracy of clinical prediction. Of course, the presence of opposing experts will tend to lessen this effect.

On moral grounds, the state should not be allowed to use suspect data when the deprivation of significant rights is threatened. The best approach probably is to disqualify clinical prediction as a matter of expertise on the grounds that there is little evidence that clinical predictions by experts are better than predictions by laypersons. See CAL. EVID. CODE § 801(a) (West 1966) (expert opinion limited to subjects sufficiently beyond common experiences so that expert opinion will assist trier of fact). Clinical prediction by experts should be allowed only if hard empirical evidence demonstrates that such prediction on the question at issue is considerably more accurate than actuarial prediction or lay prediction.

training, should not be qualified as experts. Conversely, a paraprofessional who has worked in a clinic for ten years is likely to be a very acute observer of craziness. The ability to unearth crazy behavior is not limited to any professional discipline, and all experienced clinical mental health workers should qualify as experts. Of course, if there is a question of physical illness involved, only a relevantly trained physician should be allowed to testify.

On the question of responsibility, expert testimony may be useful for demonstrating the relationship between craziness and legally relevant behavior and for producing probability data concerning the actor’s behavior. Again, any experienced clinician ought to be qualified as an expert concerning the actor’s craziness, regardless of his or her professional discipline. Further, any expert with hard probability data, including those from non-mental health disciplines such as sociology, should be allowed to testify about such data.

Let us take an example. Suppose the actor has been reliably identified as epileptic or as hearing voices; the question is whether his assaultive behavior was the product of epilepsy or of the voices. A relevant question would be: “What percentage of epileptics of this type or of people who hear voices of this type engage in random assaultive behavior or similar behav-

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206. This group includes most physicians, a group that tends to have little training, interest, or expertise in mental health matters. Of course, the prevailing law is that physicians in general are qualified to be experts on mental disorder. 31 AM. JUR. 2d Expert and Opinion Evidence §§ 87, 90 (1967). It is submitted, however, that the law is entirely irrational on this point.

At present, however, increasing numbers of mental health laws require that testifying experts be specialists, usually psychiatrists and psychologists. See, e.g., CAL. WELF. & INST. CODE §§ 6307-6309 (West Supp. 1978) (mentally disordered sex offender commitment examinations). Also, some statutes provide for appointment of psychiatrists or psychologists with forensic skills. See, e.g., id. § 5303.1 (postcertification for dangerousness commitment examinations).

Psychiatry and psychology are presently considering creating boards for certification of forensic specialists. Because mental health law cases tend to raise similar questions, such certification might be useful for courts and clients if those certified were to have the relevant knowledge and skills suggested by this Article. On the other hand, the thesis of this Article is that the questions that should be asked of professionals are not “legal,” and the expertise professionals ought to contribute requires little or no knowledge of or experience with the law. Consequently, an expert with legal experience would not necessarily be more useful than an expert without legal experience who is equally competent to provide the nonlegal data and observations that the law needs. In sum, the author has no major objection to certification of forensic mental health professionals if it is recognized first, that certification means only that those certified possess knowledge and skills relevant to the law’s needs, and second, that noncertified professionals, including those from non-mental health disciplines, may also possess that knowledge and skill.

207. If a question of brain damage or neurological pathology is raised, experts other than physicians who are trained in neuropsychological assessment techniques (usually psychologists) should also be qualified as experts on this question. See M. LEZAK, NEUROPSYCHOLOGICAL ASSESSMENT TECHNIQUES (1976).
ior?" It is quite possible that a very competent clinical neurologist or psychologist would have no hard data on these questions whereas a sociologist might have made careful studies of them. Accordingly, for these questions the sociologist is more expert than the neurologist or psychologist, even though the sociologist may have little expertise in recognizing epilepsy per se or in unearthing auditory hallucinations.

Concerning predictions of future behavior, an expert from any field who possesses data relevant to the specific prediction in issue is competent to be qualified. Questions about dangerousness, for example, are studied by sociologists and lawyers as well as by mental health professionals.

Thus, this Article suggests a very functional approach to qualifying experts. The questions raised by mental health laws call for many different types of expertise, and there is no reason to believe that any one expert is able to answer all of them in a given case. Further, the relevant expertise may come from many disciplines, including non-mental health disciplines. Mental health professionals may have more information generally on most mental health-related questions, but they do not have a monopoly.

To date, the mental health legal system has been both too restrictive and too lenient in qualifying experts. By qualifying only psychiatrists and sometimes psychologists as experts, the courts have lost the services of other professionals who may be of use.208 Such restriction has promoted the mistaken view that crazy behavior and its consequences are uniquely medical or quasi-medical matters. Conversely, courts have been too lenient in allowing mental health professionals to testify about matters that are broadly within their discipline but about which given professionals are not particularly expert.

The suggested functional approach matches the true expertise of the professional, from whatever discipline, to the precise question being asked. Compared to present practice, this approach is a far more rigorous means of employing expertise in answering legal questions. This scheme would be fairly expensive to implement, but in an area where expertise is so limited and where fundamental rights are often involved, the law should strive to make the optimum use of experts. Thus, true expertise should be heard, and false expertise should be excluded because it is not helpful and often is prejudicial.

208. Psychiatrists now represent only 33% of mental health professionals. Further, they are mal-distributed demographically. B. Brown, The Federal Government and Psychiatric Education: Progress, Problems, and Prospects 11-14, 26 (Fig. 2) (1977). In some areas there are very few, if any, psychiatrists or psychologists, whereas other professionals may be available. Further, even where all professionals are available, quality will be increased by enlarging the size of the pool from which experts may be drawn.
5. Summary and Conclusions

Mental health experts should be limited to testifying about those matters in which they are more skilled than laypersons. This Article has suggested that experts may be useful in two specific ways: (1) as acute and efficient first-hand observers of crazy behavior; and (2) as sources of scientifically rigorous data. Further, descriptions and data should be presented in a commonsense and ordinary language fashion. If experts are so limited, their testimony will tend to be far more useful than it is at present. They should not, however, be allowed to draw conclusions about any issue to be decided by mental health law. These are moral and legal issues that should be decided by legal decisionmakers.

In addition to suggesting the type of expert testimony that ought to be considered and the form in which it should be offered, some further suggestions flow from the analysis of expertise. First, psychiatric experts cannot be value-neutral scientists and should properly function as advocates. In proceedings such as civil commitment where liberty is at stake, defendants should be entitled as a matter of due process to an advocate expert of their choice paid for by the state. It is almost impossible to defend oneself against or to prove mental health allegations without the assistance of an advocate expert. Even though the battles of the experts may be confusing, it is submitted that if expert testimony is limited in the manner proposed in this Article, confusion will be reduced enormously because legal factfinders will not be led to believe that there are scientific “answers” to the questions being presented. Moreover, disputes over the precision of observational data or over the soundness of probability statistics reflect the uncertainties and ambiguities in the field, and there is no reason for juries and judges not to be aware of the level of uncertainty of mental health science.

Second, in those cases where an advocate expert is not required by due process or is not available for any other reason, the court should attempt to ensure that the jury recognize that the sole expert is not impartial. The court should also ensure that the expert is fully cross-examined. Judges should know and juries should be instructed first, that unopposed testimony should be assessed cautiously, and second, that unopposed testimony may be disregarded. Finally, it is suggested that an appellate or trial court should never overturn a matter of law a judge or jury’s decision, even if the decision clearly disregards unanimous psychiatric expertise to the contrary. Mental health law decisions involve too little science and too much social

209. See Farrell, supra note 156.
and moral judgment to allow a factfinder’s decision to be overridden because it opposes the weight of “expert” testimony.

Restricting the use of experts as suggested heretofore is opposed to the long-term trend in evidence law that suggests that it is a mistake to limit the information witnesses can supply.\(^{210}\) Still, an exception should be made for mental health professionals, primarily because their expertise is limited on most issues and their unrestricted testimony tends to obscure the moral and social nature of the questions being asked. Competent cross-examination and jury instructions may be partial antidotes to the medicalization of morals, but they cannot be complete. Many of the cases are not truly adversarial; too few attorneys are skilled at cross-examining psychiatrists, laypersons overweight the testimony of experts, and, in any case, unrestricted use of experts promotes the incorrect view that the questions are primarily scientific. There is, however, no antidote for the major difficulty with mental health “experts”—that they simply are not experts except in the areas delineated. In realms beyond their true expertise, the law has little special to learn from them; too often their testimony is inefficient and wasteful and, at worst, it is prejudicial.

**B. THINKING ABOUT MENTAL HEALTH LAW**

This section will discuss, in light of the foregoing parts of this Article, the following exemplary substantive areas of mental health law: involuntary civil commitment and treatment, the insanity defense, and various aspects of civil law such as competence to contract and craziness as a ground for recovery. The purpose of this section is not to recreate and resolve the complex debates in each of these areas. Many important aspects of those debates will not be addressed. Rather, the purpose here is only to explore briefly those rationales for special legal treatment of mentally disordered persons that are affected by the argument of this Article.\(^{211}\) An argument is offered that contends that many of the rationales for special legal treatment are undermined by the analysis of this Article. It is also suggested that some of those laws might be replaced by more explicit and functional standards that allow legal regulation, but that do not treat crazy persons as a special class.\(^{212}\)


\(^{211}\) For example, the following subsections will not analyze in detail all the complex substantive and procedural arguments pro and con for abolishing or limiting involuntary civil commitment or the insanity defense. Some of these arguments will be addressed briefly in passing, but the major goal of this section is the more limited task of applying the thesis of this Article to the substantive rationales affected by the thesis.

\(^{212}\) Even now, many competency laws are operationalized and include a more general causal factor like “unsound mind” rather than mental illness or disorder. In practice, however,
The core of the argument throughout this section is that for legal purposes there is little persuasive scientific evidence that crazy people should be treated differently from noncrazy people. Crazy people have a great deal of control over their behavior and their future behavior is not more predictable than that of normals. Craziness is only a predisposing cause of other legally relevant behavior. If the law is unwilling to consider the relevance of other predisposing causes, such as poverty, to legal questions such as dangerousness or criminal responsibility, it is difficult to maintain a compelling argument that craziness is different and therefore should be relevant. As we shall see, the consistently offered rationale for special legal treatment of crazy persons is that they cannot control their behavior. But this rationale can be supported only by intuitive hunch, albeit a powerful one in some cases, and not by scientific evidence. A similar argument applies to the predictability issue. Knowledge that a person is crazy or suffers from a specific mental disorder does not usually increase significantly the accuracy of predictions of legally relevant behavior.

In sum, crazy persons should be treated like normals. Crazy persons should not be treated differently on the grounds that they alone cannot behave otherwise or that their future behavior is uniquely predictable.

1. *Involuntary Civil Commitment*\(^{213}\) and Treatment

Civil commitment and treatment aim to prevent or ameliorate social and personal harms by protecting society from dangerous persons or by protect-

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Other recent writers who have debated the propriety of civil commitment are K. Miller, *supra* note 11; M. Peszke, *Involuntary Treatment of the Mentally Ill* (1975); A. Stone, *supra* note 10, at 43-52. Dr. Stone also has provided the most sensible and balanced background analysis of the mental health legal system. A. Stone, *supra* note 10, at 8-19. He describes the interrelationship of the mental health system, the welfare system, the law enforcement system, and the family. All writers on mental health law owe him a debt for sensibly placing mental health law in its institutional context.

A useful categorization of the reasons mental illness justifies civil commitment is Shapiro, *supra* note 57, at 767-81.
ing persons from themselves.\textsuperscript{214} Our society does not authorize involuntary civil confinement and treatment, however, even where the harm seems clear, unless the actor is crazy. For example, predictably dangerous people may not be incarcerated and rehabilitated unless they transgress the criminal law; physically ill people generally may not be involuntarily hospitalized unless, for example, they are unconscious\textsuperscript{215} or suffer from certain dangerous, infectious diseases. Mentally ill persons, however, may be committed and treated on the basis of predicted dangerousness or the need for treatment.

Before continuing, it is necessary to consider the three primary behavior components of commitment laws: danger to others, danger to self, and the need for care or treatment. The major substantive issues raised by the dangerousness criteria are the likelihood of danger required and how serious the danger must be. Threshold levels are rarely specified, but it seems clear that they must be substantial.\textsuperscript{216} For example, simply disturbing or annoying behavior is not sufficiently dangerous.\textsuperscript{217} The definition and likelihood of danger required, however, are not primarily mental health issues and they are not defined in psychiatric terms. By contrast the "need for treatment" or "hospitalization" criterion is expressed in mental health terms.\textsuperscript{218} Here one must consider the extent to which mental health standards should be incorporated into the law. Even if treatment is available, a pure "need for treatment" criterion based on psychiatric standards alone should not justify involuntary state intervention and certainly not involuntary incarceration. Those who need treatment according to psychiatric standards are a much

\textsuperscript{214} Justifications, supra note 36; Developments, supra note 6, at 1207-12, 1223-28. Commitment has been justified on both police power and parens patriae grounds. The United States Supreme Court has made it clear that it is unconstitutional to commit persons either (1) to give them custodial care without more when they could manage to live in the community with the help of family or friends or (2) to remove them from the community because they are deviant or disturbing, although otherwise harmless. O'Connor v. Donaldson, 422 U.S. 563, 573-76 (1975).

\textsuperscript{215} Even if they are in such condition, the care provided does not involve long-term involuntary incarceration, nor is the assistance provided often refused once the person is conscious. These cases are arguably not truly voluntary.


\textsuperscript{218} See, e.g., Ohio Rev. Code Ann. § 5122.01(B)(4) (Page Supp. 1976). See also Cal. WELF. & INST. CODE § 5250 (West 1972) (authorizing commitment for "grave disability," defined as an inability, at an unspecified level, to provide for basic food, clothing, and shelter needs. Id. § 5008(h)(1) (West Supp. 1978)). It has also been suggested that "suffering" should be a commitment criterion. A. Stone, supra note 10, at 67, 69. Of course, all "need for treatment" criteria are "danger to self" criteria in the broadest sense.
larger class of persons than those who are so disabled or endangered that deprivation of their liberty seems socially and morally necessary. Liberty and legal goals in general should not depend on psychiatric criteria that reflect the social values of the defining group and that were not created for legal purposes.\(^{219}\)

According to mental health standards, vast numbers of persons "need" some form of intervention although the large majority of them are not dangerous to themselves or significantly disabled unless one accepts an enormously stretched conception of danger or disablement.\(^{220}\) Intervention in such cases attempts to force the recipient to live or behave in the "right" way, whether or not he is significantly harming himself or wishes to be changed or helped.

To protect liberty and dignity, the law must define for itself the normative issue of how much danger of harm to others or self is necessary to justify commitment. Surely the requisite degree of danger and its likelihood should be quite substantial. Civil commitment represents a major deprivation of liberty and autonomy;\(^{221}\) our society should therefore balance this deprivation very carefully against the goals that might be achieved by commitment.\(^{222}\)

\(^{219}\) See United States v. Blocker, 274 F.2d 572 (D.C. Cir. 1959); notes 38, 43, 161-64 and accompanying text supra.

\(^{220}\) See note 38 and accompanying text supra. People who suffer from mental disorders need treatment, at least in the sense that they are not in an optimum state of "health" and might benefit from it according to some standards.


Even if intervention appears warranted by the actor's dangerousness to self or others, it is
The primary rationale for prohibiting the civil confinement of normal persons is the belief that they are responsible for their behavior. In a society that values liberty and autonomy, preventive detention generally is not justified, even for humane and other worthy ends. By contrast, the standard primary rationale for authorizing civil commitment of crazy persons is that they are not responsible for their behavior—it is assumed that crazy persons are sick and cannot control their harmful behavior. Consequently, civil commitment of crazy persons does not appear to be an unjustified deprivation of liberty, autonomy, and dignity.

Let us take some examples. First, consider the differential treatment of persons who are dangerous to others. There may be a high probability that a normal dangerous person will violate the criminal law, but it is believed that this individual can always choose not to engage in illegal conduct. Moreover, a dangerous normal person arguably can be affected by the criminal law and its sanctions. To preserve the normal actor’s autonomy and dignity, society and the law allow him to remain at liberty unless he chooses to transgress the criminal law. Conversely, it is believed that crazy persons who are dangerous cannot control their antisocial behavior and cannot consider rationally the law’s sanctions as part of a freely chosen decision. If the crazy person is not responsible, confining him does not infringe on his autonomy, as he has little autonomy to begin with, and the confinement still necessary to ask if involuntary incarceration is required. Do all mentally disordered people who are dangerous to themselves or others need to be hospitalized? Intervention can take two forms: First, physical restraint or care for those who are directly physically dangerous to themselves or others, or who alone simply cannot protect themselves in freedom; second, treatment aimed at changing dangerous behavior. Hospitals are not always needed for either purpose, however. For those persons who are dangerous to others, hospitals do serve an incapacitative function, but they are less necessary for this purpose than is often supposed. The criminal justice system is arguably the more appropriate means for dealing with such persons. See note 136 and accompanying text supra; notes 245, 257 and accompanying text infra.

Hospitalization is rarely needed for those who are dangerous to themselves unless the person is imminently suicidal or utterly incompetent to protect himself in the community and other methods of protection such as nursing visits are unavailable. Treatment usually does not require hospitalization. The primary exception is those cases where the actor refuses treatment and must be kept under supervision and restraint in order to force treatment on him. In sum, hospitalization seems justified only if it is the sole means, first, to protect others or to protect a person from himself, and second, to force treatment in those cases where involuntary treatment as well as protection is justified. Involuntary treatment will be discussed in detail in notes 228-34 and accompanying text infra. It is sufficient to note here that even if a person is utterly dangerous to himself and refuses treatment, treatment should be forced on the person only if the treatment refusal itself is deemed incompetent.

223. It is assumed for purposes of discussion that a rational legislator or judge would be persuaded by the considerable evidence demonstrating that crazy persons are not considerably more dangerous than noncrazy persons. Thus, the older policy rationale that preventive detention is authorized because crazy persons are especially dangerous is certainly no longer easily acceptable. See Developments, supra note 6, at 1230-31; notes 24, 98 and accompanying text supra.
does protect society from supposedly uncontrollable depredations. 224

Now consider the case of a person whose behavior is enormously self-endangering because he has a history of heart disease but who continues to overeat, smokes excessively, and refuses to take his medication. Although forcibly hospitalizing such a person might seem humane in one respect (i.e., it may save his life), it seems an undue infringement on autonomy and dignity values to force hospitalization on a person who chooses freely to endanger himself. On the other hand, it is believed that self-endangering crazy persons are not freely choosing to endanger themselves and that they cannot rationally weigh the costs and benefits of their behavior. Hospitalization of a crazy self-endangering person, therefore, does not seem to infringe unduly on that person’s autonomy and, thus, is a humane and just response to unfreely irrational behavior. 225

As we have seen, however, crazy people are not particularly dangerous as a class. 226 Moreover, no way exists to determine whether or not they are capable of controlling their dangerous behavior. It is not claimed, of course, that no crazy person is dangerous to others or himself. It is asserted, however, that crazy persons are not considerably more dangerous than normal persons and that little scientific evidence exists to demonstrate that crazy persons’ legally relevant behavior is beyond their control. Because society has a strong general presumption against preventive detention and because civil commitment is not allowed for dangerousness, incompetence, or irrationality per se, there is little reason to authorize civil commitment on grounds of lack of free choice only for the mentally ill. A hunch about nonresponsibility or incapacity is a weak foundation for a superstructure of involuntary confinement that deprives citizens of liberty, dignity, and autonomy. 227 Commitment of only the mentally ill is an unfair and unsuccessful


225. See Developments, supra note 6, at 1212-19, 1223-28. Involuntary treatment is discussed in greater detail in text accompanying notes 228-34 infra. See also text accompanying notes 104-06 supra.

226. See notes 24, 98 and accompanying text supra. Indeed, mentally disordered persons are probably not more dangerous than the general population, and they are clearly less dangerous than other identifiable subgroups in the population such as young males, who account for one quarter of all persons arrested and nearly one-half of all those arrested for “index crimes.” See In re Balby, 482 F.2d 648, 666 (D.C. Cir. 1973); Boland & Wilson, Age, Crime, and Punishment, Pub. Interest, Spring, 1978, at 22, 23.

227. Society might decide to institute a scheme for preventive detention for all citizens, crazy and normal, based on a constitutional balancing of societal protection against individual liberty and autonomy. Assuming that the system accurately identifies dangerous persons, such a scheme might very well be constitutional. See Developments, supra note 6, at 1228-29. Such a system would not need to rely on stigmatizing and improvable assumptions about the nonresponsibility of crazy persons or anyone else. Moreover, it would be far more effective than
means for achieving the primary goals of preventive detention— to protect society from dangerous persons and to protect self-endangering persons from themselves. The vast majority of persons who are dangerous to others or self are not mentally ill, and little evidence demonstrates that normal dangerous persons are more freely choosing to behave dangerously.

A second rationale for civil commitment and consequent treatment, based on a parens patriae theory, assumes that some "crazy" persons are incompetent to make rational decisions about whether to enter the protective environment of the hospital or to accept further treatment that may be offered. Enormous numbers of people refuse mental health treatment when it is suggested or offered. As a general rule, persons are entitled to refuse hospitalization and medical or quasi-medical treatment, but crazy persons are often hospitalized and treated despite their express refusal. Clearly, substitution of judgment raises substantial problems of intrusion on autonomy and dignity. Is it correct to consider only "crazy" persons incapable of rational judgments and thus to override only their judgments? What is incompetence and the relevance of craziness to it?

At issue in deciding whether to respect a person's hospitalization and treatment refusal is his decisionmaking competence, that is, the person's ability, within reasonable, culturally determined limits, to attend to and weigh data relevant to the decision whether to accept or reject hospitalization limiting preventive detention only to the mentally ill. See generally Dershowitz, Preventive Confinement: A Suggested Framework for Constitutional Analysis, 51 Tex. L. Rev. 1277 (1973). See also note 244 and accompanying text infra (discussion of involuntary treatment of dangerous persons, whether or not they are "crazy").

228. A. STONE, supra note 10, at 68-70; Developments, supra note 6, at 1207-19. In some cases the person's hospitalization and treatment decisions may be separable. A "crazy" person may be crazy in regard to some matters but able to behave perfectly reasonably in relation to others. Thus, some persons may be unable to decide rationally about hospitalization but may be able to decide rationally about further treatment. Consider the case of a gravely disabled person who seems unable to decide rationally whether to enter the protective environment of the hospital. Society may wish to hospitalize this person on both parens patriae and police power grounds. Once in the hospital, however, the person may be able to decide rationally about further treatment. He may prefer extended incarceration to behavior changes. Overriding the refusal of treatment under these conditions would have to be justified on grounds other than parens patriae. Conversely, the person may be quite able to weigh rationally the costs and benefits of hospitalization, but may refuse hospitalization. Then, society might hospitalize him under a police power theory. Once hospitalized, the person may seem unable to weigh rationally the decision to accept treatment. In that case, his treatment refusal decision might be overridden on a parens patriae theory.

229. The importance of the issue of the right to refuse treatment has lead to increasing commentary and new law. Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973); Mackey v. Precomier, 477 F.2d 877 (9th Cir. 1973); Winters v. Miller, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 985 (1971); Aeden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (1976); Price v. Sheppard, 307 Minn. 250, 239 N.W.2d 905 (1976); CAL. WELF. & INST. CODE §§ 5325, 5326.2, 5326.6, 5326.7, 5326.85 (West Supp. 1977); A. STONE, supra note 10, at 97-108; Murphy, Total
tion and treatment.\textsuperscript{230} This type of determination focuses on the person's ability to perform the process of deciding rather than on the final decision. Focusing on this process avoids the logical fallacy of assuming that because a decision seems inexplicable, disturbing, or irrational in a given instance or series of instances,\textsuperscript{231} it must be true that the decisionmaker is incapable of rational decisionmaking. After all, many noncrazy people have bad judgment and make terrible decisions. Moreover, concentrating on decisionmak-

\textit{Institutions and the Possibility of Consent to Organic Therapies}, 5 J. HUMAN RIGHTS 25 (1975);
\textit{Schwartz, In the Name of Treatment: Autonomy, Civil Commitment, and Right to Refuse Treatment}, 50 NOTRE DAME LAW. 808 (1975); Shapiro, \textit{Legislating the Control of Behavior: Control: Autonomy and the Coercive Use of Organic Therapies}, 47 S. CAL. L. REV. 237 (1974);

A full appreciation of the parens patriae rationale for overriding treatment refusal necessitates further analysis of the nature of mental health treatments and their application to involuntary mental patients. The central issue raised by involuntary mental treatment is under what conditions society is justified in forcibly changing a person’s behavior. Mental health treatments operate by attempting to change behavior, not by curing objectively identifiable underlying pathology. See notes 134-36 and accompanying text supra. (Of course, some treatments change some craziness, such as crazy thinking, that leads to other disabilities such as general social incompetence.)

The analysis of this Article suggests that forcing behavioral change may be justified, but not primarily because the actor’s legally relevant behavior is the product of an illness he wishes to have cured. Moreover, crazy persons often do not wish to be freed of their condition. See, e.g., Van Putten, Crompton, & Yale, \textit{Drug Refusal—Schizophrenia and the Wish to Be Crazy}, 33 ARCHIVES OF GENERAL PSYCHIATRY 1443 (1976) (some patients preferred delusions of grandeur to “grayness” of ordinary life caused by drug treatment). Society may wish to change behavior forcibly, but it should recognize honestly that doing so is not the same as curing a physical illness. As we have seen, the existence of curable, underlying illnesses is unproven and scientific evidence does not demonstrate persuasively that, in general, crazy persons as a class are any less responsible or more tractable for their legally relevant behavior than normal persons. See notes 58-112 and accompanying text supra; note 243 and accompanying text infra.

Further, on utilitarian grounds there is as much or more reason to change identifiable dangerous normal persons involuntarily as crazy ones because more social harm would be prevented.

\textsuperscript{230} See notes 104-12 and accompanying text supra.

\textsuperscript{231} Here, one should note the great difficulty in deciding when an action or reason is itself irrational. See, e.g., \textit{Goldstein, On the Right of "Institutionalized Mentally Infirm" to Consent to or Refuse to Participate as Subjects in Biomedical and Behavioral Research}, in \textit{National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, Research Involving Those Institutionalized As Mentally Infirm,} SI 2-1 app., 2-13 app. (1978); \textit{Moore, supra} note 14, at 1487. \textit{See generally Murphy, supra} note 104.
ing ability is respectful of the actor's autonomy and dignity; freedom to decide as one wishes is preserved, so long as the person is capable of attending to and weighing data relevant to the decision.

Deciding that a person is incompetent is difficult, and doing so has serious consequences for the actor's liberty and dignity. Indeed, some noted commentators have suggested that it is inherently unjust to treat any adult as incompetent and that all adults should be conclusively presumed to be competent for all purposes. Society need not go this far in rejecting the notion of incompetence, however. As a moral matter, society may not be willing to allow persons to harm themselves, impoverish their families, or the like when it is believed on strong intuition that an actor is incapable of making sensible decisions.

Yet what reason is there to believe that decisionmaking incompetence is unique to crazy persons? This Article has suggested already that it is impossible in nearly all cases to determine when any behavior, including reasoning, is the inexorable or near inexorable product of alleged mental disorder. Moreover, there is little reason to believe that craziness is the

232. E.g., Goldstein, supra note 231.

[E]ther the competence of the institutionalized mentally infirm to decide must be presumed and, therefore, their freedom to exercise their capacity to choose must be safeguarded from violation by those in authority.

Id. at 2-12 app. (emphasis in original).

To empower a group of self-appointed (or politically appointed) wisemen to determine whether an adult individual has the competence to judge what is best for himself or herself is a total affront to his or her human dignity. To force upon potential subjects a determination of the "rationality" of their processes of decision in accord with some philosophical or psychological dogma about what and who is rational, is to deny autonomy to all such persons and to affront their dignity even if their choices are determined to be "rational" and "informed." To establish such a process would defeat its professed function of safeguarding each person's right to consent. Finally, it is beyond the competence of law which is, after all, a gross instrument for the regulation and control of interpersonal relationships, to provide guidelines for deciding whether a person's consent or refusal to consent is "informed" or "rational" or more to the point, whether the person wishes to be restricted to "rational" decisions, if there be such, to participate as a subject of non-therapeutic or non-beneficial research experiments.

Id. at 2-15 app.

The burden in law for incompetence should be very high. No evidence other than a showing that the patient is comatose should ordinarily be accepted as proof of incompetence.

Id. at 2-26 app.

Although Professor Goldstein's article deals with consent to participation in research and not with treatment refusal, the principles adduced would seem to apply in the latter context as well. See id. at 2-32 app. to 2-34 app. Professor Goldstein recognizes that the Constitution perhaps does not require this degree of respect for autonomy, but he urges that decisionmaking processes be adopted that are "fully sensitive to the sanctity of human beings" rather than barely comporting with the Constitution.

Id. at 2-10 app. Finally, Professor Goldstein suggests that the state's role in research participation decisions should be to ensure that the person has been given all relevant information in a noncoercive atmosphere. Then the person's decision must be respected completely. Id. at 2-19 app. to 2-26 app., 2-34 app. to 2-39 app.

233. See notes 95-112 and accompanying text supra. This is not to say, however, that a
primary or only cause of allegedly mistaken and seemingly irrational decisions. Noncrazy people make such decisions all the time, often with consequences that are perilous to them. One need only consider the many persons with heart disease who refuse to lose weight or who continue to smoke. Indeed, some otherwise normal and apparently rational persons seem habitually to make irrational decisions concerning various aspects of their lives.\textsuperscript{234} If such a person, however, were physically ill and refused treatment when he desperately needed it, the law would not intervene and force him to behave in ways that those around him perceived as more rational.

If, however, a crazy person irrationally refuses hospitalization and treatment, the law is much more willing to intervene because it is assumed the person is incapable of refusing rationally. But as we have seen, there is little compelling scientific evidence to justify distinguishing the two cases and substituting judgment only in the case of the crazy person.

Of course, society can make a distinction between crazy and normal people, but it must be on the intuitive basis that crazy persons are fundamentally different and cannot behave rationally. The allegedly scientific rationale cannot serve as an adequate basis for overriding the decisions of crazy people. There is little empirical reason to believe that the person with habitual bad judgment is capable of rational decisionmaking whereas the crazy person is not. Substitution of judgment must be decided on a normative basis after a thorough and commonsensical analysis of the person's behavior.

The third general rationale supporting civil commitment of only mentally ill persons is the belief that experts can predict the future behavior of crazy persons with special accuracy. This rationale is operative at two points in the commitment process: initially, at the commitment decision, and later, at the release decision. As we have seen, however, the data does not support the rationale;\textsuperscript{235} most predictions of future legally relevant behavior are far more likely to be wrong than right, and predictions are likely to err in the direction of overpredicting legally relevant behavior.\textsuperscript{236}

\textsuperscript{234} There is, of course, the possibility that if a person makes enough irrational decisions of a crazy sort he will be considered crazy rather than a normal person with bad judgment in a given area of his life.

\textsuperscript{235} See text accompanying notes 116-44 supra.

\textsuperscript{236} See notes 137-40 and accompanying text supra.
Consequently, many persons are and will be incorrectly incarcerated and will be incorrectly kept incarcerated when they ought to be released. A society that values liberty should be extremely cautious when sanctioning civil incarceration based on predictions that are highly inaccurate.\textsuperscript{237}

A fourth general rationale for civil commitment is that once a person is hospitalized, treatment will be available to help him.\textsuperscript{238} Moreover, if a least

\textsuperscript{237} A possible exception would be presented in a case of emergency commitment where the individual was behaving in a legally relevant manner at the time or had done so in the immediate past. In such a case, prediction of future behavior would be based on temporally contiguous behavior in the real world. As noted, the best data for prediction is similar past behavior; thus, emergency predictions are much more likely to be accurate than are predictions based on long past behavior or predictions about real world behavior based on behavior in a hospital. If this argument has merit, calls for the abolition of commitment in any form cannot be predicated on the lack of predictability. Monahan, Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration, 135 AM. J. PSYCHIATRY 198, 200-01 (1978). But see Roth, Dayley, & Lerner, Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes, 13 SANTA CLARA LAW. 400, 416 (1973). Of course, such predictability would be true of normal as well as crazy persons, and thus would not constitute grounds for distinguishing the two groups. Professor Monahan has also proposed a research strategy for testing the accuracy of predictions in the emergency commitment context. J. Monahan, Strategies for an Empirical Analysis of the Prediction of Violence in Emergency Civil Commitment (July 1977) (Unpublished ms.) (on file with the Southern California Law Review).

If future research should support Professor Monahan’s hypothesis, analysis of emergency commitment and treatment for only the mentally ill would have to proceed on the basis of the rationales of nonresponsibility, irrationality, and treatment. Continued lack of support for the nonresponsibility, irrationality, and treatment rationales still would lead to the conclusions that emergency commitment is not justified and that presently dangerous behavior can be handled best by the criminal justice system. See A. Stone, supra note 10, at 36-37. Finally, if one were willing to allow emergency commitment largely because predictability was great, it is worth noting that only emergency commitment would be justified on that analysis.


Indeed, one noted commentator has recently called for an explicitly treatment-based parens patriae standard for commitment. A. Stone, supra note 10, at 65-70. If the person is suffering, needs treatment, gives an irrational reason for refusing treatment, and treatment is available, then commitment is justified. Under this standard, hospitalization is necessarily
restrictive alternative limitation on the state's power to commit were adopted, commitment would be justified if the necessary treatment could be provided only by in-patient hospitalization. The treatment rationale fails for a number of reasons, however. First, it assumes that the inmate initially was properly incarcerated. From the foregoing discussion, it is clear that this assumption is theoretically doubtful and factually false in many cases. Second, the treatment rationale assumes that because society has grounds to incarcerate a person, the right to force treatment on the inmate necessarily follows. As we have seen, however, there is no reason to believe that a person who is both crazy and dangerous or crazy and incompetent in some respects is therefore incompetent with respect to all decisions concerning his life, including the decision to accept or refuse treatment.

Third, the treatment rationale assumes that crazy people are specially treatable. Many crazy persons are not treatable, however, and there is mainly in order to force treatment on the individual. The critical issues in this scheme are whether suffering, even intense suffering, justifies involuntary incarceration in the absence of great danger and when a person's decision to refuse hospitalization and treatment should be overridden. See notes 228-34 and accompanying text supra.

A point, only peripherally related to the analysis of this Article, but which is most relevant here, is that the treatment rationale assumes that adequate treatment will be available. In many (if not most) public hospitals, however, no adequate treatment is provided even under the limited scope of present knowledge. See, e.g., Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971); R. Stuart, supra note 133, at 28-34; Birnbaum, supra, at 97-114, 117-19, 125, 138-40; Mendel, supra note 133; Rosenhan, supra note 50, at 254-57.

The conditions in public mental hospitals are constantly being exposed as disgraceful, even in the more "advanced" states. See, e.g., N.Y. Times, Oct. 9, 1977, § 1, at 5, col. 1; Gillam, More Mental Hospital Deaths 'Questionable,' L.A Times, Nov. 20, 1976, pt. 1, at 1, col. 1. Such conditions are not surprising: public hospital work is not attractive, extensive staffing and treatment are enormously expensive, the public is not generally sympathetic to the mentally ill, and mental patients are not a cohesive and effective political group that is likely to seek vindication of its rights. Most public hospitals today provide little more than custodial services of varying comfort and the prescription of appropriate psychoactive drugs with varying care and precision. As a result, many patients receive only minimally humane custody in a depersonalized atmosphere and are subject to inappropriate drugging. See, e.g., Mason, Nerviano, & DeBurger, Patterns of Antipsychotic Drug Use in Four Southeastern State Hospitals, 38 Diseases Nervous Sys. 541 (1977); sources cited supra.

239. See note 222 supra.

240. See notes 216-27, 235-37 supra.

241. See, e.g., Winters v. Miller, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 985 (1971); notes 228-34 and accompanying text supra.


The problem of untreatability may be especially acute for geriatric patients who allegedly suffer from irreversible brain deterioration. Such patients supposedly suffer from atherosclerosis, but the diagnosis is rarely pathologically verified and most treatments predicated on the diagnosis have not proved efficacious. Sandok, Organic Brain Syndromes Associated with
good reason to believe that the legally relevant behavior of sane persons is as treatable or changeable as the legally relevant behavior of crazy persons. Further, the disturbing or dangerous legally relevant behaviors of crazy people are performed in even greater numbers by sane persons; thus sane persons pose a greater problem for society than crazy persons. Special legal treatment of crazy persons, then, cannot be bottomed on the assumption that crazy persons are specially treatable by mental health methods or that treating only crazy people will substantially ameliorate social harms.

Society can and probably will continue to commit and treat involuntarily crazy persons for a variety of reasons, but if it does so it must recognize that the fundamental scientific rationales for involuntary commitment and treatment are not well supported theoretically or empirically. If involuntary civil commitment and treatment were abolished or severely limited compared to present practice, society would not be faced with disastrous results compared to the present. Society would not be substantially unprotected from dangerous persons nor would the streets be crammed with...
seriously disturbed persons.\textsuperscript{245} Further, self-endangering behavior would not increase significantly. The slight and probably imperceptible rise in social disturbance, mostly of a very mild variety, that probably would result from abolition or limitation is hardly a heavy price to pay when compared first, with the costs to the hundreds of thousands of persons who are every year deprived of their liberty and treated against their wills, and second, with the costs of maintaining them in institutions. The community would still be required to provide life-support services for some people; indeed, full-time custodial care might be needed for some. But those services are cheaper and more humane when they are provided voluntarily and in the community or in smaller, local residential facilities. Further, money now spent for unnecessary and expensive hospitalization could be spent on treatment services in the community that are less costly and probably more effective.\textsuperscript{246} Abolition of or strict limitations on civil commitment perhaps would not guarantee to those persons now committed the benefits they currently receive.\textsuperscript{247} But, those benefits can be provided largely without

order to ensure human survival and happiness. Skinner feels no need to balance these laudable goals against individual dignity and freedom because he considers the latter to be illusions. See B.F. Skinner, supra note 60. In a sense, then, craziness operates as a limiting principle that restricts the state's right to force treatment on persons who are socially harmful and fixable. Still, the limitation to crazy persons is not warranted by assumptions that they are ill, specially lacking in control, specially treatable, or specially incompetent.

\textsuperscript{245} The decarceration movement of the 1960's and 1970's has not led to much violence or nuisance on the part of crazy persons. It is certainly true that there is some increase in both, but there is no evidence that the increase is intolerable or near that level, especially compared to other sources of violence and nuisance in our society. This outcome is not surprising considering that crazy persons as a class are not especially dangerous and that few fit the stereotype of the bothersome raving lunatic.

It is also true, however, that some persons who otherwise would have been hospitalized are now processed through the criminal justice system, perhaps at somewhat greater cost than if they had been through the mental health system. See ENKI, THE BURDEN OF THE MENTALLY DISORDERED ON LAW ENFORCEMENT (1973). The numbers of such persons are evidently not large. See Morris, Conservatorship for the “Gravely Disabled”: California’s Nondeclaration of Nonindependence, 15 SAN DIEGO L. REV. 201, 206 n.28 (1978); cf. Atkinson, Current and Emerging Models of Residential Psychiatric Treatment, with Special Reference to the California Situation, 132 AM. J. PSYCHIATRY 391, 395 (1975) (paucity of studies; some indicate minimal increase). Arguably, the criminal justice system is the appropriate mechanism for dealing with persons who violate the law. But see ENKI, supra. Even if the criminal justice system is judged inappropriate, it is by no means clear that involuntary hospitalization is the most efficacious alternative. See notes 133, 222 and accompanying text supra. See generally A. SCULL, DECARCERATION: COMMUNITY TREATMENT AND THE DEVIANT: A RADICAL VIEW 64-94 (1977); Early & Nicholas, Dissolution of the Mental Hospital: Fifteen Years On, 130 BRIT. J. PSYCHIATRY 117 (1977).

\textsuperscript{246} See notes 133, 238 supra and 247 infra.

\textsuperscript{247} At present, the services being provided to crazy persons in the community are probably as disgraceful in general as the services provided in public mental hospitals. Community treatment services are not provided and large numbers of persons are institutionalized in community board-and-care homes or inner city slums where they live on welfare in residential hotels and the like. Indeed, some persons have less food, shelter, and clothing in the community than they would have in a mental hospital. See Arnhoff, supra note 133; Kirk & Therrien,
involuntary commitment, and abolition or limitation will provide those now committed with a greater measure of freedom.

2. The Insanity Defense

The usual rationale for the insanity defense is that moral and legal responsibility for criminal behavior can be ascribed to an actor only if he possesses certain capabilities, such as the ability to know or understand the nature of his actions or to resist or control his urges to behave criminally. It is considered unfair, immoral, and nonutilitarian to blame and retributively punish a person who lacks these capacities because such a person is allegedly not able to conform his behavior to the law. Mentally ill people are treated specially because insanity is thought to destroy these capabilities. The insanity defense is a cognitive/volitional incapacity defense that is limited only to those whose incapacity is allegedly the result of insanity.

Once again the question arises: Is there a scientific basis for differentiating between crazy and normal people? We do not excuse persons who arguably may be unable to appreciate the wrongfulness or criminality of their conduct because of subcultural influences, or who may have impaired capacity to conform their conduct to law because of lifelong, habitual Community Mental Health Myths and the Fate of Former Hospitalized Patients, 38 Psychiatry 209 (1975); Wolpert & Wolpert, The Relocation of Released Mental Hospital Patients into Residential Communities, 7 Pol'y Sci. 31 (1976); Sansweet, Out in the Street, Wall St. J., Aug. 19, 1976, at 1, col. 1.

From this appalling state of affairs it does not follow, however, that the decarceration movement should be limited or terminated. After all, there are many noncrazy people who are incompetent and inadequately fed, clothed, and sheltered in our society; it is not suggested that they be involuntarily incarcerated and treated. The proper response is not to return many crazy people to expensive, inefficacious, and perhaps destructive hospitals, but to expend resources for at least minimal human needs and treatment in the community. It seems clear that adequately funded community services are as efficacious as and cheaper than hospitalization and they allow persons to remain at liberty. See notes 133, 238 supra.

It should be recognized, however, that community treatment is not a panacea. States and municipalities apparently are not willing to expend sufficient resources either for hospitals or community treatment to ensure the highest probability of humane care or adaptive behavioral change for each patient. Moreover, even if unlimited resources were expended, massive treatment success might not follow because of limitations in treatment knowledge.

In sum, craziness will not be eliminated completely in our society, but much can be done without depriving people of their liberty. See generally K. Heller & J. Monahan, Psychology and Community Change 291-96 (1977); J. Rappaport, Community Psychology: Values, Research, and Action 273-304 (1977); Eisenberg, Psychiatric Intervention, 229 Sci. Am. 117 (1973).


249. There are other cognitive defenses such as mistake and other volitional defenses such as duress, but these are limited defenses that refer to the particular circumstances in which the crime occurred. For adults, the insanity defense and the related defense of automatism are the only complete defenses that are based totally on the actor's characteristics rather than on an interaction between the actor and the circumstances.
character traits such as impetuosity, rashness, or even immorality. Suggest that there should be a nonresponsibility defense that would consider factors such as culture or character, however, are often objected to because it is believed that these factors do not destroy agency and free choice. Yet there is no scientific evidence to demonstrate that persons whose criminal behavior is affected by craziness are less able to obey the law than persons similarly affected by cultural influences or character traits. Indeed, available evidence would point to the opposite conclusion. A fairer conclusion would be that nearly all persons are capable of obeying the law, even though it may be harder for some to obey than for others.

The most persuasive, least question-begging answer to calls for abolition of the insanity defense is that societies have always treated crazy persons as nonresponsible; moral intuition about such persons is simply too entrenched to permit society to abolish the defense and to impose blame.

250. Cf. N. Morris & C. Howard, supra note 65, at 93-99 (Aborigine murder defendants in Australia were entitled to instruction on provocation that was based on the subcultural traits of the Aborigines).


252. Morse, supra note 63.

253. Indeed, limiting a broad nonresponsibility defense to cases of insanity is a severe restriction on such a general defense. Compare United States v. Moore, 486 F.2d 1139, 1240-61 (D.C. Cir.) (Wright, J., dissenting), cert. denied, 414 U.S. 980 (1973) and Bazelon, supra note 73 with United States v. Moore, 486 F.2d at 1144-48 (Wilkey, J.), 1178-81 (Leventhal, J., concurring) and Morse, supra note 63.

254. See In re Ballay, 482 F.2d 648, 666 (D.C. Cir. 1973); Morris, supra note 248, at 520; notes 24, 98 and accompanying text supra. See generally notes 58-112 and accompanying text supra. In those areas of homicide law where objective standards of mens rea apply, the rigorously of the objective standard is often qualified by consideration of certain factors that rendered a person incapable of behaving as an ordinary, reasonable person. These factors are considered only when they are not the result of culpable behavior on the part of the actor. For instance, the Model Penal Code allows a murder conviction to be mitigated to manslaughter if the killing occurred as a result of extreme emotional distress for which there was reasonable explanation or excuse. The examples given of such explanations or excuses are traumatic injury, blindness, distraction from grief, and an unanticipated drug reaction. Model Penal Code § 201.3, Comments, at 48 (Tent. Draft No. 9, 1959). Even though it is often believed that a person is not responsible for character traits that are a product of life-long influences over which he had no control, see J. Rawls, supra note 82, at 103-04, character traits such as excessive excitability will not qualify an objective mens rea standard, even if the jurisdiction allows such qualifications for other reasons. The Queen v. McGregor, [1962] N.Z.L.R. 1089, 1081-82, quoted in S. Kadish & M. Paulsen, CRIMINAL LAW AND ITS PROCESSES 231-32 (3d ed. 1975). See generally Fletcher, The Individualization of Excusing Conditions, 47 S. Cal. L. Rev. 1269 (1974).

255. E.g., A. Goldstein, supra note 10, at 223-25; Dershowitz, Abolishing the Insanity Defense: The Most Significant Feature of the Administration's Proposed Criminal Code—An Essay, 9 Crim. L. Bull. 434, 438-39 (1973). This response is the least question-begging because it does not entirely depend on the unprovable empirical assumption that the alleged disease is
This argument contends that abolition would weaken the criminal law's claim to the moral respect of the community. A closely related argument for maintaining the defense is that it reinforces noncrazy persons' sense of responsibility by differentiating those who appear different and nonresponsible.\textsuperscript{256} Thus, both arguments claim that craziness must be considered in decisions concerning criminal culpability.

The critics of abolition of the insanity defense correctly assert that craziness is relevant to culpability. Because craziness is itself behavior, it must be relevant to culpability when it is related to the criterion behavior of criminal culpability. Despite the need to consider craziness when it is relevant to criminal behavior, however, the insanity defense in its present form might not need to be retained. Craziness can be considered in determinations of criminal responsibility by adopting, for example, an "elements" approach as suggested by Professors Goldstein and Katz, and Morris.\textsuperscript{257}

\textsuperscript{256} A. Goldstein, supra note 10, at 224; Monahan, Abolish the Insanity Defense?—Not Yet, 26 Rutgers L. Rev. 719, 720-25 (1973). See also Monahan & Hoofd, Psychologically Disordered and Criminal Offenders: Perceptions of Their Volition and Responsibility, 3 Crim. Just. & Behavior 123, 124 (1976) (offenders perceived as psychologically disordered are generally perceived to have less "free will" and thus are considered less responsible and blameworthy).

\textsuperscript{257} Goldstein, The Brawner Rule—Why? or No More Nonsense on Non Sense in the Criminal Law, Please!, 1973 Wash. U.L.Q. 126, 150-52; Goldstein & Katz, Abolish the "Insanity Defense"—Why Not?, 72 Yale L.J. 853, 857-58 (1963); Morris, supra note 248, at 518-19. The article by Morris also includes a useful appendix at 544-47, which summarizes most of the leading arguments for abolition of the insanity defense. The writers of the "elements" persuasion believe that the criminal justice system should be less concerned with hypocritical exculpation—persons acquitted by reason of insanity usually are committed to institutions for the criminally insane that are highly punitive in fact. See Brief of Donald McEwan, Petitioner Pro se, in J. Katz, J. Goldstein, & A. Dershowitz, supra note 18, at 700-01. See generally German & Singer, Punishing the Not Guilty: Hospitalization of Persons Acquitted by Reason of Insanity, 29 Rutgers L. Rev. 1011 (1976); Kaplan, supra note 255, at 269-80. The now abandoned § 522 of the proposed Criminal Justice Reform Act of 1975 (known as S.1) incorporated the elements approach. See Senate Comm. on the Judiciary, 94TH Cong., 1ST Sess., CRIMINAL JUSTICE REFORM ACT OF 1975, at 103-17 (Comm. Print 1975). After extensive study of the operation of the insanity defense in New York, the New York State Department of Mental Hygiene has recommended that the insanity defense should be abolished and replaced by a system wherein insanity would be used only to affect the degree of crime for which the
According to this view, no special defense is necessary; insanity (and other factors) would be relevant to the standard determination of whether or not an element of the crime such as a specific mens rea was present. Thus, to take an old example, a person who sincerely believed that he was squeezing a lemon when he really was strangling his wife could not be guilty of criminal homicide on an intent to kill theory. 258

A few comments need to be made about the hypothetical and the reaction to it by the Model Penal Code. First, it is very unusual for defendants raising the insanity defense to claim that they had no idea what they were doing—such hypotheticals do not stimulate sensible debate. But see, e.g., People v. Wetmore, 63 Cal. App. 3d 169 [citation is to Cal. Official Rep. Adv. Sh.], 133 Cal. Rptr. 529, 530 (1976), hearing granted, Cr. 19738 (Dec. 16, 1976). In this case a burglary defendant who had been surprised by the police in the home of another claimed that he had believed the home and its possessions belonged to him. When the police arrived he was allegedly shocked and embarrassed by their presence and then, allegedly, immediately understood that he had misinterpreted the situation. The defendant had been a mental patient, and as is well documented, many patients know very well how to play successfully the mental illness game. See notes 88-89 supra. Indeed, based on more than a decade of research with insanity acquittees at St. Elizabeth’s Hospital, two therapist-researchers have concluded that most are playing a game in order to avoid responsibility for their actions and prison. S. YOCHELSON & S. SAMENOW, 1 THE CRIMINAL PERSONALITY 529-30 (1975). Taking a more sympathetic view, confusion about the ownership of the apartment is conceivable, albeit unlikely, and such immense confusion is rare in insanity defense situations. Belief that a person was a lemon, however, would be utterly incredible even for a very crazy person. More often, the defendant raising the insanity defense knew what he was doing, at least to some degree, but had a crazy reason for doing it or felt that he just could not help himself.

Second, it is simply assumed that crazy persons cannot control themselves, cannot be deterred, and should not be blamed. As we have seen, the systematic empirical evidence bearing on this question is hardly persuasive. Even if a person sincerely has a crazy reason for his crime, there is little scientific evidence to support the positions that the actor was incapable of attending to and weighing alternative data and that he could not control his behavior based on
There are, of course, objections to various forms of the elements approach, but such an approach does have the virtue of allowing craziness to be considered where it seems relevant without simultaneously stigmatizing crazy people as a class by providing them with a special defense based on their allegedly unique incapacities. In addition, the increased threat of criminal sanctions might affect crazy persons and encourage them to control the possible criminal consequences of their craziness. Finally, there is little danger that large numbers of dangerous defendants would be acquitted because they entirely lacked mens rea; the insanity defense is rarely crazy people do respond to cost incentives. Finally, there is little danger that large numbers of dangerous defendants would be acquitted because they entirely lacked mens rea; the insanity defense is rarely crazy people do respond to cost incentives. Finally, there is little danger that large numbers of dangerous defendants would be acquitted because they entirely lacked mens rea; the insanity defense is rarely

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insanity defenses were abolished, the procedural difficulties attending the insanity defense would be avoided\(^{265}\) and crazy but culpable criminals would be sent deservedly to prison for a term proportionate to their culpability. Further, voluntary treatment services can and should be provided in prison for those who desire therapy.

3. Craziness and Civil Law

In civil law, insanity plays two different roles. First, it is a disability that in some situations negates the usual significance of a person's behavior. For example, crazy persons may sometimes avoid enforcement of their contracts, have a defense to tort liability, or, post mortem, fail to have their wills admitted to probate. Second, craziness sometimes seems to be the outcome of various stresses and serves as a basis for recovery against the stressors or for receiving transfer payments from the government. For example, crazy persons may recover money to compensate them for their craziness if they are disabled by it or if it is the result of work-related injury or tortious harms. This section will discuss these two branches of civil mental health law. It will be argued that in civil law, mental health rationales are not used to restrict the liberty of unwilling persons; rather, they are used to authorize various seemingly desirable social outcomes, the achievement of which would otherwise violate other important social policies.

\[^{265}\text{Administration of the insanity defense raises numerous procedural difficulties: e.g., who may raise the defense; the weight of the presumption of sanity; who has the burden of persuasion on the issue of insanity; and the relationship of the insanity defense to the partial defense of diminished responsibility. Further, numerous problems are raised if the defendant is acquitted. For a collection of cases and materials on these issues, see S. Morse, Cases and Materials on the Mental Health Legal System 1588-1654 (tent. mimeographed ed. 1977).}\]
a. **Civil competence:** In our society persons engage in various private and public civil activities that create legal rights and duties or that are regulated by law.\(^{266}\) Individuals order their private relations by contract, dispose of their property at death by will, serve as witnesses or jurors, and so on. There is a presumption in all these situations that the actor is fully competent to engage in these activities. Permitting incompetent persons to perform such activities, however, would undermine the results society seeks to accomplish by allowing or requiring persons to engage in them.

Freedom of testation, for instance, is founded on the policy assumptions, *inter alia*, that: (1) testators can best provide for their own desires and needs, and allowing them to do so leads to a maximum utilization of property; and (2) if testators know their property will be disposed of as they wish, their incentive to create and accumulate wealth is increased.\(^{267}\) As a matter of logic, these policies would be undermined if a testator had little idea what he was doing when he made his will. To serve these policies, the law has developed the following criteria for testamentary capacity: the testator must know and understand three elements: first, the identity of his heirs; second, the nature and extent of his property; and third, the disposition of his property.\(^{268}\) In addition, the testator must be able to appreciate the foregoing three elements in relation to one another and to form an orderly desire as to the disposition of his property.\(^{269}\) If a testator meets these criteria, his property will be disposed of as he wishes. If the criteria are not met, the will is not admitted to probate, and the testator’s property is disposed of by the laws of intestacy or by private agreement of the heirs.

The usual reasons for ascriptions of civil incompetence are “unsound mind” or insanity.\(^{270}\) Simply performing the activity badly or unwisely is political beliefs. The black trial judge accepted the defendant’s desire. On appeal, Judge Bazelon held that the decision not to impose the insanity defense “may not rest solely on the unchallenged testimony of the government experts in the absence of testimony of the other experts.” 507 F.2d at 1159. The case was remanded for an evidentiary hearing. The defendant thereafter decided to assert the insanity defense. The trial court found an evidentiary basis for the insanity defense; the court of appeals agreed and remanded for a new trial. 529 F.2d 879 (D.C. Cir. 1976). At the new trial, the defendant then refused to assert the insanity defense; the court thereafter found no basis for raising the insanity issue *sua sponte*. 430 F. Supp. 444, 448 (D.D.C. 1977).

\(^{266}\) See generally H.L.A. Hart, *supra* note 64, at 44-46.

\(^{267}\) Note, *supra* note 10, at 1119-21. Of course, freedom of testation is not absolute, but enormous discretion is given to testators. *Id.* at 1121-24.


\(^{269}\) See sources cited in note 268 *supra*.

\(^{270}\) E.g., Cal. Civ. Code § 38 (West 1970) (a person entirely without understanding has no power to make a contract of any kind); *Id.* § 39 (conveyance or contract of a person of unsound mind but with some understanding is subject to rescission if made before incapacity is judicially determined); *Id.* § 4425(c)(marriage voidable if either party was of unsound mind at
not sufficient, although a quite abnormal performance such as drawing an "unnatural" will may be taken as evidence of unsound mind or craziness.\footnote{Green, Proof of Mental Incompetency and the Unexpressed Major Premise, 53 Yale L.J. 271, 298-306 (1944). For a classic case, see Cooper v. Livingston, 19 Fla. 684 (1883), where the court refused to allow recovery on a note made by decedent as payment to a person hired to cure him of his ills by conjuring. After quoting Hawkins' Pleas of the Crown on conjuring, the court concluded: "conjuring" over a sick man "to make him well" is not a valid consideration for a promissory note; and no man with a healthy mind would voluntarily give a note for $250, with interest at two per cent a month, for the services of a conjurer, who proposes to cure a lingering disease by conjuring or incantations. Id. at 694.}

A more recent example that raises currently topical issues is In re Strittmater's Estate, 140 N.J. Eq. 94, 53 A.2d 205 (1947). There, decedent's will was contested by some distant relatives with whom she had little contact. Decedent had been an ardent feminist, and had left all her money to the National Women's Party. There was evidence that sometime after the death of her parents when she was in her late thirties, Ms. Strittmater had developed a hatred for males and her parents. A general practitioner testified that the decedent was insane, and there was some evidence that she was a tormented person, but the evidence also showed that her financial affairs had always been conducted in an orderly fashion and that she was firmly in contact with reality. The Master below had found that the proofs demonstrated "incontrovertibly her morbid aversion to men" and "feminism to a neurotic extreme." The court felt these characterizations were not strong enough. And, indeed, Ms. Strittmater was a radical and furious feminist who had evidently claimed that she wished for the obliteration of men. (It is not clear whether this was meant as rhetoric, was stated or written in a fury, or was a coolly deliberate wish). The court concluded as follows:

"The question is whether Miss Strittmater's Will is the product of her insanity. Her disease seems to have become well developed by 1936. In August of that year she wrote, 'It remains for feminist organizations like the National Women's Party, to make exposure of women's "protectors" and "lovers" for what their vicious and contemptible selves are.' She had been a member of the Women's Party for eleven years at that time, but the evidence does not show that she had taken a great interest in it. I think it was her paranoid condition, especially her insane delusions about the male, that led her to leave her estate to the National Women's Party. The result is that the probate should be set aside."

Id. at 95, 53 A.2d at 205-06. It should be noted, however, that the only evidence of her disease was Ms. Strittmater's extreme feminism and some indicators of inner torment. Indeed, the general practitioner, the Master below, and the court must have formed the opinion that Ms. Strittmater was insane simply because they believed first, that no one in her right mind would have held Ms. Strittmater's attitudes and beliefs, and second, that only such insanity would cause her to leave her money to the National Women's Party.

\textbf{But see} 1 W. Page, ON THE LAW OF WILLS § 12.37, at 645 (Bowe-Parker eds. 1960) (discussing cases involving eccentric testators).

The fact that the testator was filthy, forgetful, and eccentric, or that he was miserly and filthy, or that he was blasphemous, filthy, believed in witchcraft, and had dogs eat at the same table with him, or that he was pathological, frequently refused to eat, and would lie in bed with his clothes on for two weeks at a time, or that he would leave his home only at night, and would count and recount his money, or that he was high temper and violent, or used violent and abusive language towards his son, or was irritable and profane, or that testator thought that others were plotting against him and was afraid to go out in the dark, or that he was inattentive when spoken to and mumbled when trying to talk, does not establish lack of capacity. One who occasionally has violent fits of rage is not necessarily insane, and his will is valid, especially if not made in one of such fits (footnote omitted).
unfair or unjust outcome resulted. Some policies might then be furthered (e.g., protection of heirs from pauperization), but another fundamental legal policy would be violated: the presumption that persons should be free, within limits, to manage their affairs and should abide by the consequences of their decisions. This presumption protects the dignity and autonomy of actors even if it sometimes results in unfairness to others such as heirs, or in unfortunate consequences to the actor such as tort liability or financial loss from a business decision.

When unfortunate consequences result from craziness, however, the law is able to avoid the quandary presented by the conflict between allowing freedom to actors and protecting them or others from their unwise actions. To choose another example, it seems much less unfair to let a foolish businessman impoverish himself and his family by a bad deal than to let a crazy businessman impoverish himself and his family by the same deal. The reason for the difference, of course, is that it is assumed that the crazy actor's incompetence was beyond his control and not simply a matter of carelessness, lack of wisdom, poor judgment, or the like. When craziness seems related to incompetent conduct, this assumption of uncontrollable incompetence saves society and the legal system from facing the hard moral and social problem of deciding when nullification of an actor's conduct is justified.

It often seems to be the case, however, that an unjust or unwise result leads tautologically to the conclusion that the actor was crazy or of unsound mind; that is, it is assumed that no one in his right mind would have behaved that way. If the assumption of lack of free choice is the foundation for nullification, however, then to avoid uncertainty there ought to be both independent evidence of craziness and evidence that links the craziness directly to the absence of one or more of the criteria for competence.

This Article has already discussed the theoretical and practical difficulties involved in making such determinations. It makes little sense, however, to limit incompetence (by law or by practice) to insanity or related conditions (e.g., senility). First, other factors, such as extremely poor judgment, may lead to unjust results. Second and more importantly, there is little reason to believe that incompetence caused by craziness is "unfree" incompetence whereas incompetence caused by other factors is "free." There is no scientific reason to believe, for example, that an actor "over-

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272. Green, supra note 271, at 308-11.  
273. See id. at 306-10; Note, supra note 10, at 1141-42.  
274. See text accompanying notes 95-97 supra.  
275. See text accompanying notes 26-57, 95-97 supra.
come” by craziness who then behaves tortiously\textsuperscript{276} is less free than a similarly tortious actor who has a lifelong pattern of carelessness or who is overcome by a careless moment.

To the extent that the law serves important policies by considering various incompetencies, it should continue to do so. But it should do so generally and on the basis of careful application of explicit behavioral standards. The law should not create stigmatizing and unjustified limitations based on unproven assumptions about crazy people. If a crazy person or anyone else is truly incompetent, then arguably the law should interfere.\textsuperscript{277} Tautological conclusions linking craziness and incompetence, however, should not be dictated by the desire to reach an apparently more just result. The law should interfere and nullify the usual legal significance of a person’s actions, if at all, only if it is satisfied that the individual was incapable, for whatever reason, of meeting the functional criteria for competence and full legal responsibility.

b. Craziness as a ground for recovery: Craziness serves as a basis for compensating crazy persons if it is caused by tortious conduct or work-related conditions, or if it disables the person by preventing him from working or fulfilling his usual roles. The direct analogy for such recovery is clearly to physical harm or disease and their effects. The issue for analysis here is whether and to what extent craziness and its alleged effects should be compensable.

The first issue for determination is whether the individual is crazy. As we have seen, however, there are no agreed on criteria for craziness other than crazy behavior itself. The causes of craziness are largely unknown,\textsuperscript{278} and it is difficult to ascertain what further uncontrollable effects are caused by craziness.\textsuperscript{279} Proof that the person is truly crazy, or that any particular factor was the cause of craziness, or that the craziness is the cause of any other disability is quite problematic. There are simply no scientific means to

\textsuperscript{276} E.g., Breunig v. American Family Ins. Co., 45 Wis. 2d 536, 173 N.W.2d 619 (1970); Buckley & Toronto Transp. Comm’n v. Smith Transp. Ltd., [1946] 4 D.L.R. 721. If the person had forewarning of the onset of the craziness, there is a duty to take steps to prevent harm that might result from the craziness, 45 Wis. 2d at 541, 173 N.W.2d at 623.

\textsuperscript{277} In the civil law area, incompetence will not always lead to invalidation of the actor’s performance because strongly competing policies may dictate enforcement even if the actor was incompetent. For instance, the contract of an incompetent who cannot control his behavior may be voidable if the other party had reason to know of the actor’s mental illness. If the contract is fair on its face, the other party did not know of the actor’s mental illness, and the contract has been partially or wholly performed, the power of avoidance may be limited by equitable considerations. \textsuperscript{278} RESTATEMENT (SECOND) OF CONTRACTS § 18C (Tent. Draft No. 1, 1964). Further, even total incompetents are liable for the reasonable value of necessities furnished to them or their families. See \textit{Cal. Civ. Code} § 38 (West 1954).

\textsuperscript{279} See notes 26-30, 71-78 and accompanying text supra.

\textsuperscript{278} See notes 95-112 and accompanying text supra.
determine with reasonable certainty what caused a person’s craziness or whether, following an experience of severe stress, the victim could have “pulled himself together” and controlled his craziness or its related consequences. Moreover, there is no persuasive evidence to demonstrate that experts can detect malingering, a possibility that presents serious difficulties in recovery situations.\(^1\)

Despite these difficulties, one may point to cases where a person has undergone without fault on his part a severe mental stress and now seems disabled in ways clearly related to that stress. For instance, suppose a truckdriver runs over and fatally injures a good friend. Afterwards, the trucker claims he is unable to return to work.\(^2\) Or, take the case of a worker who watches a friend killed by a fall and who narrowly escapes serious injury himself when the scaffolding on which they are working gives way. Suppose he claims that he cannot return to the scaffold even though he may know rationally that the particular accident was unusual.\(^3\) If it is clear to any reasonable observer that these workers are not faking (e.g., the scaffold worker faints when he climbs a scaffold), these situations present a sympathetic and compelling case for compensation, and perhaps the workers should be considered disabled.

The issue, however, is not whether the worker suffers from an alleged disease. Assertions about “traumatic neurosis,” “anxiety neurosis,” or “phobic neurosis,” do not explain the situation; these labels are used only to state conclusions, even if they seem to provide a disease-like reason for the disability and consequently a scientific rationale for recovery.\(^4\) Nor does the fact that the claimed disability comports with various theories of

\(^{1}\) See notes 180-86 supra and 283-85 and accompanying text infra. Contra, Larson, Mental and Nervous Injury in Workmen’s Compensation, 23 Vand. L. Rev. 1243 (1970). “In the last analysis, the problem of malingering is one of fact, which must be left to the skill and experience of medical and psychiatric experts, and of compensation administrators, who usually manage in time to develop considerable facility in detecting malingerers at the factfinding level.” Id. at 1259. This statement is unsupported and one wonders what objective evidence separates psychiatric illness from malingering in cases where there is no clear admission by the claimant or persuasive circumstantial evidence that he is faking.

An additional problem is the difficulty of distinguishing between normal reactions to stress and behavior that perhaps ought properly to be considered illness. J. Zusman, Disasters and Mental Health: Contradictory Findings (1978) (unpublished ms.) (on file with the Southern California Law Review). Perhaps these two responses should be compensated differently, but at present there is no agreed-on dividing line and it is unlikely that scientific considerations will provide society with the cutting point.

\(^{2}\) See Todd v. Goostree, 493 S.W.2d 411 (Mo. Ct. of Appeals 1973).


\(^{4}\) The attempt to base such claims on medical knowledge to ensure that they are “real” can best be demonstrated by the federal definition of disability for social security benefits:
The term “disability” means—[an] inability to engage in any substantial gainful activity by reason of any medically determinable . . . mental impairment . . .
behavior\textsuperscript{284} tell us whether the worker in question is truly incapable or simply unwilling to return to work. All that is known is that the worker claims that he is unable to return to work and there seems to be an explicable reason for that feeling.\textsuperscript{285} In the end, there is no way to determine if the worker cannot or will not work; compensation must finally be bottomed on a commonsense and humane assessment of the entire situation. The question must be whether, in light of all the circumstances, the choice to return to work is too hard. This question should be decided without resort to comforting fictions.

Even if one accepts that craziness may be both a result of stress and a cause of uncontrollable disability, the question of remediation presents additional difficulties. For example, persons seeking social security disability benefits or worker’s compensation can be compelled to undergo reasonable treatment that may help remedy their disability.\textsuperscript{286} Once again,

\begin{quote}
\textquotedblleft[M]ental impairment” is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.\textsuperscript{1}
\end{quote}

\textsuperscript{1}\textit{Id.} § 423 (d)(1)(3) (1970) (emphasis added).

At base, however, the finding of disability rests on the belief that the worker is not shamming when he claims that he feels unable to work and that he in fact is somehow prevented from working.

The medicalization of such claims reaches sublime heights in cases of “compensation neurosis,” wherein the worker’s neurotic disability is in part influenced by an “unconscious desire to obtain or prolong compensation,” or by “sheer anxiety over the outcome of compensation litigation.” Larson, supra note 280, at 1256; see Hood v. Texas Indem. Ins. Co., 146 Tex. 522, 524, 209 S.W.2d 345, 346 (1948) (workman’s neurosis in part influenced by an “unconscious desire for compensation, and after termination of . . . litigation he will begin to improve”). Of course, compensation neurosis must be distinguished from conscious malingering, although one wonders how this is to be done. See Larson, supra note 280, at 1255-59.

284. The workman’s fear in either Todd v. Goostree, 493 S.W.2d 411 (Mo. Ct. of Appeals 1973) or Bailey v. American Gen. Ins. Co., 154 Tex. 430, 279 S.W.2d 315 (1955) could be explained well by either psychodynamic theory or any of the major branches of learning theory. Still, one would like to know what percentage of workers in similar circumstances claim that they are unable to work. Moreover, one wonders how compensating such claims might affect the workers involved or similar future disability claims. Learning theory especially might predict that compensation will increase the likelihood that disability will result from such accidents (e.g., by rewarding subjectively experienced inability).

285. Of course, in many cases there will be other observable evidence that bears on the worker’s condition. For instance, the worker may break out in cold sweats or undergo apparent anxiety attacks when he returns to his place of work or even thinks about it. If so, on a commonsense basis, the credibility of his claim is increased. Claims about illness will add little of hard scientific value and will only serve to obscure the moral and social determination that must be made.


An impairment that can be remedied by treatment will not serve as a basis for a finding of disability. “An individual will be deemed not under a disability if, with reasonable effort and safety to himself, the impairment can be diminished to the extent that the individual will not be prevented by the impairment from engaging in any substantial gainful activity.”
of protecting society and caring for disabled people that do not stigmatize crazy persons and deprive them of rights.

If any class of crazy persons is to be treated differently, every attempt should be made to ensure that only the tiny fraction of crazy persons who seem clearly and totally crazy should be singled out. Further, such clear cases can be recognized by anyone, laypersons and experts, crazy and non-crazy alike. Finally, no matter what role craziness may play in legal decisionmaking, it should be recognized that the ultimate decisions are moral and social and that special treatment rests on strong intuition and not on a scientific rationale. The role of experts should be limited and lay decisionmakers should assume full responsibility for the hard social, moral, and legal decisions that must be made.