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“Johnny’s in the Basement/Mixing Up His Medicine”[†]: Therapeutic Jurisprudence and Clinical Teaching

Keri K. Gould*
Michael L. Perlin**

I. INTRODUCTION

Clinical education has progressed through astonishing permutations during the last two decades.¹ Experiential learning,² the crux of clinical legal pedagogy, was initially the province of practitioners only marginally admitted into the sanctuary of law school education. Now

† BOB DYLAN, *Subterranean Homesick Blues*, on BRINGING IT ALL BACK HOME (Columbia Records 1965). Many thanks to the members of the Clinical Theory Workshop at New York Law School and the University of Utah College of Law Brown Bag Presentation Series for their comments and insights when this paper was presented in an earlier form, and to our respective schools, St. John’s University School of Law and New York Law School for providing us with supportive environments within which we may pursue our scholarly interests. The authors also wish to thank Milan Dey-Chao for her diligence, much-appreciated research and editorial assistance, and late nights; Darice Guzman, Jenna Anderson, Joanna Tomas, and Steve Madra for their invaluable research assistance; Lisa Bloch Herman, Brian Gorman, and Alison Bloom for their retrospective reflections on the value of Therapeutic Jurisprudence to their field placement work; and Lisa for her work on the “Alan Andrews” case.

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1. See Louise G. Trubeck, *U.S. Legal Education and Legal Services for the Indigent: A Historical and Personal Perspective*, 5 MD. J. CONTEMP. LEGAL ISSUES 381 (1994). See also Peter A. Joy, *Political Interference with Clinical Legal Education: Denying Access to Justice*, 74 TUL. L. REV. 235, 265-67 (1999).

2. For the purposes of this Article, the phrase “experiential learning” will be used to describe the “hands-on” learning that comes about when representing clients in live-client clinics, externships, and simulation courses. In the context of clinical legal education, experiential learning also embodies training in how to learn from experience and the taking of responsibility by a student for his or her own learning. Through such learning, students develop an awareness of role identity as well as legal skills proficiency. Linda Morton, *Creating a Classroom Component for Field Placement Programs: Enhancing Clinical Goals with Feminist Pedagogy*, 45 ME. L. REV. 19, 20-21 (1993); Linda F. Smith, *Pedagogy in Designing an Extern Clinical Program: Or as You Sow, So Shall You Reap*, 5 CLINICAL L. REV. 527, 530 (1999).

it is seen, albeit grudgingly by many traditionalists, as an important aspect of law school education.³ For those, like us, who envision law school as a "holistic"⁴ means of bridging the gap between practical substance and methodology and traditional course content, we wish to propose a teaching paradigm that integrates the positive aspects of both educational approaches. This Article attempts to do just that: juxtapose the experiential learning found in clinical courses with the theoretical premises of therapeutic jurisprudence.

Therapeutic jurisprudence (TJ) has been hailed as a means of viewing the law as a potentially therapeutic agent, giving law practitioners the means to explore the extent to which legal roles influence legal process and, conversely, how legal process may affect legal roles.⁵ The study of legal process should begin at the point in which it is taught and absorbed by law students and new lawyers. One would think, therefore, that legal education—a subject that has been deconstructed from every imaginable perspective over the past decade⁶—would be a natural laboratory for TJ inquiries, especially given the universal level of dissatisfaction that law students report.⁷ Yet, just as

3. TASK FORCE ON LAW SCHOOLS AND THE PROFESSION: NARROWING THE GAP, SECTION OF LEGAL EDUCATION AND ADMISSIONS TO THE BAR, AMERICAN BAR ASSOCIATION, LEGAL EDUCATION AND PROFESSIONAL DEVELOPMENT: AN EDUCATIONAL CONTINUUM (Robert MacCrate ed., 1992). See also Steven Keeva, *Profiting from Experience*, ABA J., April 1999, at 56; Thomas A. Mauet & Dominic J. Gianna, *Tomorrow Litigation Training for the Next Century*, LITIGATION, Winter 2000, at 12-14.

4. For views on holistic lawyering, see Thomas A. Dye, *Law School's Contribution to Civility and Character*, 22 LAW PRAC. MGMT. 40 (1996), and William van Zyverden, *Holistic Lawyering: A Comprehensive Approach to Dispute Resolution*, 3 B.U. PUB. INT. L.J. 5 (1993).

5. Amiram Elwork & G. Andrews H. Benjamin, *Lawyers in Distress*, 23 J. PSYCHIATRY & L. 205 (1995), reprinted in LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE 569 (David B. Wexler & Bruce J. Winick eds., 1996) [hereinafter LAW IN A THERAPEUTIC KEY]; Michael L. Perlin, *A Law of Healing*, 68 U. CINN. L. REV. 407, 412-13 (2000).

6. See, e.g., Frank S. Bloch, *The Andragogical Basis of Clinical Legal Education*, 35 VAND. L. REV. 321 (1982); George Critchlow, *Professional Responsibility, Student Practice, and the Clinical Teacher's Duty to Intervene*, 26 GONZ. L. REV. 415 (1991)(ethical perspective); Jonathan Rose, *The MacCrate Report's Restatement of Legal Education: The Need for Reflection and Horse Sense*, 44 J. LEGAL EDUC. 548 (1994), excerpted in CLINICAL ANTHOLOGY, READINGS FOR LIVE-CLIENT CLINICS 20 (Alex J. Hurder et al. eds., 1997)(skills training perspective); Trubeck, *supra* note 1 (social lawyering perspective); K.C. Worden, *Overshooting the Target: A Feminist Deconstruction of Legal Education*, 34 AM. U. L. REV. 1141 (1985) (feminist perspective).

7. See Report of the AALS Special Committee on Problems of Substance Abuse in the Law Schools, 44 J. LEGAL EDUC. 35 (1994); James J. Alfini & Joseph N. Van Vooren, *Is There a Solution to the Problem of Lawyer Stress?: The Law School Perspective*, 10 J.L. & HEALTH 61 (1996); Joanne Martin & Bryant G. Garth, *Clinical Education as a Bridge Between Law School and Practice: Mitigating the Misery*, 1 CLINICAL L. REV. 443 (1994). Studies confirm the common experience of student distress during law school and the negative public perception of lawyers; simple observation of lawyer behavior shows that lawyers as a group to be stressed and relatively unhappy people. See Smith, *supra* note 2, at 537; Lawrence S. Krieger, *What We Are Not Telling*

there is minimal literature on TJ and the practice of law, there has been, to our knowledge, only a few other applications of TJ to any aspect of legal education.⁸

In particular, TJ seems a natural "fit" with clinical legal education. Clinical courses, whether live-client clinics, externships, or simulation courses, tend to focus on ethics, interpersonal communication, and collaboration among students, faculty, and clients under very different circumstances than those found in a traditional law school class. Clinical work is both a more stressful and a more exhilarating educational experience for most students.⁹ Nowhere else in a law school will students confront first-hand the diversity of a poverty practice,¹⁰ be challenged on their reflections of their experiences, and be forced to integrate new doctrine, theory, and practice.¹¹

Law Students and Lawyers—That They Really Need to Know: Thoughts in Action Toward Revitalizing the Profession from Its Roots, 13 J. L. & Health 1 (1998–1999).

8. Very recently, *Psychology, Public Policy, and Law* published a special theme issue: *Therapeutic Jurisprudence and Preventive Law: Transforming Legal Practice and Education*, 5 PSYCHOL. PUB. POL'Y & L. 795 (1999). See also Elwork & Benjamin, *supra* note 5 (looking to the principals of therapeutic jurisprudence to suggest a means of reducing distress in lawyers and law students); Dennis P. Stolle & David B. Wexler, *Therapeutic Jurisprudence and Preventive Law: A Combined Concentration to Invigorate the Everyday Practice of Law*, 39 ARIZ. L. REV. 25 (1997) (using seminars on TJ to discuss preventive law and the concept of legal checkups); David B. Wexler, *Some Thoughts and Observations on Teaching Therapeutic Jurisprudence*, 35 REV. D.P. 273 (1996).

9. "The gaps between knowledge and skill, on the one hand, and role demands, on the other, contribute to a high level of anxiety in most students." Kenneth R. Kreiling, *Clinical Education and Lawyer Competency: The Process of Learning to Learn from Experience Through Properly Structured Clinical Supervision*, 40 MD. L. REV. 284, 287 (1981). Prior to entering law school, students have few models for counseling, which seems to require a daunting mix of judgment and skill. Robert Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 ARIZ. L. REV. 501, 509 (1990).

10. A majority of law school clinics represent only indigent clients. Historically, this grew out of the 1960s explosion in poverty law practice and governmental programs; the period was also marked by an increase in activism in social movements. Later, in 1974, the legislative history of the Legal Services Corporation supported a vision of law school involvement with federally funded legal services. Trubeck, *supra* note 1, at 385. Concurrently, beginning in the 1960s, the Council on Legal Education for Professional Responsibility (CLEPR) was promoting programs, which later became clinics, tying together the pro bono role of the profession, the public service obligations of law schools, and the utilization and education of law students. *Id.* at 385.

The issue of defining the mission of law school clinics and who such clinics represent remains at the forefront of clinical scholarship. Nina W. Tarr, *Current Issues in Clinical Legal Education*, 37 HOW. L.J. 31, 33 (1993) (arguing the importance of a poverty perspective). See Joy, *supra* note 1. But see Gary Laser, *Significant Curricular Developments: The MacCrate Report and Beyond*, 1 CLINICAL L. REV. 425, 441 (1994) (fee-generating in-house clinic meets law school's obligation to provide best possible legal education to produce competent, ethical, and reflective practitioners).

11. See Kreiling, *supra* note 9, at 287. The emergence of critical lawyering theory, theoretic of practice scholarship, and the influence of other postmodernist schools of legal thought have heightened the academy's interest in concepts of client and community empowerment and in

This Article has been generated from our experiences as clinical education teachers and TJ scholars. Recently, we combined these two "hats." Michael L. Perlin (MLP) teaches a Mental Disability Litigation Seminar and Workshop and a Seminar in Therapeutic Jurisprudence. Keri K. Gould (KKG) teaches an intensive trial advocacy course, Mental Health Law, and, as the Assistant Dean for Externships, she has created the curriculum for, and taught in, a variety of externship courses. KKG's latest clinical teaching endeavor is a new domestic violence family court litigation clinic. In these courses, each of us has made an effort to specifically incorporate TJ into our teaching philosophy and methodologies, our practice of law, and our critique of other lawyering observed by our students.¹²

Our thesis is both simple and modest: therapeutic jurisprudence provides a new and exciting approach to clinical teaching. By incorporating TJ principles in both the classroom and out-of-classroom components of clinic courses, law professors can give students new and important insights into some of the most difficult problems regularly raised in clinical classes and practice settings.

This Article will proceed in three sections. The first section briefly provides some background about TJ and how it has been employed to investigate other areas of the law. Then, the Article discusses some of the important new theoretical developments in clinical legal education, mostly from the "critical lawyering" perspective. Finally, in the last section, the Article illustrates the use of TJ as a paradigm for teaching in the clinical law setting—both to encourage, shape, and inform classroom discussions, and to teach specific lawyering skills. We will conclude with some brief recommendations and suggestions.

Thirty-five years ago, Bob Dylan electrified his fans with the song, *Subterranean Homesick Blues* (which contains the often-cited line, "You don't need a weatherman to know which way the wind blows").¹³ The song begins with the lines, "Johnny's in the basement/

transforming the social consciousness of law students by deconstructing power and privilege in law. John C. Dubin, *Clinical Design for Social Justice Imperatives*, 51 SMU L. REV. 1461, 1469 (1998).

12. Although at this point in our careers we are both involved with clinical placement courses, we both have taught in in-house clinics and have logged substantial numbers of years as attorneys representing institutionalized psychiatric patients. MLP was the Director of the Division of Mental Health Advocacy in the New Jersey Department of the Public Advocate, and KKG was a senior attorney for New York's Mental Hygiene Legal Service.

This is apparently the second article to discuss this intersection. See Mary Berkheiser, *Frazier Meets CLEA: Therapeutic Jurisprudence and Law School Clinics*, 5 PSYCHOL. PUB. POL'Y & L. 1147, 1148 n.4 (1999) (discussing an earlier draft of this article).

13. BOB DYLAN, *Subterranean Homesick Blues*, on BRINGING IT ALL BACK HOME

Mixing up his medicine."¹⁴ This couplet serves as an appropriate epigram for this entire inquiry.

Clinics have traditionally been relegated to "basement" status, both literally and figuratively.¹⁵ Other law professors often had only the vaguest idea about what really *does* go on in clinical education.¹⁶ In this article, we contend that the incorporation of TJ into clinical methods can be a tonic¹⁷—for students, for teachers, and ultimately, for case clients. Like Dylan's protagonist, we "mix up the medicine," and offer it to our colleagues as a remedy for much that ails the clinical learning process.

II. THERAPEUTIC JURISPRUDENCE

In the past ten years, the microuniverse of "mental disability law scholars" has turned its attention with increasing frequency to the area of TJ. Therapeutic jurisprudence proponents argue that *all* legal interactions may have therapeutic or antitherapeutic effects, view the law as a potentially "therapeutic agent,"¹⁸ and characterize TJ as a

(Columbia Records 1965). This couplet has been cited by many courts. See, e.g., *Ball v. Posey*, 222 Cal. Rptr. 746, 749 (Cal. Ct. App. 1985); *Easton v. Strassburger*, 199 Cal. Rptr. 383, 392 (Cal. Ct. App. 1984); *Godfrey v. Steinpress*, 180 Cal. Rptr. 95, 112 (Cal. Ct. App. 1982); *Jorgensen v. Beach 'N' Bay Realty, Inc.*, 177 Cal. Rptr. 882, 887 (Cal. Ct. App. 1981). See generally Michael L. Perlin, "With Great Lawyers You Have Discussed": *References to Bob Dylan in Published Legal Cases*, ON THE TRACKS 16, 17-18 (1995).

14. DYLAN, *supra* note 13.

15. Marjorie Anne McDiarmid, *What's Going On Down There in the Basement: In-House Clinics Expand Their Beachhead*, 35 N.Y.L. SCH. L. REV. 239 (1990).

16. *Id.* Despite the official recognition, clinical scholarship was, and to some extent continues to be, largely ignored, rather than challenged in academic discourse. Minna Kotkin, *Creating True Believers: Putting Macro Theory into Practice*, 5 CLINICAL L. REV. 95 (1998).

17. See Paul Appelbaum, Jacket cover to ESSAYS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1991) [hereinafter ESSAYS].

18. See generally ESSAYS, *supra* note 17; LAW IN A THERAPEUTIC KEY, *supra* note 5; PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION (Dennis Stolle et al. eds., 2000) [hereinafter PRACTICING TJ]; THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (David B. Wexler ed., 1990) [hereinafter THERAPEUTIC JURISPRUDENCE]; David B. Wexler, *Therapeutic Jurisprudence: New Directions in Law/ Mental Health Scholarship*, in MENTAL HEALTH AND LAW: RESEARCH, POLICY AND SERVICES 357 (Bruce D. Sales & Saleem A. Shah eds., 1996); Michael L. Perlin, *What Is Therapeutic Jurisprudence?*, 10 N.Y.L. SCH. J. HUM. RTS. 623 (1993); Bruce D. Sales & Daniel W. Shuman, *Mental Health Law and Mental Health Care: Introduction*, 64 AM. J. ORTHOPSYCHIATRY 172 (1994); Robert F. Schopp, *Integrating Restorative Justice and Therapeutic Jurisprudence*, 67 REV. JUR. U.P.R. 665 (1998); David B. Wexler, *Applying the Law Therapeutically*, 5 APPLIED & PREVENTIVE PSYCHOL. 179 (1996); David B. Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, 1 PSYCHOL. PUB. POL'Y & L. 220 (1995); David Wexler, *An Orientation to Therapeutic Jurisprudence*, 20 N. ENG. J. ON CRIM. & CIV. CONFINEMENT 259 (1994); David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research*, 45 U. MIAMI L. REV. 979 (1991); Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCHOL. PUB. POL'Y & L. 184 (1997).

“vehicle for bringing mental health insights into the law’s development.”¹⁹ The aim is to suggest that legal decision-makers explicitly take account of the potential impact that legal judgments may have on an individual’s psychological well-being, and in doing so, become more sophisticated about and make better use of the insights and methods of the behavioral sciences.²⁰ Therapeutic jurisprudence also calls for the empirical audit of the law’s success or failure in this regard.²¹

TJ began as one of the most exciting and controversial contemporary developments in mental disability law, capturing the attention of prominent forensic experts, academic psychologists, psychiatrists, and practitioners.²² It has been the subject of symposia in law reviews,²³ special issues in behavioral and “crossover” journals,²⁴ academic workshops,²⁵ and books.²⁶ It has been hailed by its advocates as “a tonic for mental health law,”²⁷ as a discipline “brimming” with “new ideas,”²⁸ and as “provocative and compelling.”²⁹ In recent years,

19. Michael L. Perlin, *Where the Winds Hit Heavy on the Borderline: Mental Disability Law, Theory and Practice*, “Us” and “Them,” 31 *LOY. L.A. L. REV.* 775, 784 (1998); David B. Wexler, *New Directions in Therapeutic Jurisprudence: Breaking the Bounds of Conventional Mental Health Law Scholarship*, 10 *N.Y.L. SCH. J. HUM. RTS.* 759, 761 (1993).

20. See David B. Wexler & Bruce J. Winick, *Introduction to ESSAYS*, *supra* note 17, at ix, xi. See also Bruce Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 *J. CONTEMP. LEGAL ISSUES* 37, 38 (1999).

21. *Id.* at xi.

22. See, e.g., Symposium, *Therapeutic Jurisprudence: Restructuring Mental Disability Law*, 10 *N.Y.L. SCH. J. HUM. RTS.* 623 (1993); Symposium, *Therapeutic Jurisprudence: Bridging the Gap from Theory to Practice*, 20 *N. ENG. J. ON CRIM. & CIV. CONFINEMENT* 243 (1994); Special Section, *Mental Health Law and Mental Health Care*, 64 *AM. J. ORTHOPSYCHIATRY* 172 (1994); Symposium, *Mental Disability Law*, 31 *LOY. L.A. L. REV.* 775 (1998).

23. See sources cited, *supra* note 22.

24. See, e.g., Special Theme, *Therapeutic Jurisprudence*, 1 *PSYCHOL. PUB. POL’Y & L.* 1 (1995); Symposium, *Therapeutic Jurisprudence and Preventive Law: Transforming Legal Practice and Education*, 5 *PSYCHOL. PUB. POL’Y & L.* 795 (1999); Symposium, *International Perspectives on Therapeutic Jurisprudence, Part I*, 17 *BEHAV. SCI. & L.* 553 (1999); Symposium, *International Perspectives on Therapeutic Jurisprudence, Part II*, 18 *BEHAV. SCI. & L.* 411 (2000); Dennis P. Stolle, *Advance Directives, AIDS and Mental Health: TJ Preventive Law for the HIV-Positive Client*, 4 *PSYCHOL., PUB. POL’Y & L.* 854 (1998); Bruce A. Arrigo & Jeffrey Tosca, *Right to Refuse Treatment, Competency to Be Executed, and Therapeutic Jurisprudence: Toward a Systemic Analysis*, 23 *PSYCHOL. REV.* 1 (1999).

25. See, e.g., Fifth Annual National Symposium, *Mental Health and the Law: Ethical, Therapeutic and Legal Issues in Mental Health*, sponsored by Forensic and Clinical Psychology Associates, P.A. and University of Miami Law School (Apr. 1995); Symposium, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 *J. CONTEMP. LEGAL ISSUES* 37 (1999).

26. See, e.g., *LAW IN A THERAPEUTIC KEY*, *supra* note 5; *LAW, MENTAL HEALTH, AND MENTAL DISORDER* (Bruce D. Sales & Daniel W. Shuman eds., 1996); *PRACTICING THERAPEUTIC JURISPRUDENCE* (Dennis P. Stolle et al. eds., 2000).

27. Appelbaum, *supra* note 17.

28. John Monahan, Jacket cover to *ESSAYS*, *supra* note 17.

29. Bruce Sales, Jacket cover to *ESSAYS*, *supra* note 17.

TJ scholars have gone far beyond the original mental health framework and staked out compelling territory in other substantive areas.³⁰

On the other hand, TJ has not escaped criticism. The most pointed commentary has come from John Petrila and, to a lesser extent, from Joel Haycock and Chris Slobogin. Petrila has noted the failure of scholars writing in this area to explicitly incorporate the perspective of both the voluntary and involuntary consumer of mental health services.³¹ In addition, Haycock has stated, "The success of therapeutic jurisprudence will depend in part on the degree to which it empowers the objects of therapeutic and judicial attention."³² In the face of this criticism, David Wexler has restressed that in his model TJ does *not* trump civil rights and civil liberties: "Therapeutic jurisprudence in no way supports paternalism, coercion, or a therapeutic state. It in no way suggests that therapeutic considerations should trump other considerations. . . ."³³

Subsequently, Slobogin described several of the dilemmas he sees in the maturing therapeutic jurisprudence movement: (1) the need to define the term "therapeutic," (2) the seemingly inevitable problems with empirically measuring the therapeutic outcome of a given law or procedure, and (3) the problem of potential outcome indeterminacy in the practices and procedures viewed through the lens of therapeutic jurisprudence.³⁴ Likewise, MLP recently has warned that therapeutic jurisprudence analyses must be undertaken with a full awareness of the impact of sanism and pretextuality on all aspects of the mental disability law system.³⁵

30. See *infra* notes 53-58.

31. John Petrila, *Paternalism and the Unrealized Promise of Essays in Therapeutic Jurisprudence*, 10 N.Y.L. SCH. J. HUM. RTS. 877, 881-82 (1993) (book review), reprinted in *LAW IN A THERAPEUTIC KEY*, *supra* note 5, at 685. It is essential that therapeutic jurisprudence incorporate the viewpoints and perspectives of the eventual consumers of mental health services, both those who voluntarily and those who involuntarily enter the mental health system. See Michael L. Perlin, *A Law of Healing*, 68 U. CINN. L. REV. 407, 413-15 (2000). John Petrila, *Paternalism and the Unrealized Promise of Essays in Therapeutic Jurisprudence*, 10 N.Y.L. SCH. J. HUM. RTS. 877, 881-82 (1993) (book review), reprinted in *LAW IN A THERAPEUTIC KEY*, *supra* note 5, at 685.

32. Joel Haycock, *Speaking Truth to Power: Rights, Therapeutic Jurisprudence, and Massachusetts Mental Health Law*, 20 N. ENG. J. ON CRIM. & CIV. CONFINEMENT 301, 317 (1994), reprinted in *LAW IN A THERAPEUTIC KEY*, *supra* note 5, at 669.

33. Wexler, *supra* note 19, at 762.

34. See Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCHOL. PUB. POL'Y & L. 193 (1995), reprinted in *LAW IN A THERAPEUTIC KEY*, *supra* note 5, at 763, 766, 772-83.

35. MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL*, 266-67 (2000). See also Michael L. Perlin, *Therapeutic Jurisprudence: Understanding the Sanist and Pretextual Bases of Mental Disability Law*, 20 N. ENG. J. ON CRIM. & CIV. CONFINEMENT

The early TJ articles, as well as many of the precursors, focused primarily on "typical" mental disability law questions.³⁶ Subsequent pieces applied TJ principles to issues somewhat more collateral (e.g., corrections³⁷ and sexual battery³⁸). Later articles bridged the gap between mental disability law and traditional legal inquiries (e.g., jury service,³⁹ contracts,⁴⁰ torts,⁴¹ and estate planning⁴²). Perhaps a tad per-

369, 371-72 (1994); Michael L. Perlin, *A Law of Healing*, 68 U. CIN. L. REV. 407, 419-33 (2000); Michael L. Perlin, "Half-Wracked Prejudice Leaped Forth": *Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did*, 10 J. CONTEMP. LEGAL ISSUES 3 (1999).

Sanism is an irrational prejudice of the same quality and character of other irrational prejudices that cause, and are reflected in, prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry. It infects our jurisprudence and our lawyering practices. It is largely socially acceptable and largely unacknowledged. It affects judges, lawyers, expert witnesses, therapists, hospital administrators, legislators, jurors, and the general public. When social science data appear to rebut sanist myths, we simply ignore that data because it does not comport with our *a priori* views. See, e.g., Michael L. Perlin, *On "Sanism"*, 46 SMU L. REV. 373 (1992) [hereinafter Perlin, *On Sanism*]; Michael L. Perlin & Deborah A. Dorfman, *Sanism, Social Science, and the Development of Mental Disability Law Jurisprudence*, 11 BEHAV. SCI. & L. 47 (1993).

The entire relationship between the legal process and mentally disabled individuals is often pretextual. By this we mean that courts accept, either implicitly or explicitly, testimonial dishonesty and engage similarly in dishonest and frequently meretricious decision-making, specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625, 627 n.3 (1993). The pretexts of the forensic mental health system are reflected both in the testimony of forensic experts and in the decisions of legislators and fact-finders. Experts frequently testify in accordance with their own self-referential concepts of morality and often openly subvert statutory and caselaw criteria. This testimony is often further warped by a heuristic bias. Expert witnesses, like the rest of us, succumb to the meretricious allure of simplifying cognitive devices in their thinking, and employ such heuristic gambits as the vividness effects or attribution theory in their testimony. See *id.*

36. For a comprehensive list, see 1 MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* § 2D-3, at 534-41 (2d ed. 1998).

37. See Fred Cohen & Joel Dvoskin, *Therapeutic Jurisprudence and Corrections: A Glimpse*, 10 N.Y.L. SCH. J. HUM. RTS. 777 (1993), excerpted in *LAW IN A THERAPEUTIC KEY*, *supra* note 5, at 149. See also T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. CRIM. L. 283 (1997).

38. See Nathalie Des Rosiers et al., *Legal Compensation for Sexual Violence: Therapeutic Consequences and Consequences for the Judicial System*, 4 PSYCHOL. PUB. POL'Y & L. 433 (1998); Bruce Feldthusen, *The Civil Action for Sexual Battery: Therapeutic Jurisprudence?* 25 OTTAWA L. REV. 205 (1993), reprinted in *LAW IN A THERAPEUTIC KEY*, *supra* note 5, at 845.

39. See Daniel W. Shuman et al., *The Health Effects of Jury Service*, 18 LAW & PSYCHOL. REV. 267 (1994), reprinted in *LAW IN A THERAPEUTIC KEY*, *supra* note 5, at 949.

40. See Jeffrey L. Harrison, *Class, Personality, Contract, and Unconscionability*, 35 WM. & MARY L. REV. 445 (1994), reprinted in *LAW IN A THERAPEUTIC KEY*, *supra* note 5, at 525.

41. Daniel W. Shuman, *The Psychology of Compensation in Tort Law*, 43 U. KAN. L. REV. 39 (1994), reprinted in *LAW IN A THERAPEUTIC KEY*, *supra* note 5, at 433.

42. Jennifer K. Robbenault & Monica Kirkpatrick Johnson, *Legal Planning for Unmarried Committed Partners, Empirical Lessons for a Preventive and Therapeutic Approach*, 41 ARIZ. L. REV. 417 (1999).

versely, we, in a paper co-authored with Debbie Dorfman,⁴³ an attorney now working for the Washington State Office of Protection and Advocacy, took this inquiry full circle by examining, *inter alia*, the constitutional cases that are the “grandparents” of mental disability law: *O'Connor v. Donaldson*,⁴⁴ *Wyatt v. Stickney*,⁴⁵ and *Lessard v. Schmidt*.⁴⁶ This examination was an effort to determine whether the development of the bodies of law that these cases spawned—primarily, the placement of constitutional limitations on the civil commitment process and the right to treatment—has been therapeutic.

One of our specific focal points was the actual litigation strategy of the lawyers representing patients in some of these cases. For years, social critics—notably H. Richard Lamb, E. Fuller Torrey, Rael Isaac and Virginia Armat—have scapegoated patients’ rights lawyers as the true villains in the development of mental disability law.⁴⁷ A reexamination of the key cases in question, *specifically* ones that these critics list as the true *bete noires*,⁴⁸ suggested that their analysis was simply “dead wrong”⁴⁹ and that the cases in question were greatly illuminated by therapeutic jurisprudence.⁵⁰

This research led us again to step back and reflect on David Wexler’s initial premise, which he stated when he edited the 1990 book of essays, *Law as a Therapeutic Agent*: that every aspect of the legal system has a TJ potential—not simply judicial decisions, legislative enactments, and administrative regulations, but “lawyers’ roles” as well. In the introduction to this collection, Wexler honed in on two separate issues:

43. Michael L. Perlin et al., *Therapeutic Jurisprudence and the Civil Rights of Institutionalized Mentally Disabled Persons: Hopeless Oxymoron or Path to Redemption?*, 1 PSYCHOL. PUB. POL’Y & L. 80 (1995), excerpted in LAW IN A THERAPEUTIC KEY, *supra* note 5, at 739.

44. 422 U.S. 563 (1975) (constitutional right to liberty).

45. 325 F. Supp. 781 (M.D. Ala. 1971), *aff’d sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (constitutional right to liberty).

46. 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473, and on remand, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975), and reinstated, 413 F. Supp. 1318 (E.D. Wis. 1976) (application of substantive and procedural due process at involuntary civil commitment hearing).

47. See, e.g., RAELE JEAN ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL 107-60 (1990); E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL 156-60 (1988); H. Richard Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUN. PSYCHIATRY 899, 902 (1984).

48. See Keri A. Gould, “Madness in the Streets” Rides the Wave of Sanism, 9 N.Y.L. SCH. J. HUM. RTS. 567 (1992) (reviewing ISAAC & ARMAT, *supra* note 46); Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 87-88 (1991) (discussing Torrey’s criticisms of Lessard, O’Connor, and Wyatt).

49. Michael L. Perlin, *Law and the Delivery of Mental Health Services in the Community*, 64 AM. J. ORTHOPSYCHIATRY 194, 202-03 (1994).

50. See Perlin et al., *supra* note 43, at 740-41.

Apart from specific substantive rules of law, the legal system itself—especially the legal apparatus used to litigate questions of committability and the like—should be examined, and perhaps restructured, to maximize its therapeutic aspects and to minimize its antitherapeutic aspects.⁵¹

A final aspect of therapeutic jurisprudence to be discussed here is the examination of and eventual tinkering with the roles and behavior of judges and attorneys so that those persons may perform in a fashion that meshes with professional ethics and yet is therapeutically beneficial.⁵²

We concur with Slobogin's suggested definitional adoption of therapeutic (for purposes of therapeutic jurisprudence) as meaning "beneficial in the sense of improving the psychological or physical well-being of a person."⁵³ Under this definition, TJ may be seen as "*the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects.*"⁵⁴

Interestingly and surprisingly, little attention has been paid to the question of the psychological effect of the attorney's role on the client, the attorney him or herself, or the legal process as a whole.⁵⁵ In Wexler's first book, he included excerpts from some of the most important work that had then been done, especially a *Yale Law Journal* student note on counsel's role in the involuntary civil commitment process⁵⁶ and John J. Ensminger and Thomas D. Liguori's break-

51. David B. Wexler, *An Introduction to Therapeutic Jurisprudence*, in THERAPEUTIC JURISPRUDENCE, *supra* note 18, at 3, 14; David Wexler, *Therapeutic Jurisprudence and the Culture of Critique*, 10 J. CONTEMP. LEGAL ISSUES 263, 267 (1999) (bringing an explicit culture of care into law practice will better serve clients, harmonize law practice for clients and lawyers, contribute to satisfaction and decrease lawyer distress, and begin to attract those in the legal profession who opted out of practicing in the culture of critique).

52. *Id.* at 16.

53. Slobogin, *supra* note 34, at 767. See also Christopher Slobogin & Mark Fondacaro, *Rethinking Deprivations or Liberty: Possible Contributions from Therapeutic and Ecological Jurisprudence*, 18 BEHAV. SCI. & L. 499 (2000).

54. *Id.* Cf. Eric Y. Drogin, *From Therapeutic Jurisprudence . . . to Jurisprudent Theory*, 18 BEHAV. SCI. & L. 489 (2000) (analyzing mental health science, practice, and roles in terms of their "jurisprudent," neutral, or "antijurisprudent" effects).

55. Professor Philip Schrag notes that in constructing a clinic, the clinician should consider the role of emotions in a student's transition from the role of student to the role of an attorney. Philip G. Schrag, *Constructing a Clinic*, 3 CLINICAL L. REV. 175, 182 (1996).

By far the most important recent work is that of Susan Daicoff. See, e.g., Susan Daicoff, *Asking Leopards to Change Their Spots: Should Lawyers Change? A Critique of Solutions to Problems with Professionalism by Reference to Empirically-Derived Attorney Personality Attributes*, 11 GEO. J. LEGAL ETHICS 547 (1998). See generally SUSAN DAICOFF, LAWYER, KNOW THYSELF (American Psychological Ass'n, forthcoming 2001).

56. Steven J. Goode, Note, *The Role of Counsel in the Civil Commitment Process: A Theoret-*

through article on the therapeutic potential of that process.⁵⁷ Since then, only a few consciously therapeutic jurisprudence articles have been written in this field,⁵⁸ including two by KKG (a therapeutic analysis of competency requests and the use of TJ to evaluate certain provisions in the Federal Sentencing Guidelines),⁵⁹ one by Janet Abisch (on mediational lawyering in the civil commitment context),⁶⁰ one by Professor Jan Costello (on how counsel's role is perceived by the various participants in the system),⁶¹ another by Professor Robert Schopp (on balancing client autonomy and therapeutic consideration),⁶² and one by Professor David Wexler (on teaching therapeutic

ical Framework, 84 YALE L.J. 1540 (1975), excerpted in THERAPEUTIC JURISPRUDENCE, *supra* note 18, at 309.

57. John J. Ensminger & Thomas D. Liguori, *The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential*, 6 J. PSYCHIATRY & L. 5 (1978), excerpted in THERAPEUTIC JURISPRUDENCE, *supra* note 18, at 245. Other relevant excerpts published in THERAPEUTIC JURISPRUDENCE include: Marc Amaya & W.V. Burlingame, *Judicial Review of Psychiatric Admissions: The Clinical Impact on Child and Adolescent Inpatients*, 20 J. AM. ACAD. CHILD & ADOLESC. PSYCHIATRY 761, 281 (1981); Paul Appelbaum, *Paternalism and the Role of the Mental Health Lawyer*, 34 HOSP. & COMMUN. PSYCHIATRY 211, 325 (1983); and Michael L. Perlin, *An Invitation to the Dance: An Empirical Response to Chief Justice Warren Burger's "Time-Consuming Procedural Minuets" Theory in Parham v. J.R.*, 9 AM. ACAD. PSYCHIATRY & L. 149, 291 (1981).

58. The most important recent inquiry is Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37 (1999). "Not only must the legal rules governing the civil commitment hearing seek to accomplish [Therapeutic Jurisprudence] values, but lawyers, judges, and clinicians should learn how to play their roles so as to apply the law therapeutically and not antitherapeutically." *Id.* at 60. See also Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433 (1992).

One of us (MLP) alludes to this question elsewhere. See Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 LAW & HUM. BEHAV. 39, 57-58 (1992) ("Finally, the recent interest demonstrated by scholars in 'therapeutic jurisprudence' should force all participants in the system to begin to critically weigh the therapeutic (or antitherapeutic) effect of the mental disability system. Here, adequate counsel is needed to ensure consideration of the therapeutic potential inherent in mental disability litigation.").

59. Keri A. Gould, *A Therapeutic Jurisprudence Analysis of Competency Evaluation Requests: The Defense Attorney's Dilemma*, 18 INT'L. J.L. & PSYCHIATRY 83 (1995) [hereinafter Gould, *Attorney's Dilemma*]; Keri A. Gould, *Turning Rat and Doing Time for Uncharged, Dismissed, or Acquitted Crimes: Do the Federal Sentencing Guidelines Promote Respect for the Law?*, 10 N.Y.L. SCH. J. HUM. RTS. 835 (1993) [hereinafter Gould, *Sentencing Guidelines*] reprinted in LAW IN A THERAPEUTIC KEY, *supra* note 5, at 171.

60. Janet B. Abisch, *Mediational Lawyering in the Civil Commitment Context: A Therapeutic Jurisprudence Solution to the Counsel Role Dilemma*, 1 PSYCHOL. PUB. POL'Y & L. 120 (1995).

61. Jan Costello, "Why Would I Need a Lawyer?" *Legal Counsel and Advocacy for People with Mental Disabilities*, in LAW, MENTAL HEALTH, AND MENTAL DISORDER, *supra* note 26, at 15.

62. Robert F. Schopp, *Therapeutic Jurisprudence and Conflicts Among Values in Mental Health Law*, 11 BEHAV. SCI. & L. 31 (1993), reprinted in LAW IN A THERAPEUTIC KEY, *supra* note 5, at 723.

jurisprudence).⁶³ Professor James Holstein's excellent (but still generally undiscovered by the world of law professors)⁶⁴ sociologically-grounded work, *Court-Ordered Insanity: Interpretive Practice and Involuntary Commitment*,⁶⁵ provides much food for thought from a TJ perspective, but does not make any reference to this school of thought. More recently, TJ has been connected to preventive law with an eye toward explicitly applying the law therapeutically rather than seeking to reform the law. Dennis Stolle and David Wexler have suggested that periodic "legal checkups" can provide lawyers with an ongoing opportunity to counsel clients "about ways in which the law may be applied or invoked in a sensitive and therapeutic manner."⁶⁶

III. CLINICAL LEGAL EDUCATION: THE NEW WAVE

The interest in and expansion of TJ literature has coincided with a similar explosion in clinical legal scholarship.⁶⁷ Over the past decade, clinical education has climbed many steps in asserting its right to come up out of the basement and into mainstream law school offerings.⁶⁸ In doing so, clinical law teachers have been at the forefront of

63. Wexler, *supra* note 8.

64. *But see* Susan Stefan, *Silencing the Different Voice: Competence, Feminist Theory and Law*, 47 U. MIAMI L. REV. 763, 778 & n.80 (1993) (citing to James A. Holstein, *Court Ordered Incompetence: Conversational Organization in Involuntary Commitment Hearings*, 35 SOC. PROB-LEMS 458, 459 (1988)).

65. JAMES A. HOLSTEIN, *COURT-ORDERED INSANITY: INTERPRETIVE PRACTICE AND INVOLUNTARY COMMITMENT* (1993).

66. Stolle & Wexler, *supra* note 8; PRACTICING TJ, *supra* note 18. *See also* Marc W. Patry et al., *Better Legal Counseling Through Empirical Research: Identifying Psycholegal Soft Spots and Strategies*, 34 CAL. W.L. REV. 439 (1998); David B. Wexler, *The Development of Therapeutic Jurisprudence: From Theory to Practice*, 68 REV. JUR. U.P.R. 691 (1999).

67. Not unsurprisingly, a similar trend has been noted between the developmental stages of feminist pedagogy and clinical legal education. Phyllis Goldfarb, *A Theory-Practice Spiral: The Ethics of Feminism and Clinical Education*, 75 MINN. L. REV. 1599, 1618 n.75 (1991) (noting that Professors Mark Tushnet and Carrie Menkel-Meadow have commented on the similarities between feminism and clinical education without focusing on the relationship between feminist theory and clinical legal education.); Linda Morton, *Creating a Classroom Component for Field Placement Programs: Enhancing Clinical Goals with Feminist Pedagogy*, 45 ME. L. REV. 19, 38-39 (1993).

68. McDiarmid, *supra* note 15, at 266-68 (discussing the belief of many law school clinicians that they are relegated to second class status within the law school faculty). In essence, the university law school has constrained clinical education from the core curriculum by marginalizing clinics in terms of space, budget allocations, prestige, and conceptualizations and by infiltrating clinical programs with the traditional techniques of the university law school. Phillip C. Kissam, *Lurching Toward the Millennium: The Law School, the Research University, and the Professional Reforms of Legal Education*, 60 OHIO ST. L. J. 1965, 1994 (1999).

Not that the fight for equality is over. Clinical education still remains marginalized in the law school curriculum despite the recommendations of the MacCrate Report and the AALS and ABA regulations. It is often asserted that instructional costs are the greatest barrier to expanding clinical education within the law school curriculum. While a clinical course may require the

invigorating clinical scholarship⁶⁹ through the investigation of adult learning styles,⁷⁰ clinical teaching methodology,⁷¹ and theories of lawyering and legal practice.⁷² An important aspect of this research has been the recognition of the narrative voice within the context of multiple jurisprudential viewpoints, including feminist jurisprudence,⁷³ critical race theory,⁷⁴ law and literature,⁷⁵ ethnographic

commitment of resources beyond those required for a traditional class, see David F. Chavkin, *Training the Ed Sparer of Tomorrow: Integrating Health Law Theory and Practice*, 60 BROOK. L. REV. 303, 333 (1994), commentators suggest that the cost debate should be shifted and broadened to address the reallocation of resources to implement curriculum reform. See Beverly Balos, *Conferring on the MacCrate Report: A Clinical Gaze*, 1 CLINICAL L. REV. 349, 352-54 (1994). "[T]he focus on cost places teachers concerned with professional skills in a defensive posture. It permits the issue to be framed around a construct that inherently marginalizes the skills and values that the MacCrate Task Force concluded were vital to becoming a responsible, caring, and competent lawyer." *Id.* at 354.

69. See, e.g., Robert D. Dinerstein, *Clinical Scholarship and the Justice Mission*, 40 CLEV. L. REV. 469 (1992); Mary J. Eyster, *Designing and Teaching the Large Externship Clinic*, 5 CLINICAL L. REV. 347 (1999); Peter Toll Hoffman, *Clinical Scholarship and Skills Training*, 1 CLINICAL L. REV. 93 (1994); Peter A. Joy, *Clinical Scholarship: Improving the Practice of Law*, 2 CLINICAL L. REV. 385 (1996); Harriet O. Katz, *Using Faculty Tutorials to Foster Externship Students' Critical Reflection*, 5 CLINICAL L. REV. 437 (1999); Peter Morgulies, *Re-framing Empathy in Clinical Legal Education*, 5 CLINICAL L. REV. 605 (1999); Gary Palm, *Reconceptualizing Clinical Scholarship as Clinical Instruction*, 1 CLINICAL L. REV. 127 (1994).

70. See, e.g., Liz Ryan Cole, *Training the Mentor: Improving the Ability of Legal Experts to Teach Students and New Lawyers*, 19 N.M. L. REV. 163 (1989); Jennifer P. Lyman, *Getting Personal in Supervision: Looking for That Fine Line*, 2 CLINICAL L. REV. 211 (1995); Linda Morton et al., *Not Quite Grown Up: The Difficulty of Applying an Adult Education Model to Legal Externs*, 5 CLINICAL L. REV. 469 (1999); Don Peters & Martha M. Peters, *Maybe That's Why I Do That: Psychological Type Theory, the Myers-Briggs Type Indicator, and Learning Legal Interviewing*, 35 N.Y.L. SCH. L. REV. 169 (1990) (exploring the value of using the Myers-Briggs Type Indicator to predict interviewing skills and styles); Fran Quigley, *Seizing the Disorienting Moment: Adult Learning Theory and the Teaching of Social Justice in Law School Clinics*, 2 CLINICAL L. REV. 37 (1995).

71. Gary L. Blasi, *What Lawyers Know: Lawyering Expertise, Cognitive Science, and the Functions of Theory*, 45 J. LEGAL EDUC. 313 (1995); Howard Lesnick, *Being a Teacher, of Lawyers: Discerning the Theory of My Practice*, 43 HASTINGS L.J. 1095 (1992); James E. Moliterno, *In-House Live Client Clinical Programs: Some Ethical Issues*, 67 FORDHAM L. REV. 2377 (1999); William P. Quigley, *Introduction to Clinical Teaching for the New Clinical Law Professor: A View from the First Floor*, 28 AKRON L. REV. 463 (1995); Mary Marsh Zulack, *Rediscovering Client Decisionmaking: The Impact of Role Playing*, 1 CLINICAL L. REV. 593 (1995).

72. See, e.g., Kimberlee K. Kovach, *The Lawyer as Teacher: The Role of Education in Lawyering*, 4 CLINICAL L. REV. 359 (1998); Richard D. Marsico, *Working for Social Change and Preserving Client Autonomy: Is There a Role for "Facilitative" Lawyering?*, 1 CLINICAL L. REV. 639 (1995); Carrie Menkel-Meadow, *The Legacy of Clinical Education: Theories About Lawyering*, 29 CLEV. ST. L.J. 555 (1980); Catherine O'Grady, *Clinical Education, Collaborative Pedagogy and the Realities of Practice for the New Lawyer*, 4 CLINICAL L. REV. 485 (1998).

73. See, e.g., Goldfarb, *supra* note 67; Minna J. Kotkin, *Creating True Believers: Putting Macro Theory into Practice*, 5 CLINICAL L. REV. 95 (1998).

74. Margaret M. Russell, *Entering Great America: Reflections on Race and the Convergence of Progressive Legal Theory and Practice*, 43 HASTINGS L.J. 749 (1992).

Clinical Education [provides a level of understanding of the relationship between law and justice] by facilitating transformative experiential opportunities for exploring the

theory,⁷⁶ ecological learning theory,⁷⁷ and case theory.⁷⁸ At least one commentator has linked all of the theoretical views, with the exception of case theory, under the rubric of critical lawyering.⁷⁹ Critical lawyering also focuses on the application of these movements as practice formulations focusing on constructing legal theories grounded by the stories of the pluralist perspectives of subordinated peoples.⁸⁰

Whatever theoretical perspective we as law professors bring to the clinical classroom, most of us, if not all of us, incorporate a client-centered approach to the practice of lawyering.⁸¹ Client-centered lawyering seeks to empower clients⁸² to make important decisions at each step of the legal process. It encourages an egalitarian relationship between lawyer and client, or at least a relationship that is more egalitarian than is found within the traditional power structure of a paternalistic attorney-client relationship.⁸³ Lawyers and clients are urged to

meaning of justice and developing a personal sense of justice through exposure to the impact of the legal system on subordinated persons and groups and through the deconstruction of power and privilege in the law.

Dubin, *supra* note 11, at 1477.

75. See, e.g., James Boyd White, *Law and Literature: "No Manifesto,"* 39 MERCER L. REV. 739 (1988); Nancy L. Cook, *Outside the Tradition: Literature as Legal Scholarship*, 63 U. CIN. L. REV. 95 (1994); Teree E. Foster, *But Is It Law? Using Literature to Penetrate Societal Representations of Women*, 43 J. LEGAL EDUC. 133 (1993).

76. See, e.g., Gay Gellhorn et al., *Law and Language: An Interdisciplinary Study of Client Interviews*, 1 CLINICAL L. REV. 245 (1994). We are prompted by ethnography to examine those behaviors that we take for granted and to rethink our basic values and assumptions by standing outside ourselves and looking at beliefs and behaviors in new ways. *Id.* at 251. The ethnographic research model is dialectic, not linear, and it offers a social science metaphor within which the richness and variety of group life can be expressed as it is learned from direct involvement with the group itself. *Id.* at 251 n.12.

77. See, e.g., Brook K. Baker, *Beyond MacCrate: The Role of Context, Experience, Theory, and Reflection in Ecological Learning*, 36 ARIZ. L. REV. 287 (1994).

78. See, e.g., Binny Miller, *Give Them Back Their Lives: Recognizing Client Narrative in Case Theory*, 93 MICH. L. REV. 485 (1994).

79. *Id.* at 486-87.

80. Phyllis Goldfarb, *A Clinic Runs Through It*, 1 CLINICAL L. REV. 65, 65 (1994).

81. See generally DAVID A. BINDER ET AL., *LAWYERS AS COUNSELORS: A CLIENT-CENTERED APPROACH* (1991); Robert D. Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 ARIZ. L. REV. 501 (1990); Stephen Ellmann, *Client-Centeredness Multiplied: Individual Autonomy and Collective Mobilization in Public Interest Lawyers' Representation of Groups*, 78 VA. L. REV. 1103 (1992). For a critique of client-centeredness lawyering, see Paul R. Tremblay, *A Tragic View of Poverty Law Practice*, 1 D.C. L. REV. 123 (1992).

82. Jennifer Howard, a law student writing about her clinical experience in *Learning to "Think Like a Lawyer" Through Experience*, 2 CLINICAL L. REV. 167 (1995), wrote that one of the most important lessons she learned in the clinic was that lawyers empower, not save. *Id.* at 189.

83. While clinicians have been somewhat successful in challenging the previously accepted norms of power imbalance within the professional relationship, clinical practitioners express great variability in opinion as to the appropriate degree of egalitarianism to be encouraged within the professional relationship. See Stephen Ellmann, *Empathy and Approval*, 43 HASTINGS L.J. 991, 1001-02 (1992) (supporting the belief that lawyers should intervene to express their moral

consider legal alternatives and to weigh the advantages and disadvantages of various options in a supportive relationship that stresses the autonomous decision-making capabilities of the client. At each decisional juncture, critical theorists view both lawyers and clients as the tellers of stories or narratives. Giving voice to the subordinated or disenfranchised client is seen as an important, and perhaps even dominant, goal of lawyering.⁸⁴ Contextual narrative inculcates the clinical theorist in the identification and redefinition of the allocation of power within the legal context.⁸⁵ Case theory, as differentiated from a particular jurisprudential perspective, contemplates even greater encouragement of storytelling by and about clients within the legal process.⁸⁶ Case theory has an individualized empowerment focus rather than a group-based analysis of the allocation of power. Case theory acts as a litigation theory that empowers clients by allowing them to choose silence or a lawyer's narrative over the client's own to improve their chances of winning or achieving some other goal.⁸⁷

Therapeutic jurisprudence allows us to examine the dynamics of the legal encounter in a different way. Therapeutic jurisprudence focuses on the law's impact on emotional life.⁸⁸ Using TJ, the lawyer seeks to become aware of the ways the law or legal procedure might be most therapeutically applied,⁸⁹ thereby producing the greatest sense of well-being for the client. This, however, only begins the inquiry. Next, the lawyer must determine the legal efficacy and consequences of the therapeutic outcome. Therapeutic jurisprudence also incorporates the use of social science data as empirical evidence to support the perception of therapeutic or counter-therapeutic voice within the legal system. Therapeutic jurisprudence seeks to inform lawyering practices⁹⁰ and influence policy⁹¹ by using social science data and method-

perspective); Peter Margulies, *Access, Connection, and Voice: A Contextual Approach to Representing Senior Citizens of Questionable Capacity*, 62 *FORDHAM L. REV.* 1073, 1085-90 (1994) (arguing that when representing challenged seniors, client-centeredness must be influenced by the client's variability of state of mind, her ability to understand consequences, the irreversibility of the decision, the substantive fairness of the transaction, and the consistency of lifetime commitments); Schopp, *supra* note 62 (explicitly constructing a framework for balancing client autonomy and therapeutic considerations).

84. See GERALD P. LOPEZ, *REBELLIOUS LAWYERING: ONE CHICANO'S VISION OF PROGRESSIVE LAW PRACTICE* (1992); Anthony V. Alfieri, *The Antinomies of Poverty Law and a Theory of Dialogic Empowerment*, 16 *N.Y.U. REV. L. & SOC. CHANGE* 659 (1987); Angelo N. Ancheta, *Community Lawyering*, 81 *CAL. L. REV.* 1363 (1993) (reviewing LOPEZ, *supra*).

85. See Anthony V. Alfieri, *Reconstructive Poverty Law Practice: Learning Lessons of Client Narrative*, 100 *YALE L.J.* 2107 (1991).

86. Miller, *supra* note 78, at 524-25.

87. *Id.* at 525.

88. Stolle & Wexler, *supra* note 8.

89. See Wexler, *Applying the Law Therapeutically*, *supra* note 18.

90. See, e.g., Gould, *Attorney's Dilemma*, *supra* note 59; Dennis P. Stolle, *Professional*

ology to study the extent to which a legal rule, procedure, or practice promotes the psychological and physical well-being of the people it affects.⁹² This unique perspective distinguishes TJ from the other jurisprudential theories whose central focus may be the recognition of power inequality for a specific group rather than therapeutic results *per se*.⁹³

Our thesis is that using TJ in clinical teaching creates in students an affinity for engaging in multidisciplinary investigation and evaluating the therapeutic effects of the lawyering process or the case disposition.⁹⁴ When examining the clinical education setting, the therapeutic focus may be on the client, the clinical student, the clinical professor, the supervising lawyer (who may also be the professor), or some other "player" within the legal system.

As a scholarly matter, we find it useful to use therapeutic jurisprudence as a framework within which to investigate and reformulate areas of law reform aimed at resolving difficult societal dilemmas.⁹⁵ As a practical legal tool, we believe that TJ has far-reaching potential in its application to teaching and conceptualizing lawyering skills, pro-

Responsibility in Elder Law: A Synthesis of Preventive Law and Therapeutic Jurisprudence, 14 BEHAV. SCI. & L. 459 (1996); David B. Wexler, *Practicing Therapeutic Jurisprudence: Psychological Soft Spots and Strategies*, 67 REV. JUR. U.P.R. 317 (1998).

91. See, e.g., Gould, *Sentencing Guidelines*, *supra* note 59; Jeffrey A. Klotz, *Sex Offenders and the Law: New Directions*, in MENTAL HEALTH AND LAW: RESEARCH, POLICY AND SERVICES, 257 (Bruce D. Sales & Saleem A. Shah eds., 1996) excerpted in LAW IN A THERAPEUTIC KEY, *supra* note 5, at 131; Kay Kavanagh, *Don't Ask, Don't Tell: Deception Required, Disclosure Denied*, 1 PSYCHOL. PUB. POL'Y & L. 142 (1995) reprinted in LAW IN A THERAPEUTIC KEY, *supra* note 5, at 343; Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL'Y & L. 6 (1995) reprinted in LAW IN A THERAPEUTIC KEY, *supra* note 5, at 17.

92. Slobogin, *supra* note 34, at 767.

93. *Id.* at 771. Therapeutic jurisprudence may also lend dignity to the voice of persons subordinated even by those who profess to represent the powerless. Professor Rogelio Lasso, in an article published by the Society of American Law Teachers (SALT), and in response to a paper by MLP presented at a SALT conference on diversity, wrote in his review of the conference that he found it particularly disturbing that "Sane-ism" merited a plenary presentation but the "disgraceful lack of racial diversity of law school faculties" did not. Rogelio Lasso, *Diversity Is As Diversity Does*, THE SALT EQUALIZER, Dec. 1994, at 18-19.

94. See generally Ensminger & Liguori, *supra* note 57.

95. See, e.g., Rose A. Daly-Rooney, *Designing Reasonable Accommodations Through Co-Worker Participation: Therapeutic Jurisprudence and the Confidentiality Provision of the Americans with Disabilities Act*, 8 J.L. & HEALTH 89 (1993) reprinted in LAW IN A THERAPEUTIC KEY, *supra* note 5, at 365; Richard P. Wiebe, *The Mental Health Implications of Crime Victim's Rights*, in LAW, MENTAL HEALTH, AND MENTAL DISORDER (Bruce D. Sales & Daniel Shuman eds., 1996) reprinted in LAW IN A THERAPEUTIC KEY, *supra* note 5, at 213; David B. Wexler, *Some Therapeutic Jurisprudence Implications of the Outpatient Civil Commitment of Pregnant Substance Abusers*, 15 POL. & LIFE SCI. 73 (1996) reprinted in LAW IN A THERAPEUTIC KEY, *supra* note 5, at 145. For a discussion of the issue of lawyers as problem solvers, see Janet Reno, *Lawyers as Problem-Solvers: Keynote Address to the AALS*, 49 J. LEGAL ED. 5,5 (1999).

fessional and supervisory relationships, ethical concerns, case strategy, systemic and institutional critique, and student performance.

IV. THERAPEUTIC JURISPRUDENCE AND CLINICAL TEACHING

How may therapeutic jurisprudence enrich clinical teaching? Our initial overview suggests at least four applications. Therapeutic jurisprudence (1) improves our teaching of skills, (2) gives us a better understanding of the dynamics of clinical relationships, (3) investigates ethical concerns and the effect on lawyering roles, and (4) invigorates the way we as teachers and students question accepted legal practice.

First, the learning of skills, whether through a strictly Binder & Price-ian "client-centered" focus, a Lopez-White-Alfieri-filtered "theoretics of practice," or an Ellmannesque emphasis on empathy, is a natural laboratory for TJ inquiries. Our years of supervising clinical and externship students have shown us that students "get" clinical skills at very different levels of understanding. Some students appear born to it; some learn, absorb, and eventually make these skills part of their "lawyering unconsciousness"; some learn enough to spout the right words and express the right emotions (while internally having none of it); and others resist the entire enterprise.

We have often discussed why this is. We have variously attributed it to varying levels of moral development, parenting styles, where students grew up, whether they had successful therapy experiences, their selection of undergraduate majors, and whether they are "like us."⁹⁶ This may just be meaningless rumination, or it may simply demonstrate that we take seriously the notions of transference and countertransference in clinical settings.⁹⁷ The underlying factual basis, however, is undeniably real: different students process learning skills in very different ways. Therapeutic jurisprudence can help us understand why that is: why some may be unable to learn these skills,

96. Although we have a ten-year span in our ages, a gender difference, a difference in community of origins (one of us grew up in the suburbs and the other in an urban area), and different college majors, we have felt an experiential mutuality since the first time we met and we have had very similar career paths.

97. See Odeana R. Neal, *Transference and Countertransference in the Clinical Supervisory Experience*, preliminary draft presented at the Clinical Theory Workshop, New York Law School (1995) (urging clinical faculty to examine the supervisory process and to make their relationship with their students a part of the learning process) (on file with author); Kathleen A. Sullivan, *Self-Disclosure, Separation, and Students: Intimacy in the Clinical Relationship*, 27 IND. L. REV. 115 (1993) (discussing the level of intimacy inherent in the clinical supervisory relationship).

For a thoughtful new approach to this issue, see Marjorie A. Silver, *Love, Hate, and Other Emotional Interference in the Lawyer/Client Relationship*, 6 CLINICAL L. REV. 259 (1999).

and why some may require different approaches.⁹⁸ It can also inform us about the efficacy of our teaching and can highlight the extent to which we tend to reinforce, through grades and other kinds of feedback, those students whose skill learning comfort zone is like ours, and how we react to the detriment of those students whose zone is quite different from ours.

In relation to the teaching of skills, as we will explain later in this Article, TJ can give students a framework for interviewing a client or planning a counseling session. Therapeutic jurisprudence insights may suggest to students how to focus empathy, frame questions, and probe client responses.

Second, therapeutic jurisprudence can be a powerful tool for understanding the various interpersonal dynamics inherent in clinical relationships: student-client, student-student, student-professor, student-significant other,⁹⁹ and student-predecessor/successor student. In a superb article,¹⁰⁰ Naomi Cahn and Norman Schneider, take an extended psychodynamic look at the latter issue, and provide a blueprint for further investigations in this area. Furthermore, TJ allows us to speculate about the therapeutic and antitherapeutic content of all these relationships, the impact of that content on the job we do as professors and as lawyers, and also the quality of growth and performance by our students.

Therapeutic jurisprudence gives us the tools to recognize and problem-solve issues of stress that can inhibit clinical law students—potentially becoming habitual as young lawyers continue in the profession. Being a lawyer is stressful. Being a law student is very stressful. Being a clinical professor is stressful.¹⁰¹ Representing our “clientele” is stressful. No doubt, being a client of a law school clinic is stressful. The clinic, simply, can be a stressful place or, at best, a place filled with stressed people.¹⁰²

98. See Liz Ryan Cole, *Lessons from a Semester in Practice*, 1 CLINICAL L. REV. 173 (1994); Fran Quigley, *Seizing the Disorienting Moment: Adult Learning Theory and the Teaching of Social Justice in Law School Clinics*, 2 CLINICAL L. REV. 37 (1995).

99. We are both reminded of students who came to us distraught over the impact the clinic was having on their spousal relationships. One student said that her husband threatened to leave her if she continued to work with “those people,” and another decried another clinical professor’s exhortation that when you are working on a case, everything, including your spouse and children, must take second place.

100. Naomi R. Cahn & Norman G. Schneider, *The Next Best Thing: Transferred Clients in a Legal Clinic*, 36 CATH. U. L. REV. 367 (1986).

101. Because we both are now teaching clinical externship courses, our role is probably less stressful than that of a clinical professor with the primary responsibility for on-going cases.

102. We also believe that these roles become more stressful each year for a variety of reasons: student uncertainty about the job market, which makes the choice of electing a nonbar, non-“business success”-oriented course a more difficult and problematic one to many; the

Ann Juergens' list of factors that can influence client cases—" [c]riminal matters, medical conditions, working conditions, community conditions, race, cultural traditions, gender, poverty, youth or age, mental illness, alcoholism, abuse, illiteracy and underlying anger or depression"¹⁰³—is simultaneously a list of stressors in contemporary urban society. The student thrust into a clinical setting without much warning or preparation is forced to confront difficult, complex, and often contradictory feelings about what he or she is doing and how he or she is doing it. Each student comes to the clinic with his or her own "ordinary common sense,"¹⁰⁴ comprised of "a 'prereflective attitude' exemplified by the attitude of 'What I know is "self-evident"; it is "what everybody knows."¹⁰⁵ The anxiety that is often spawned by the first student-client contact can flow to other students, to the significant others in the students' lives, to the professor and, of course, to the client.

We can safely say that most students do not initially enter the clinic seminar room having assimilated all of Stephen Ellmann's and Carrie Menkel-Meadow's work on empathy,¹⁰⁶ or Anthony Alfieri's pieces on postmodernism and clinical legal education.¹⁰⁷ We are ask-

increasingly conservative tone of the electorate and the judiciary; additional pressures on untenured clinical teachers to do scholarship that approximates that of nonclinicians (as part of the tenuring or long-term contracting process) and to continually "justify their existence" to often-hostile colleagues.

A plethora of articles have commented on the stressfulness of the law school experience as well as the clinical experience. See, e.g., Susan Daicoff, *Making Law Therapeutic for Lawyers: Therapeutic Jurisprudence, Preventive Law, and the Psychology of Lawyers*, 5 PSYCHOL. PUB. POL'Y & L. 811, 817 (1999); Elwork & Benjamin, *supra* note 5; Lani Guinier et al., *Becoming Gentlemen: Women's Experiences at One Ivy League Law School*, 143 U. PA. L. REV. 1 (1994) (feminist perspective); Howard, *supra* note 82 (from the perspective of a clinical law student); Marjorie A. Silver, *Emotional Intelligence and Legal Education*, 5 PSYCHOL. PUB. POL'Y & L. 1173, 1182 (1999). These observations are not all new. See Andrew S. Watson, *The Quest for Professional Competence: Psychological Aspects of Legal Education*, 37 U. CIN. L. REV. 91 (1968).

103. Ann Juergens, *Teach Your Students Well: Valuing Clients in the Law School Clinic*, 2 CORNELL J.L. & PUB. POL'Y 339, 355 (1993).

104. See generally Bill Ong Hing, *Raising Personal Identification Issues of Class, Race, Ethnicity, Gender, Sexual Orientation, Physical Disability, and Age in Lawyering Courses*, 45 STAN. L. REV. 1807, 1810 (1993) ("Common sense, without training, is dangerously fashioned by our own class, race, ethnicity/culture, gender, and sexual background."); Michael L. Perlin, *Psychodynamics and the Insanity Defense: "Ordinary Common Sense" and Heuristic Reasoning*, 69 NEB. L. REV. 3 (1990).

105. Richard K. Sherwin, *Dialects and Dominance: A Study of Rhetorical Fields in the Law of Confessions*, 136 U. PA. L. REV. 729, 737 (1988). See Perlin, *On "Sanism"*, *supra* note 35, at 380 n.46.

106. Stephen Ellmann, *supra* note 83; Carrie Menkel-Meadow, *Narrowing the Gap by Narrowing the Field: What's Missing from the MacCrate Report—Of Skills, Legal Science and Being a Human Being*, 69 WASH. L. REV. 593 (1994).

107. See, e.g., Anthony V. Alfieri, *Disabled Clients, Disabling Lawyers*, 43 HASTINGS L.J. 769 (1992).

ing our students not to simply learn about the law, interviewing, and lawyering, but also to absorb vast bodies of legal theory generally unknown to 90% or more of the practicing bar. We are deluding ourselves if we fail to recognize the stress that this can beget.

One of the few essays to explicitly address these issues is, interestingly, one from an earlier generation of clinical literature, an article by Kenneth Kreiling on clinical education and lawyer competency.¹⁰⁸ Kreiling notes that clinical education “thrusts students into situations where they not only must learn substantive and procedural law, but also must understand lawyering tasks and the system within which lawyers operate, confront issues of professional responsibility, integrate [this] knowledge, and take action.”¹⁰⁹ The “very depth of the involvement and the newness of the role make the experience potentially debilitating,” he warns, adding that the “gaps between knowledge and skill, on the one hand, and role demands, on the other, contribute to a high level of anxiety in most students.”¹¹⁰ Because of this, he adds a specific warning to clinical supervisors: “Unless the supervisor appreciates the possibility for debilitating anxiety and properly structures the clinical experience, both to avoid overtaxing the student’s integrative capacity and to facilitate the learning process, the enormous potential of the experience will not be realized.”¹¹¹ The TJ potential in Kreiling’s essay is limitless.

Third, TJ can be of great value in how we weigh the multiple ethical issues we face in clinical education. These issues are inextricably intertwined with subissues of power, of class, of race, and of gender. Therapeutic jurisprudence allows us (perhaps, *forces us*) to take a hard look at the impact of these issues on our students’ well-being in their roles as clinical participants. We do not believe we can, or should try, to eviscerate all of our students’ preexisting “-isms” in one 14-week semester. On the other hand, we have to acknowledge them, let the students know we are acknowledging them, and work through with the students how these “-isms” are affecting their clinical roles. Again, therapeutic jurisprudence can be a great aid in this venture.

Profound experiential learning takes place in clinical courses. It is fed by student recognition that clinical clients will likely have far more personal experience with “extreme poverty, illiteracy, hunger,

108. Kenneth Kreiling, *Clinical Education and Lawyer Competency: The Process of Learning to Learn from Experience Through Properly Structured Clinical Supervision*, 40 MD. L. REV. 284 (1981).

109. *Id.* at 287.

110. *Id.*

111. *Id.* at 288.

homelessness, mental illness, the dehumanization of minimum wage jobs or the welfare office" than will clinical students.¹¹² Clinics represent "outsiders, poor or otherwise disadvantaged people who are subordinated within the culture."¹¹³ As these are by and large individuals without access to the legal world that is the focus of most of legal education, clinics thus create an opportunity for students to obtain alternative understandings of clients' lives and experiences.¹¹⁴ Consciousness and sensitivity to class, race, and other social variables in a clinical setting can contribute to good lawyering.¹¹⁵ Representing "real clients" in clinics presents "profound moral implications" for every person in a clinical setting who assumes that responsibility.¹¹⁶

V. THERAPEUTIC JURISPRUDENCE IN THE CLINIC

A. *As a Paradigm for Teaching Lawyering Skills*

Finally, we want to turn to the special impact of TJ on those of us whose caseload, in whole or in part, involves the representation of persons with mental disabilities. Each of us uses TJ as a teaching tool in our clinical courses. In our class meetings, we both use case examples to teach TJ theory and practice. The following case is an example of how KKG used a TJ perspective when teaching the lawyering skill of counseling.

An externship student met with me to prepare for a counseling session with a newly assigned client.¹¹⁷ Over the course of several informal meetings, I (KKG) attempted to use the insights and tools of TJ to help the student prepare for and engage in an empathetic, informative legal counseling session. The TJ lens provided the student and

112. Juergens, *supra* note 103, at 363.

113. Ann Shalleck, *Constructions of the Client Within Legal Education*, 45 STAN. L. REV. 1731, 1740 (1993).

114. *Id.* at 1739.

115. See Hing, *supra* note 104, at 1823.

116. Ann Juergens, *Using the MacCrate Report to Strengthen Live-Client Clinics*, 1 CLINICAL L. REV. 411, 418 (1994).

In clinics, one experiences a defining characteristic of lawyering—responsibility for another's affairs. In clinics, that responsibility will likely revolve around clients' homes, children, freedom, employment, income maintenance, medical care or physical security. Other persons' dignity, trust for the legal system, and sometimes survival are in one's hands.

Id.

117. The way in which the clinical professor handles issues of client confidentiality and case preparation may differ depending upon the type of clinic or externship in which the student is enrolled and the scope of the professional relationship between the clinical professor and the client. However, these issues are not the focus of the present article. For an article on externship clinics, see Eyster, *supra* note 69, at 347.

me with an initial framework from which the student could address the core considerations involved in her representation of the client in the counseling session and throughout their professional relationship. I felt, in turn, that TJ gave me an interdisciplinary orientation within which I could acknowledge the student's response to my teaching methods and work through the student's reactions to the particular case eccentricities.

The student came to me with the following information: the client, Matthew Paskin (a pseudonym), was admitted to the psychiatric ward of a city hospital on an emergency admission.¹¹⁸ Two weeks later and the day before a scheduled court hearing,¹¹⁹ his lawyer (who works for a publicly funded agency that represents institutionalized psychiatric patients) was notified of Mr. Paskin's presence on the ward and the placement of his case on the court calendar. The student, an extern at the agency, accompanied the lawyer assigned to Mr. Paskin's case to interview Mr. Paskin. The student observed the initial interview, but did not participate. After interviewing the client, the attorney and the student read Mr. Paskin's hospital record.

The student described Mr. Paskin as an articulate, intelligent, angry, and extremely thin man dressed in many layers of ragged clothes. Mr. Paskin had an unkempt beard and long hair. It was obvious to the student that Mr. Paskin had not bathed in a long time.¹²⁰

During the initial interview, the student learned that Mr. Paskin is the 41-year-old son of a prominent psychiatrist. Mr. Paskin lived in his own apartment located on a floor of his parents' brownstone. Mr. Paskin did not seem to be delusional to the student. He told his attorney that he has obsessive-compulsive disorder, that he was illegally brought and committed to the psychiatric ward, that he refuses to take a bath or take any medication, and that he wishes to return to his apartment. He said that he was brought in because he was engaged in an altercation with his neighbors. He also told his lawyer that he wanted to go forward with the scheduled involuntary medication hearing,¹²¹ even if it meant that the lawyer had less time to prepare and

118. A typical emergency admission statute permits the limited involuntary commitment of a person brought to the hospital by the police and certified by a physician to be a danger to himself or others.

119. The hearings are held in a makeshift courtroom set up in the psychiatric center. This room also doubles as a lunchroom for the lawyers working for the agency that provides representation to the patients at the psychiatric center.

120. During the interview, Mr. Paskin told his lawyer that he has not bathed in five years.

121. In this jurisdiction, the relevant standard for a hospital to override a patient's right to refuse treatment is set out in *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986). The State bears the burden of demonstrating by clear and convincing evidence the patient's incapacity to make a

that he would most likely be facing an unfavorable judge. After the initial interview, the attorney and the student returned to their offices. The attorney called the psychiatrist on Mr. Paskin's treatment team (the person most likely to testify against him at the hearing) and was informed that the hospital was requesting a one week adjournment. The case was then reassigned to the clinic student.

In approaching the meeting with the student, I discussed that the first task was to define and set the goals for the counseling session. Looking through the lens of TJ,¹²² I wanted the student to think about the therapeutic or nontherapeutic parameters of the counseling session and the upcoming hearing. I wanted the student to keep in mind the goal of finding a legal outcome most supportive of the client's well-being. I felt it was important to think about what factors the student was prioritizing when trying to determine the client's emotional well-being; how the student's perceptions might be influenced by issues of gender, economic status, race, culture, or personal prejudices;¹²³ what insights and empirical information could be gleaned from social science data as to how psychiatric patients view their lawyers, their legal rights, or understand the legal process they are going through; and what role institutional coercion may play in the decision-making process.

Second, I wanted the student to consider what legal and nonlegal steps needed to be taken to effectuate a therapeutic outcome. Was the outcome that purported to support the client's emotional serenity legally tenable? I suggested to the student that she prepare alternative strategies so that the client and student could arrive at an informed legal decision.¹²⁴ The same considerations I mentioned with regard to defining the goals of the counseling session came into play at this stage as well, with the added concern that the student might become

treatment decision. The fact of involuntary commitment has no legal bearing on a patient's competency to refuse medical intervention. If the court determines that the patient lacks the capacity to determine the course of his own treatment, the court must determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits and adverse effects associated with the proposed treatment, and any less intrusive alternative treatments. *Id.* at 344.

122. See *supra* notes 18-20 and accompanying text.

123. See, e.g., Hing, *supra* note 103; Michelle S. Jacobs, *People from the Footnotes: The Missing Element in Client-Centered Counseling*, 27 GOLDEN GATE U. L. REV. 345 (1997); Joan S. Meier, *Notes from the Underground: Integrating Psychological and Legal Perspectives on Domestic Violence in Theory and Practice*, 21 HOFSTRA L. REV. 1295 (1993).

124. See generally Steven Zeidman, *Sacrificial Lambs or the Chosen Few?: The Impact of Student Defenders on the Rights of the Accused*, 62 BROOK. L. REV. 853 (1996).

invested in a particular predicted outcome, thereby becoming less sensitive to *hearing the client's voice*.¹²⁵

Third, I wanted the student to evaluate whether the steps needed to effectuate the therapeutic outcome were acceptable to the client and to the student. If not, the student had to investigate other alternatives.

Returning to Mr. Paskin's case, what factors were available to the student to determine which result would give the client the greatest sense of well-being? In this case the client had said what he wanted—he wanted to go home, he did not want any medication, and he did not wish to bathe. Mr. Paskin did not appear psychotic or delusional, although he admitted to having obsessive-compulsive disorder. A look at the hospital records revealed that Mr. Paskin was a fairly accurate reporter. The records also revealed that Mr. Paskin's parents were involved in his life.

Over the next few days, the student determined that she should be thoroughly prepared to support the case resolution that seemed to give Mr. Paskin the greatest emotional comfort. However, the student had reservations about Mr. Paskin's chosen legal strategy, namely to pursue the case on the earliest possible court date.

The student and I agreed that she must preliminarily research the legal steps that had to be taken to effectuate the therapeutic outcome. By reading the court papers, the student found out that Mr. Paskin was scheduled for an involuntary medication hearing, at which the hospital would ask the court's permission to give Mr. Paskin antidepressants and psychotropic medication and to insert a feeding tube if Mr. Paskin did not gain weight at a pace that met with the hospital staff's satisfaction. The student did preliminary research to determine how Mr. Paskin could be released to go home, to defeat the hospital's motion to involuntarily medicate him, and to resist the hospital's efforts to bathe him. As to the first question, the student needed to determine under what status the client was being held. Looking through the hospital record, the student found that Mr. Paskin was being held as a voluntary patient and that he had signed voluntary admission papers when admitted to the hospital.¹²⁶ In order to sched-

125. See Peter Margulies, *Representation of Domestic Violence Survivors as a New Paradigm of Poverty Law: In Search of Access, Connection, and Voice*, 63 GEO. WASH. L. REV. 1071, 1098 (1995) (discussing the importance of voice as a process involving different relationships and, thus, recognizing that clients have multiple voices).

126. In this jurisdiction, voluntary status does not entitle the patient to leave whenever he or she may wish. Although it is a less restrictive status than involuntary commitment, a voluntary patient wishing to be discharged is required to write and file what is known as a "72-hour letter" stating his or her desire to leave the hospital. The hospital must then respond in writing to the written request within 72 hours. N.Y. MENTAL HYG. LAW § 9.13 (McKinney 2000). In practice, the only "writing" the patient may receive is a notice that his case for involuntary reten-

ule a release hearing, Mr. Paskin would have to file what is known as a 72-hour letter.¹²⁷ It was not clear whether a release hearing could be scheduled on the same day as the already calendared medication hearing.

Next, the student researched the standard for involuntary medication¹²⁸ and tried to determine the likelihood that Mr. Paskin would prevail at the medication hearing. The student had to take into consideration which judge would hear the case.¹²⁹ The student needed to consider how the client would appear to the judge,¹³⁰ and the effect his appearance might have on the outcome of the case.

Third, the student had to determine if the hospital could be stopped from giving Mr. Paskin a bath. When investigating this issue, the student had to be sensitive to her own bias with regard to the desired outcome. There was no doubt that Mr. Paskin was quite

tion has been placed on the court calendar.

If the hospital determines that the patient is not suitable for release, the hospital will put the case on the court calendar and petition the court to involuntarily commit the patient. *Id.* Voluntary status becomes even murkier when one examines the underside of the voluntary admissions process. Scholars have begun to question critically whether an actual difference exists in the way that voluntary patients are treated once hospitalized. See James W. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CAL. L. REV. 840, 845-46 (1974). Compare Stanley Herr, *Civil Rights, Uncivil Asylums and the Retarded*, 43 U. CIN. L. REV. 679, 722 (1974) (distinction between voluntary and involuntary often "illusory") with *New York State Ass'n for Retarded Children, Inc. v. Rockefeller*, 357 F. Supp. 752, 756 (E.D.N.Y. 1973) (voluntary residents at state school for retarded not treated differently than those who were involuntarily committed). See generally PERLIN, *supra* note 36, § 2c-7.2, at 481-88; Janet A. Gilboy & John R. Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 NW. U. L. REV. 429, 452 (1971) (noting that in a study of voluntary admissions in Illinois, a majority of individuals who voluntarily committed themselves did so under threat of involuntary commitment); John Monahan et al., *Coercion and Commitment: Understanding Involuntary Mental Health Hospital Admission*, 18 INT'L J. L. & PSYCHIATRY 249, 250-52 (1995). "[T]he voluntary-involuntary distinction is an application quite blurred." Monahan, *supra*, at 251. "[R]esearch must transcend the formal dichotomy of 'voluntary' and 'involuntary' legal status." Indeed, evidence suggests that voluntary patients are subject to "abuse" and "substantial elements of coercion." See *id.* at 259. The "distinctions between voluntary and involuntary hospitalization and treatment are often murky." David B. Wexler, *Foreword: Mental Health Law and the Movement Toward Voluntary Treatment*, 62 CAL. L. REV. 671, 676 (1974).

Voluntary patients may have even fewer opportunities to be discharged than involuntary patients. Some literature suggests that voluntary patients are hospitalized twice as long as involuntary patients and are less frequently considered to have received maximum benefits from their hospitalizations. See Robert A. Nicholson, *Characteristics Associated with Change in the Legal Status of Involuntary Psychiatric Patients*, 39 HOSP. & COMMUNITY PSYCHIATRY 424, 427 (1988).

127. See *supra* note 126.

128. See *Rivers*, 495 N.E.2d at 337. See also *Riggins v. Nevada*, 504 U.S. 127, 135 (1992).

129. In this jurisdiction, the judges hearing the mental hygiene cases rotate on a weekly or monthly schedule.

130. See *Riggins*, 504 U.S. at 138-45 (Kennedy, J., concurring). See also Marybeth Zientek, *Riggins v. Nevada: Medicated Defendants and Courtroom Demeanor from the Jury's Perspective*, 30 AM. CRIM. L. REV. 215, 223 (1992).

odorous. It was important for the student to be aware of the impact this could have on the student's ability and desire to represent him and to work toward Mr. Paskin's therapeutic outcome, particularly his desire to avoid an involuntary scrubbing. From a TJ standpoint, the student needed to think about and investigate why Mr. Paskin was so resistant to bathing. As it turned out, Mr. Paskin had extremely rigid rituals surrounding his washing and eating behavior. These rituals guided his everyday behaviors. Interference with these rituals caused Mr. Paskin to become so anxious that he avoided the entire washing process.

The student's preliminary research indicated that Mr. Paskin would have to file a 72-hour letter to schedule a release hearing. Also, Mr. Paskin had, at best, a slim chance of winning the medication hearing, and only if a sympathetic judge heard the case. The judge would need to recognize that despite Mr. Paskin's appearance and somewhat strange eating and washing rituals, he was not incompetent to make treatment decisions. In addition, the judge would need to find that the hospital was unable to substantiate its claim that without hospital care Mr. Paskin would die of malnourishment. The student's research also showed that the hospital, for the health and safety of others, has the right to force Mr. Paskin to bathe.

At another meeting prior to the counseling session, the student reexamined her original perceptions of the therapeutic outcome. Although Mr. Paskin said that he wanted to go home, he signed voluntary papers. Perhaps going home was not really what he wanted to do. It appeared that Mr. Paskin consistently refused any medical intervention. He now needed to be informed of the consequences of going forward with his case on the next court date. The student felt that it was important to counsel Mr. Paskin that the lack of time available to thoroughly prepare his case could have a negative effect on the outcome of the hearing and that the scheduled presiding judge was not one likely to be sympathetic to restraining the hospital. Mr. Paskin also needed to be counseled that there was no way to stop the hospital from giving him a bath. This way he and his student-lawyer could strategize about what action he wanted to take in response to the hospital's decision to forcibly bathe him.

At another meeting, I discussed with the student the need to reappraise the client's therapeutic outcome. In this case, during the counseling session, Mr. Paskin decided *not* to put in a 72-hour letter, to go to court on the scheduled date, and to resist nonviolently when the hospital sought to bathe him, with the understanding that the court would not support his action. He also informed the student that

his parents were going to testify against him at the hearing. At this point, the student made another appointment to meet with the client the next day.¹³¹

This initial encounter is rich in fodder for the TJ fellow-traveler. Although at first glance it may seem that I have demonstrated nothing more than a client-centered approach to lawyering¹³²—within the special context of representing a person in a psychiatric center—on closer inspection, I believe that I used TJ to systematically and explicitly provide a “sharper conceptualization of and focus on”¹³³ an interdisciplinary approach to lawyering by focusing attention on the psychological well-being of both the client and clinic participant. Therapeutic jurisprudence does not take the place of more traditional skills training methods, yet, it does give a different perspective, one that forces us as clinical teachers and students to confront issues we may recognize on a visceral level but do not cognitively acknowledge. Therapeutic jurisprudence helps raise provocative questions about roles, perceptions, and ethics, while promoting proactive lawyering.¹³⁴ I have used this case to illustrate how TJ can frame an explicit orientation to the skill of client counseling, but this case is also wonderful for exploring clinical relationships, ethical dilemmas, institutional critique, theory of the case, and trial advocacy.

B. *The Collaborative, Reflective Classroom*

I (MLP) co-teach—along with a practitioner who is director of New Jersey’s mental health advocacy office—an upper level course, Mental Disability Litigation Workshop and Seminar.¹³⁵ The students spend two hours in class and the equivalent of a full day in externship placements. Most students work with field offices of a New York state public interest law office that provides legal services to individuals facing involuntary civil commitment. Others work with the correctional health services office of a municipal department of health. Still others work in a public interest law office that represents persons with mental disabilities on law reform or test cases. Occasionally, students will work in the office of counsel for private psychiatric hospitals.

131. The case continued after the student left for the semester. It was eventually appealed, found moot, and returned to the trial court for a new hearing to consider the client’s changed circumstances.

132. See *supra* note 81.

133. Stolle & Wexler, *supra* note 8, at 29.

134. See generally Stolle & Wexler, *supra* note 8; PRACTICING TJ, *supra* note 18.

135. With very few exceptions, all students in this course have taken either Mental Health Law or Criminal Law & Procedure: The Mentally Disabled Defendant as a prerequisite.

The classroom component includes transcripts of "ordinary" involuntary civil commitment hearings and insanity retention hearings, that is, cases that are not notorious because of the individuals involved, a subsequent appellate court decision, or a high-publicity incident that led to the hearing. The class also incorporates readings on the folkways of involuntary civil commitment practice,¹³⁶ the voluntary hospital admissions process,¹³⁷ the role of counsel,¹³⁸ the roles of forensic mental health professionals,¹³⁹ "sanism,"¹⁴⁰ pretextuality,¹⁴¹ and therapeutic jurisprudence,¹⁴² as well as cases that highlight some of the issues that are the focus of these readings.¹⁴³ Classroom discussions on both students' placement experiences and on the readings, both consciously and unconsciously, incorporate TJ principles.

When students present on their placement experiences (either discussing cases to which they have been assigned¹⁴⁴ or projects on which they have been working),¹⁴⁵ they regularly apply TJ principles as part of their analysis. They assess the role and behavior of the lawyer with whom they are working, the opposite lawyer, the judge and, often, other court personnel. They focus on the critical moment of their case (perhaps a bench ruling on the admissibility of hearsay evidence, a conversation with a client's siblings as to a potential aftercare placement, or an interaction with a hospital doctor about a patient's responsiveness to a certain medication), and apply TJ principles in deconstructing that moment. In my colloquies with the students, I

136. HOLSTEIN, *supra* note 65.

137. See, e.g., Susan C. Reed & Dan A. Lewis, *The Negotiation of Voluntary Admission in Chicago's State Mental Hospitals*, 18 J. PSYCHIATRY & L. 137 (1990).

138. See, e.g., John J. Ensminger & Thomas D. Liguori, *The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential*, 6 J. PSYCHIATRY & L. 5, 15-19 (1978); Perlin, *supra* note 57.

139. See Michael L. Perlin, *Power Imbalances in Therapeutic and Forensic Relationships*, 9 BEHAV. SCI. & L. 111 (1991).

140. See, e.g., Perlin, *On "Sanism," supra* note 35.

141. See, e.g., Michael L. Perlin, *Morality and Pretextuality, Psychiatry and Law: Of "Ordinary Common Sense," Heuristic Reasoning, and Cognitive Dissonance*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 131 (1991).

142. See, e.g., David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, 16 LAW & HUM. BEHAV. 27 (1992); David B. Wexler, *Justice, Mental Health, and Therapeutic Jurisprudence*, 40 CLEV. ST. L. REV. 517 (1992).

143. E.g., *In re Melton*, 597 A.2d 892 (D.C. 1991) (interpreting conflicting evidence in involuntary civil commitment case); *Goetz v. Crosson*, 769 F. Supp. 132 (S.D.N.Y. 1991) (examining the right to independent expert witness at involuntary civil commitment hearing), *aff'd in part & rev'd in part*, 967 F.2d 29 (2d Cir. 1992), *on remand to* 838 F. Supp. 136 (S.D.N.Y. 1993), *aff'd*, 41 F.3d 800 (2d Cir. 1994), *cert. denied*, 516 U.S. 821 (1995).

144. Students placed in law offices are typically assigned commitment cases to prepare for trial and, in some cases, to take to trial.

145. Students assigned to the correctional health services office work on such issues as the availability of compassionate leave for individuals who are near death.

regularly call on them to reflect on their experiences through TJ filters and ask them to conceptualize ways that the representation process might more closely align with TJ principles. I also employ the same devices in discussing classroom readings and case transcripts.

An example may be of help. In one case, a student was assigned to work with the New York Mental Hygiene Legal Services office at Bellevue Hospital, and as part of her work, she was asked to assist in the representation of Alan Andrews (a pseudonym). An examination of the case revealed hidden issues, two of which were especially susceptible to a TJ analysis.

Andrews was a 68-year-old homeless white male who had been brought to Gotham Psychiatric Hospital (a pseudonym) by New York City Transit police from the Ferry Terminal in lower Manhattan, where he had been living. The Transit Police believed it necessary to bring Andrews to Gotham Hospital because they found him with blood all over his hands. Andrews' bloody hands were a result of his (false) belief that leeches were all over his body. He would scratch himself until he bled in a futile effort to remove these imaginary leeches.

In his first meeting with our student, Andrews was, according to the student (Lisa), generally very calm when he spoke, but became anxious when he talked about certain topics. One was the fact that he was supposed to be receiving \$1,200 per month in pension money from the Railroad Retirement Fund, stemming from his years as a railroad conductor. Since becoming homeless, he had not received any of this money.

To Lisa, the most striking thing about Andrews was that he was always holding a little yellow magnifying glass up to his eyes. In their first meeting, Lisa did not ask him about it or understand its significance, but afterward she reported, "Looking back, it seems that I thought the [patient's reliance upon the] magnifying glass was merely a manifestation of his illness. However, I later learned that the magnifying glass was the Hospital's makeshift solution to his extreme visual impairment."¹⁴⁶

Once aware of this, Lisa immediately inquired as to the proper channels for obtaining the needed eyeglasses for Andrews, but was immediately faced with "an incredible amount of resistance":

Both his psychiatrist and his social worker seemed surprised by my "zealous" representation of my client. They seemed

146. This and other data in the Andrews case come from file notes made by Lisa and from memos that she submitted to me as part of her work on this case. Lisa is now a senior trial attorney with the New York Mental Hygiene Legal Services.

annoyed by my constant inquiries. In fact, I got into one very heated argument with the social worker, when she began to yell at me, accusing me of attempting to do her job. I tried to explain (with as much deference as I could muster) that the real problem was that she was *not* doing *her* job.

Lisa decided that her first priority was to try to obtain eyeglasses for her client before his commitment hearing. Here she noted, "I realized that my initial reaction to his magnifying glass was probably not unusual. I had thought it was an indication of his illness and abnormality. I knew that a judge would be likely to think the same thing."

Her attempts were initially thwarted by what she characterized as an "incredibly bureaucratic system." Andrews' visual impairment, she observed, although a subject of many notes in his chart, was "obviously not a priority to the staff. With each inquiry I made, I was met with a new excuse."

She continued,

First, I was told, "Gotham does not do glasses." I simply would not accept this as a fact. Here was a patient suffering from both a psychiatric diagnosis and a severe visual impairment. This was a patient who imagined things that were not there (e.g., leeches) and at the same time could barely see. I could not accept the fact that the hospital was only willing to treat his psychiatric condition with medication and wholly refuse to address his visual handicap.

I asked the doctor, "Isn't it possible that his deficient visions could be related to his hallucinations? If you can't see, is it not possible that you might believe things are there which are not?" I was told that my hypothesis was possible; nonetheless, the hospital simply refused to pay for my client's glasses. Now this did not end my efforts as Mr. Andrews apparently had—on paper—more than enough money to pay for his glasses. But no one at the hospital was making any effort to locate his \$1200 per month pension that had been accumulating since he became homeless.

With a couple of telephone calls, I was able to locate the pension fund and arrange for the hospital to set aside a sufficient sum of money to pay for my client's eyeglasses. However, I was *then* told that my client would have to leave the hospital grounds in order to obtain the glasses. This did not appear to be an obstacle, since Mr. Andrews was viewed as an excellent patient and had earned "level 4 off-ward privileges" (meaning that he *could* leave the hospital grounds if accompanied by a staff member).

But, the hospital told me that, because of the under staffing, there was no staff person available to accompany him to the eye doctor. This led me to ask myself this question: "If he can't use his off ward privileges to obtain this pair of glasses (that he desperately needs), then of what benefit are these privileges to a patient?"

Unfortunately, I was unable to obtain glasses for my client prior to his hearing, and he was retained at [Gotham Hospital]. Whether the judge's decision was affected at all by the magnifying glass, I will never know. However, in the course of the hearing, there *was* testimony about the magnifying glass and my client's dire need for eyeglasses. After my externship had ended, I later learned that Mr. Andrews, while a patient at [Gotham], finally obtained a pair of glasses.

Our classroom discussion of Lisa's case was rich and far-reaching and repeatedly focused on TJ principles. Our students knew from the substantive law portions of the seminar, their clinical placements, and prior course work, that patients have a constitutional right to adequate medical care¹⁴⁷ and a statutory right to control their own funds.¹⁴⁸ In the past fifteen years, no serious arguments have been raised questioning the legal foundation of these rights. And yet, Andrews' case came to Lisa's attention *not* because of alleged violations of either of these rights, but rather because he was resisting involuntary civil commitment.

Class conversation about Lisa's work on Andrews' behalf zeroed in (without any overt urging or prodding from either professor) on the TJ aspects of Lisa's work and the commitment process. The questions raised in the classroom discussion of Andrews' case included the following:

- *Why* are health care issues not cognizable at involuntary civil commitment hearings?¹⁴⁹
- *Did* the hospital doctors consider the impact that sightlessness might have on the patient's mental state and his legal commitment?

147. See *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982).

148. See, e.g., *Shields v. Katz*, 533 N.Y.S.2d 451 (N.Y. App. Div. 1988); N.Y. MENTAL HYG. LAW § 29.23 (McKinney 2000).

149. See, e.g., *Matter of D.J.M.*, 386 A.2d 870 (N.J. Super. Ct. App. Div. 1978), discussed in PERLIN, *supra* note 36, § 2c-8.1, at 508.

- Why did the hospital administrators not exert pressure *sua sponte* on hospital social work staff to obtain glasses for Andrews and to insure that he had access to his pension money?
- Why did the hospital not recognize the pretextuality of an administrative scheme that purportedly allowed patients to go “off grounds” but failed to provide necessary staff to the patient offgrounds?
- What were the TJ implications concerning the reality that hospital staff line workers predictably become hostile to student externs seeking to provide representational services to indigent inpatients when the student’s work appears to go beyond the carefully circumscribed boundaries of the involuntary civil commitment hearing?¹⁵⁰

The class discussed Lisa’s case over at least a month-long period. In many ways, it seemed to define the semester. The frustration that Lisa felt in seeking to provide top-quality representational services (in light of bureaucratic obduracy and passive aggression) was reflected in the ways that other students empathized with both Lisa and her client.

This empathy arises from another important purpose of TJ in clinical teaching: increasing the students’ awareness that attempts to provide excellent lawyering (without question, Lisa provided *truly* excellent lawyering, and her work could serve as a model for both law students and young lawyers assigned to such cases) can be met with roadblock after roadblock. Furthermore, these roadblocks can often thwart even the most advocacy-minded legal professionals.

Lisa’s case was not the only one in which TJ values shaped class discussion or case analysis.¹⁵¹ But, it *did* serve as a near-perfect “real

150. The issues at an involuntary civil commitment hearing are whether the defendant is mentally ill, and if so, whether, as a result of his mental illness, he is dangerous to himself or others. See, e.g., *Scopes v. Shaw*, 398 N.Y.S.2d 911 (N.Y. App. Div. 1977); N.Y. MENTAL HYG. LAW § 9.35 (McKinney 2000).

151. For instance, Alison, another student, was assigned to work with lawyers for a local agency that provided health services to inmates at a city correctional facility. She worked on what are termed “compassionate release” cases: applications to courts to suspend the remainder of criminal sentences so that inmates with terminal AIDS can be released to die at home or in a hospice established specifically to care for persons with AIDS.

In our classroom discussions, we specifically considered TJ arguments that Alison could make—and did make—in seeking to persuade judges that, notwithstanding records of felony convictions, her clients should be released so that they could “die with dignity.” See N.Y. CRIM. PROC. LAW § 210.40 (McKinney 2000). See generally PERLIN, *supra* note 36, § 14.16B, at 346-55 (Cum. Supp. 1999).

case” to teach, analyze, deconstruct, and reconstruct from TJ perspectives.¹⁵² When I tracked down students from that semester’s class and asked them if they could remember a case in which we discussed TJ issues, each student responded, “Lisa’s guy with the eyeglasses.”

VI. CONCLUSION

To return to the Bob Dylan lyric that gave this paper part of its title, clinical teachers and clinical students spend much of their time “in the basement/Mixing up [the] medicine.”¹⁵³ For the purposes of the clientele that our students represent, Dylan’s next couplet is just as telling: “I’m on the pavement/Thinking about the government.”¹⁵⁴

In 1965, Dylan wrote with profound suspicion and distrust about a government that was to be feared and avoided.¹⁵⁵ Institutional mental health consumers and other persons disadvantaged by social perceptions concerning their ethnicity, gender, or socio-economic status have ample reason when they are out “on the pavement” to be “thinking about the government.” The use of therapeutic jurisprudence in clinical teaching offers new tools to teachers and students when they are pondering the fate of marginalized persons who remain, all too often, out “on the pavement” and “thinking about the government.”

152. A professor crafting a hypothetical can always manipulate the facts to make more perfect teaching tools. The fact that this was a “real” case added a dimension simply unreachable in hypothetical cases.

153. DYLAN, *supra* note 13.

154. *Id.*

155. Bob Dylan wrote in the second verse

The phone’s tapped anyway . . .

They must bust in early May

Orders from the D.A. . . .

Keep a clean nose

Watch the plain clothes

You don’t need a weather man

To know which way the wind blows.

Id.

