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# Law, Language, and Forensic Psychiatry\*

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## INTRODUCTION

As therapeutic models and psychiatric explanations of criminal behavior increasingly dominate both theoretical and applied criminology, the "heretical" challenges posed by Dr. Thomas Szasz<sup>1</sup> take on new significance. Too frequently, the growing awareness of the potential implications of Dr. Szasz' views of criminology, law, and the operation of the criminal justice system manifests itself in attacks which either misconstrue or misrepresent Szasz' rich theoretical framework.

In this article, we seek to explicate the theoretical perspective of Thomas Szasz, identify common misconceptions held by his critics, and examine the implications of his views for five ethical/legal issues in the operation of the criminal justice system: 1) the plea of "not guilty by reason of insanity," 2) the newly announced right of the mentally ill to treatment, 3) the finding of incompetency to stand trial, 4) the involuntary civil commitment process, and 5) the concept of victimless crimes. The scope of Szasz' theory and its implications for our philosophies and institutions of criminal justice can hardly be overstated. Furthermore, it is our view that reforms consistent with Szasz' theoretical perspective would produce a more effective, more just, more respected, and more humane system of criminal justice.

## THE MYTH OF MENTAL ILLNESS

The underlying theme woven into each of Szasz' books<sup>2</sup> and arti-

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1. Thomas S. Szasz is Professor of Psychiatry at the State University of New York Upstate Medical Center.

2. For an index of Szasz's major works, see Vatz & Melia, *Bibliographic Essay*, Q. J. SPEECH (1977). Particular reference is made to T. SZASZ, *THE MYTH OF MENTAL ILLNESS* (1961).

cles is that mental "illness" is a myth. Szasz argues that use of the medical model is a pretense by which psychiatrists claim to understand behavior which we find strange or frightening. In fact, the medical model primarily serves to accredit or discredit certain behaviors. A somewhat extended discussion of Szasz' views is necessary for worthwhile debate on their implications for the criminal justice system.

Szasz maintains that mental "illness" is not illness at all; rather, "illness" is used metaphorically to refer disapprovingly to socially disvalued behaviors. The problem in the metaphoric use of the term "illness" is that we have erroneously taken it literally when used in conjunction with the term "mental." "Illness" metaphors in other contexts, indeed most metaphors, are seen for what they are. For example, a headline in a recent New York Times article concerning a prolific author states, "For Edna O'Brien, Writing is a Kind of Illness,"<sup>3</sup> but no one would believe that medical help was needed. Yet, while "mental illness" is similarly nonmedical, we immediately summon physicians to "treat" this behavior which we do not like or understand. As Szasz states: "[N]ot only is there not a shred of evidence to support [the idea that mental illness is akin to physiological disease], but, on the contrary, all the evidence is the other way, and supports the view that what people now call mental illnesses are, for the most part, communications expressing unacceptable ideas, often framed in an unusual idiom."<sup>4</sup>

The literalization of the "illness" metaphor allows the medical community to intrude upon the lives of those deemed to be "ill." It was generally accepted that David Berkowitz, the "Son of Sam" killer must have been "sick" to have killed innocent teenagers in an apparently random fashion. Thus, having been defined as "ill," he was immediately "examined" by doctors and "diagnosed." In effect, there is a compounded literalization of metaphor as the mentally "ill" are "diagnosed" and "treated" instead of punished.

Psychiatrists erroneously assume, argues Szasz, that behavior, thought, and beliefs are chemically or neurologically caused. Yet it has not, and probably cannot, be demonstrated that there is a one-to-one correspondence between particular neurological or chemical occurrences and particular beliefs. While not maintaining that be-

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3. N.Y. Times, Oct. 11, 1977, at 42.

4. T. SZASZ, *IDEOLOGY AND INSANITY* 19 (1970) [hereinafter cited as *IDEOLOGY*].

havior takes place in a chemical vacuum, Szasz argues that any behavior may or may not be accompanied by particular chemical events, and that no particular chemical events have ever been associated with particular behaviors.

Additionally, Szasz distinguishes disease or illness from mental "illness" through the recognition of the differing role played by symptoms in each. For example, if a person has pains in his chest, the symptoms may point to the presence of coronary heart disease. However, in mental "illness," the "symptom" points to nothing. In fact the symptom *is* the disease. Only in the case of mental "illness" is a symptom taken as sufficient evidence for the conclusion that illness is present.<sup>5</sup>

### ETHICS AND MEDICINE

Two areas of ethical concern arise from the use of the medical model in dealing with deviant social behavior. First is the problem of the ethical defensibility of psychiatrists pretending, through the clever use of language, to be something which they are not. As Szasz suggests, psychiatry has managed to clothe itself in "the logic, the imagery, and the rhetoric of science, and especially medicine."<sup>6</sup> This deception, whether conscious or unconscious, results in unrequested "therapeutic" interventions and serious deprivations of liberty. Second, and of far more concern, is the covert ethical judgment inherent in each psychiatric "diagnosis" of mental "illness." According to Szasz, to say that an individual is mentally "ill" entails a covert judgment about either reality or ethics. For example, David Berkowitz' claim that he was directed by "Sam" to commit murder justifies a finding of mental "illness" *only* if we do not believe that he did receive such instructions,<sup>7</sup> and if we deny the possibility of his strategic lying. Thus, a disagreement about "reality" is a necessary component of this "diagnosis," unlike a diagnosis of lung cancer or kidney failure. Similarly, in a recent Pennsylvania case, *Commonwealth v. Thomas*,<sup>8</sup> a man who threw his two month daughter down a flight of concrete steps, picked her up and threw

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5. For a discussion of the role of symptoms, see T. SZASZ, *LAW, LIBERTY, AND PSYCHIATRY* 12-14 (1963) [hereinafter cited as *LAW, LIBERTY AND PSYCHIATRY*].

6. See *IDEOLOGY*, *supra* note 4, at 4.

7. Note, for example, that evangelist Billy Graham's assertions that he has spoken to God have *not* resulted in medical interventions.

8. No. 76-06031 (C.P. Allegheny County, Pa. April 26, 1977).

her down the steps again was acquitted by reason of insanity. Rather than convicting this defendant, we absolve him of legal responsibility by attributing his acts to schizophrenia, a mental "illness". In other words, certain acts which are peculiarly offensive and incomprehensible to most observers are translated into "medical" diagnoses. In effect, under the guise of medicine, we permit psychiatrists to prevail over "patients" in debates about reality and ethics.

### RESPONSIBILITY AND AUTONOMY

Thomas Szasz challenges the conventional notion that certain people should not be held responsible for their conduct when it results from mental "illness"; for Szasz, such "illnesses" are nothing but linguistic devices. The "ill" person, in other words, is the one whose definitions of reality and himself are not accepted.<sup>9</sup> Furthermore, Szasz places primary emphasis on human autonomy—the right of every individual to define for himself who he is and what is in his best interests. Following John Stuart Mill, Szasz believes that a person's definition of his own best interests is his own best interest.

Having summarized the basic theoretical position of Dr. Szasz, we attempt to further elaborate on his thinking by identifying several errors commonly made by his critics.

### MENTAL HEALTH AND MENTAL ILLNESS

A frequent criticism of Szasz focuses on the alleged contrasting conditions of mental health and mental illness. It is assumed that mental "health," like physical health, is a definable and valued condition to be achieved. Szasz is asked to demonstrate that people whom psychiatrists "diagnose" as mentally "ill" are, in fact, normal or "healthy." Such a request<sup>10</sup> entirely misses the point. As we have argued elsewhere:

Szasz does not maintain that such people are "normal"; indeed, he would find the question meaningless and irrelevant

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9. Szasz writes: "The poet persuades many to see the world as he does; the lover, one; the lunatic, none." T. SZASZ, *HERESIES* 37 (1976).

10. See Schoenfeld, *An Analysis of the Views of Thomas S. Szasz*, 4 J. L. & PSYCH. 245 (1976).

. . . . If a man machine-gunned infants in a maternity ward, Szasz would surely not say that it is "normal." He would say, however, that you will not shed light on this behavior by discussing it in medical terminology.<sup>11</sup>

### DRUGS, THERAPIES, AND ETHICS

A second major misunderstanding arises out of Szasz' position on various "treatments" to which "patients" are required to submit with or without their consent. While critics such as Richard H. Guilluly<sup>12</sup> and Dr. Jonas Rappoport<sup>13</sup> and journalists such as Howard K. Smith<sup>14</sup> continue to question whether drugs or shock "treatments" are effective, it is argued that drugs do great good and that patients later will express their gratitude for having been subjected to them. Szasz does not maintain that drugs will not relieve depression or otherwise alter moods and perceptions. However, the fact that drugs provide relief from depression does not demonstrate to Szasz that depression was caused by a chemical deficiency. Szasz suggests that more revealing than the relationship between drug therapy and patient is the drug therapy and psychiatrist relationship. He states, "[W]hatever might be the effects of modern psycho-pharmacologicals on so called mentally ill patients, their effects on the psychiatrists who use them are clear, and unquestionably 'beneficial': they have restored to the psychiatrist what he had been in grave danger of losing—namely his medical identity."<sup>15</sup>

Contrary to the misrepresentations often made concerning Szasz' supposed opposition<sup>16</sup> to the use of drugs, Szasz strongly *supports* the rights of adults to ingest any chemicals or drugs for therapeutic purposes. What he opposes is the *forced* ingestion of chemicals by physicians. The point at issue is not the advisability of drug usage, rather it is the question of who is to decide who may ingest what. Szasz argues that in a free society the individual has the right to decide whether he or she wants "treatment."

11. Weinberg & Vatz, *Szasz and the Law: An Alternative View*, 4 J. L. & PSYCH. 551, 552-53 (1977).

12. See Guilluly, *For the Sake of the Patients*, in *The Baltimore Sun*, Sept. 12, 1977, at 18, col. 2 [hereinafter cited as Guilluly].

13. Comment and Controversy, WBAL, Baltimore, January 15, 1977 [hereinafter cited as Comment].

14. *Madness and Medicine*, ABC-TV Documentary, April 26, 1977.

15. IDEOLOGY, *supra* note 4, at 22.

16. See generally Guilluly, *supra* note 12.

Perhaps the most ironic misrepresentation is the consistent effort to depict Szasz as a "radical" psychiatrist. In fact, his views have profoundly "conservative" implications. His general argument that man has the right to define himself and his own best interests without the interference of others, and his specific arguments upholding the right to commit suicide and advocating the abolition of the insanity plea and the elimination of forensic psychiatry would place him comfortably in the school of social thought currently known as "conservatism."

Finally, Szasz is commonly criticized for offering no alternatives to the system of institutional psychiatry which he claims is essentially fraudulent and destructive of human dignity and autonomy. Szasz says that many people indeed are depressed, unhappy, despondent, and even self-destructive. Clearly, he believes, such individuals are experiencing "problems in living." Such problems, Szasz argues, are typically diffuse and general but are made to appear to be specific and discrete *only* as a consequence of the psychiatric categories used to describe them. Psychiatrists, by virtue of their *medical* training, do *not* acquire any special insights into the ethical, moral, and social problems faced by men; therefore, they should not be empowered to forcibly inject drugs into others, nor deprive them of their freedom under the guise of rendering treatment. Whether it is rational to take one's own life and what society should do about mass murderers and political assassins are not medical matters. Thus, Szasz offers no alternatives because institutional psychiatry should simply not exist.

We turn our attention next to Szasz' contributions to several key ethical/legal controversies currently facing the criminal justice system.

#### ETHICAL ISSUES IN CRIMINAL JUSTICE

The major thrust of Szasz' efforts, as we have argued, is to identify the inappropriateness of the use of medical terms, concepts, and personnel to deal with "problems in living." His underlying theme is that the definitive human struggle is between the definer and the defined, with the victor being he who controls language. He argues that

the struggle for definition is veritably the struggle for life itself  
. . . . In ordinary life, the struggle is not for guns, but for words;

whoever first defines the situation is the victor; his adversary the victim . . . . In short, he who first seizes the word imposes reality on the other; he who defines thus dominates and lives; and he who is defined is subjugated and may be killed.<sup>17</sup>

The prefatory comments are crucial to understanding the relevance of Szasz to ethical issues in criminal justice. Only after we appreciate the power of linguistic definition can we see why "medical" problems such as acquittal by reason of insanity, issues of mental competency to stand trial, rights to medical "treatment," involuntary civil commitments, and victimless crimes are not matters of *medicine* but of *ethics, morality, and politics*. The kinds of issues which we address in this paper are not issues upon which medically trained people have any peculiar competence. Szasz' central contribution is, therefore, to "de-medicalize" these issues and to bring debate upon them back into the realm of ethics, morality, and politics. Neither the "effectiveness" of alternative treatment, nor the "accuracy" of competing psychiatric "diagnoses" are at stake. Rather, the issue is the desirability of our society evolving into an oppressive therapeutic state where individual freedom will be subjugated to collectivist values.

#### THE INSANITY PLEA AND THE INSANITY VERDICT

Since the case of Daniel M'Naghten<sup>18</sup> in 1843, juries have been permitted to find defendants not guilty by reason of insanity. While courts have struggled to define a proper test or standard to determine if the defendant was mentally "ill," or, more properly, "insane" at the time he committed the criminal act, Szasz would argue that the courts have failed to discuss the real issue. Since "all tests of criminal responsibility rest on the premise that people 'have' conditions called 'mental diseases,' which 'cause' them to commit criminal acts,"<sup>19</sup> the validity of these tests necessarily depends on the existence of mental "illness." Szasz disputes the very existence of such "illness." Thus, asking a psychiatrist to give a *medical* opinion on whether the defendant knew right from wrong or knew the nature or quality of his act or whether the act was the product

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17. T. SZASZ, *THE SECOND SIN* 24-25 (1973).

18. Daniel M'Naghten's Case, 8 Eng. Rep. 718 (1843).

19. IDEOLOGY, *supra* note 4, at 100.



of the defendant's mental disease or defect presents an *ethical* question masquerading as a *medical* question.

Typically, a defendant found "not guilty by reason of insanity" is sent for an indefinite period to a "hospital" for the criminally insane to be "treated." Such "treatment" raised the threat of life imprisonment in the "hospital" and was preferable only to the death penalty; thus, defendants traditionally raised the insanity defense only if the death penalty was the alternative. Today, the availability of the death penalty is much more limited, and a decrease in insanity pleas would be expected. However, some courts have become more sensitive to the legal implications of the successful invocation of the insanity defense, and we are, therefore, likely to see an increasing number of defendants raising the insanity defense. For example, the Court of Appeals for the District of Columbia held in 1968 that a defendant acquitted by reason of insanity was entitled to a new finding of fact as to his "present insanity."<sup>20</sup> "Hence persons found not guilty by reason of insanity must be given a judicial hearing [before commitment in a mental institution] with procedures substantially similar to those in civil commitment proceedings . . . . The trial determined only that there was a reasonable doubt as to the defendant's sanity in the past; present commitment is predicated on a finding of present insanity."<sup>21</sup>

In the Pennsylvania case, *Commonwealth v. Thomas*, the confusion that may result from approaching this ethics problem as a medical question becomes apparent. Pennsylvania, in line with *Bolton v. Harris*,<sup>22</sup> has a Mental Health Act under which the defendant could *not* be committed to a "hospital" following his acquittal without a showing that he was insane at the time he was to be committed. However, doctors agreed that the defendant's "mental illness" was "treatable" with "medication"—so long as he took his pills he was considered sane! To avoid releasing this defendant, the judge sent him to jail (not a hospital) for a parole violation based on a prior offense on which he *also* was found not guilty by reason of insanity.

A recent New York case further illustrates the consequences of confusing ethics and medicine. A man who stabbed his wife sixty times with a kitchen knife, then taped his baby's mouth shut and

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20. See *Bolton v. Harris*, 395 F.2d 642 (D.C. Cir. 1968).

21. *Id.* at 650-51.

22. 395 F.2d 642 (D.C. Cir. 1968).

strangled him with an electric cord was found not guilty by reason of insanity. Following one year of "treatment" in a maximum security "hospital," his *doctors* declared that he was no longer dangerous. He was transferred to a nonsecure "hospital" where he was permitted to leave at will. This defendant subsequently walked away from the institution and has not yet been found.

Clearly, to permit continued deceptive employment of the medical model to make difficult moral judgments is more than a matter of linguistics, as many of Szasz' critics insist. Szasz argues that psychiatrists cannot detect the presence or absence of criminal responsibility with a medical examination and diagnosis. Rather, the decision to hold a person criminally responsible for his unlawful conduct is solely an *ethical* one to be made by those people chosen by society to perform this awesome task — the jury. Medicine is entirely irrelevant; forensic psychiatrists are therefore equally irrelevant.

Since the insanity defense results either in extensive involuntary "hospitalization" or increasingly, in *no* punishment at all, Szasz advocates the abolition of the insanity defense. He argues:

Either we regard offenders as sane, and punish them; or we regard them as insane, and, though excusing them for crime officially, punish them by treating them as beings who are less than human. It seems to me that there is a more promising alternative. Let us not consider mental illness an excusing condition. By treating offenders as responsible human beings, we offer them the only chance, as I see it, to remain human.<sup>23</sup>

#### RIGHT TO TREATMENT

The Supreme Court's landmark decision in *O'Connor v. Donaldson*<sup>24</sup> provides clear evidence that Szasz' views have not yet penetrated the judicial system. In *Donaldson*, the Court held that Kenneth Donaldson, who spent fifteen years in a mental institution, had to be released because he was not dangerous, he was capable of living outside the institution, and he had received no "treatment" during the entire period of his confinement. The Court refused to decide whether a person confined because he *was* dangerous had a similar right to be either "treated" or released and whether a non-

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23. LAW, LIBERTY, AND PSYCHIATRY, *supra* note 5, at 137.

24. 422 U.S. 563 (1975).

dangerous "patient" such as Donaldson might be confined if "treatment" were made available.

From Szasz' point of view, the entire debate over the right to unrequested, but by the Supreme Court's decision necessary, "treatment" further obscures the real issue. If mental "illness" is a myth, then unrequested "treatment" of "patients" in "hospitals" becomes assault and battery on prisoners. After *Donaldson*, Szasz maintained that, "The crucial question thus remains unanswered: on what grounds, if any, may an individual be deprived of liberty by being incarcerated in a mental hospital."<sup>25</sup> Upon his release, Donaldson argued, "Mainly, my disease was that I refused to admit that I was ill. From what I've seen and heard, that is the worst disease you can have — refusing to admit that you have a disease."<sup>26</sup> Donaldson, in effect served a fifteen year "prison" term. His chief offense — refusing to allow others to define his failures as a husband, father, and working man as a matter of mental "illness."

While the Supreme Court has not yet decided whether a patient has the right to refuse "treatment," a few lower courts have said that absent the "patient's" consent, "treatment" can result in unconstitutional cruel and unusual punishment. In *Mackey v. Procumier*,<sup>27</sup> a prison inmate agreed to go to a mental "hospital" to undergo electroconvulsive therapy. He alleged that despite his protests, the doctors instead administered the drug anectine to him as part of a program of "aversive therapy." The drug, which creates the sensation of suffocation or drowning, was injected when his behavior was deemed inappropriate. The court held that proof of such allegations might constitute cruel and unusual punishment. In another case, the Court of Appeals for the Eighth Circuit held that the unrequested administering of apomorphine, a drug which causes vomiting, to misbehaving mental patients was cruel and unusual punishment.<sup>28</sup> The notion of a right to refuse "treatment" still begs the question posed by the theories of Thomas Szasz; there can be no "treatment" if there is no "illness." Nevertheless, it is encouraging to see courts reasoning through these cases under the framework provided by the cruel and unusual *punishment* clause. The courts,

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25. Szasz, *On Involuntary Psychiatry*, in N.Y. Times, October 15, 1975, at 46, col. 4.

26. TIME, July 7, 1975, at 44.

27. 477 F.2d 877 (9th Cir. 1973).

28. Knecht v. Gillman, 488 F.2d 1136, (8th Cir. 1973). The Iowa facility involved here considered swearing to be a sufficient misbehavior to warrant the injection of apomorphine.

perhaps, are beginning to perceive the real nature of the issue.

Szasz summarizes his attitude toward the "right to treatment" as follows: "The idea of a 'right' to mental treatment is both naive and dangerous. It is naive because it accepts the problem of the publicly hospitalized mental patient as medical rather than educational, economic, religious, and social. It is dangerous because the remedy creates another problem: compulsory medical treatment."<sup>29</sup> Psychiatrists insist on the use of the medical model for understanding behavior; on the other hand, they are not willing to accord mental "patients" the same right that medical patients now have — the right to refuse treatment. Even when a "treatment" is less offensive, it still, as Murray Edelman suggests, "superimposes a political relationship upon a medical one."<sup>30</sup> Thus, "mental" patients do not hold dances, they have dance therapy. If they play volleyball, that is recreation therapy. If they engage in group discussion, that is group therapy. Even reading is 'bibliotherapy' . . ."<sup>31</sup>

In sum, the legal debate over the "right to treatment" fails, for the most part, to reach the critical ethical, moral, and political dimensions of the problem. For "treatment" is erroneously defined as "helping," while in fact it functions to permit some people (psychiatrists) to limit the freedom and autonomy of other people (patients). As Edelman states,

Because the helping professions define other people's statuses (and their own), the special terms they employ to categorize clients and justify restrictions of their physical movements and of their moral and intellectual influence are especially revealing of the political functions language performs and of the multiple realities it helps to create.<sup>32</sup>

It is not possible to "treat" behavior which is not symptomatic of disease; to do is merely to use language to make it easier for "men considered mentally healthy to degrade and mistreat men considered mentally sick."<sup>33</sup>

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29. LAW, LIBERTY, AND PSYCHIATRY, *supra* note 5, at 215.

30. Edelman, *The Political Language of the Helping Professions*, 4 POL. AND SOC'Y 297 (1974).

31. *Id.*

32. *Id.* at 296.

33. IDEOLOGY, *supra* note 4, at 217.

## COMPETENCY TO STAND TRIAL

As we have indicated above, Szasz argues that allowing doctors to answer ethical/legal questions of sanity *as if* they were medical ones is both deceptive and dangerous. The role of doctors in determining whether a criminal defendant is "competent" to stand trial may be even more dangerous than their role in presenting the insanity defense; there have been far more involuntary mental commitments resulting from the finding of incompetency than from the finding of insanity. A recent survey by the Joint Information Service of the American Psychiatric Association indicates that "of all admissions to mental hospitals of mentally ill offenders, 52 percent result from determinations of incompetency to stand trial, and only 4 percent from findings of not guilty by reason of insanity."<sup>34</sup>

A recent article by prominent forensic psychiatrists Herbert E. Thomas and John H. Hess maintains: "Certainly most doctors would agree that their proper function in hearings to determine competency consists of a scientific evaluation of the patient and an accurate and useful presentation of the scientific conclusions to the court."<sup>35</sup> These psychiatrists then complain that too often the psychiatrist in the competency hearing "not only evaluates the defendant's psychological status, but judges his behavior, estimates its social and ethical significance, and decides on a fitting consequence, be it commitment or trial."<sup>36</sup> Hess and Thomas fail to understand that what they condone and what they condemn are identical. The "proper" "scientific" judgments which they support are, in fact, nothing more than the normative judgments which they oppose.

The justification for following a doctor's medical opinion that a defendant is not competent to stand trial is, predictably, that such a finding benefits the defendant. Yet the question of whether or not his competency will be evaluated does not lie exclusively in his hands. If the defendant does not argue his incompetency, the prosecution may request or the court may, at its own discretion, require that a defendant be "examined" before trial to assess his competency. If the defendant refuses to undergo the court-ordered "examination," he may be punished for contempt. Szasz argues: "If

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34. Hess, Pearsall, Slichter & Thomas, *Competency to Stand Trial*, in READINGS IN LAW AND PSYCHIATRY 616 (Allen, Ferster, Rubin eds. 1975).

35. *Id.* at 621.

36. *Id.*

the pretrial psychiatric examination is really for the defendant's benefit, why should he be punished for refusing it? If, on the other hand, it is not for his benefit, then it must be for the benefit of either the judge or the prosecution."<sup>37</sup> The Supreme Court has said that not only *may* a judge raise the issue of competency *sua sponte*, but that he *must* do so where there is evidence suggesting that the defendant may not be competent, even though the defendant has waived the defense of incompetency by failing to request a psychiatric examination and hearing.<sup>38</sup> As the Court stated, "it is contradictory to argue that a defendant may be incompetent, and yet knowingly or intelligently 'waive' his right to have the court determine his capacity to stand trial."<sup>39</sup>

Historically, the finding of incompetency to stand trial resulted in automatic and indefinite confinement in a mental "hospital." Since the mental "hospitals" often failed to "treat" or even "reexamine" many of their "patients," the unlucky person who, "for his own benefit," was found incompetent to stand trial might have spent the remainder of his life in a "hospital"; if convicted, he might have been eligible for parole after five years in prison. Again, the confusion is primarily caused by the mistake of allowing the medical model to be employed to handle ethical or legal matters. Paradoxically, as the legal rights of the "mentally ill" are increasingly recognized, the ethics as medicine error is compounded. In the 1972 decision of *Jackson v. Indiana*,<sup>40</sup> the Supreme Court ruled that a defendant committed to a "hospital" after being found incompetent to stand trial may only be detained as a "patient" for a reasonable time to see if he is likely to regain his competency. If he becomes competent, he must be released and then tried if the state wishes; if he appears unlikely to regain competency, he must either be released or committed under the civil commitment procedure. However, as state laws governing civil commitments are rewritten to afford greater rights to those being involuntarily committed, the results become less rational. For example, although a defendant is found incompetent to stand trial, he might *not* fall within the ever-narrowing categories of people who can be civilly committed. Or, he may be incompetent to stand trial but "treatable" with

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37. LAW, LIBERTY, AND PSYCHIATRY, *supra* note 5, at 164.

38. *Pate v. Robinson*, 383 U.S. 375, 385 (1966).

39. *Id.* at 384.

40. 406 U.S. 715 (1972).

"medication" readily available on an "outpatient" basis. In either case, it is likely that greater numbers of serious offenders will avoid the entire criminal justice system.

Szasz' theoretical model mandates the elimination of the incompetency finding. The test of legal competency is the capacity of the defendant to understand the nature of the charges against him and to assist his lawyer in preparing a proper defense. Szasz would agree that on *ethical* grounds a defendant ought not be tried in absentia; he would also agree that if a doctor can testify that a defendant is unconscious due to a brain tumor, then we can decide on *ethical* grounds that the defendant is incompetent and should not be tried. However, where no medical condition exists — and that, of course, is his basic thesis — there is *no* justification for asking *doctors* whether the defendant "understands" the charges and is "capable" of assisting in his defense. Such questions are normative, not medical, and should be decided on ethical grounds, not medical grounds.

#### INVOLUNTARY CIVIL COMMITMENT

Szasz unambiguously states: "I am unqualifiedly opposed to involuntary mental hospitalization and treatment. To me, it's like slavery; the problem is not how to improve it, but how to abolish it."<sup>41</sup> Involuntary hospitalization is legal in form, but medical in fact. Again, inordinate and unjustified power is granted to doctors to make difficult decisions of morality. One intensive study of civil commitment hearings reports that, although taking place in a legal setting, "the decisions are treated almost exclusively as medical decisions."<sup>42</sup>

A recent symposium on the new Pennsylvania Mental Health Procedures Act<sup>43</sup> reported the preliminary findings of a similar study in progress in Allegheny County. Those committed, generally unable to secure their own psychiatrists, are often quiet and nondangerous when they appear at the commitment hearing due to the drugs which they have been given during the short emergency treatment and confinement prior to the hearing. One Mental Health

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41. Szasz, *A Psychiatrist Views Mental Health Legislation*, 9 WASHBURN L. REV. 224, 234 (1970) [hereinafter cited as *Psychiatrist*].

42. Fein & Miller, *Legal Process and Adjudication in Mental Incompetency Proceedings*, SOCIAL PROBLEMS, Summer, 1972, at 63.

43. PA. STAT. ANN. tit. 50, §§ 7101-7503 (Purdon Supp. 1978-1979).

Review officer, the judge in such hearing, concluded that he therefore had to rely on the medical testimony of the state psychiatrist because the quiet condition of the respondent was generally misleading. Thus, if a respondent is angry and rebellious, it is probably assumed that he is dangerous; if he is not angry and rebellious, it is attributed to his sedated condition and discounted in favor of psychiatric "diagnosis."

A brief examination of the new Pennsylvania commitment process further demonstrates the conceptual quagmire and the continued role of psychiatrists as social control agents rather than medical agents. The 1976 legislation was required by the judicial invalidation of the prior law for its unconstitutionally vague standard.<sup>44</sup> Along with many other states, Pennsylvania now requires a finding of severe mental disability which results in a person posing a "clear and present danger of harm to others or to himself" for involuntary civil commitment.<sup>45</sup> Thus, "dangerousness" becomes the primary grounds for involuntary commitment and psychiatrists have become the experts who establish the presence of mental disabilities resulting in "dangerousness." Szasz writes: "Drunken drivers are dangerous both to themselves and to others. They injure and kill many more people than, for example, persons with paranoid delusions of persecution. Yet, people labeled paranoid are readily committable, while drunken drivers are not."<sup>46</sup> While some psychiatrists<sup>47</sup> admit they are unable to predict long-term "dangerousness," they maintain they are able to predict short-term "dangerousness" and that, at a minimum, they can identify which individuals have "mental illnesses" which will respond to "treatment." Refusing to recognize that "mental illnesses" are wholly rhetorical phenomena, both courts and psychiatrists continue to make ethical decisions in the name of medicine.

Szasz recognizes society's right to enact a criminal code which punishes people who harm other people. Szasz plainly states his view that "if someone is suspected of lawbreaking, he should be accused, tried, and, if convicted, sentenced. If the sentence calls for loss of liberty, he should be confined in an institution that's penal,

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44. See Note, *Standards for Involuntary Civil Commitment in Pennsylvania*, 38 U. PRR. L. REV. 535 (1977).

45. PA. STAT. ANN. tit. 50, § 7301(a) (Purdon Supp. 1978-1979).

46. LAW, LIBERTY, AND PSYCHIATRY, *supra* note 5, at 46.

47. See note 13 and accompanying text *supra*.



not medical, in character . . . . If jails are bad, and of course many are, they should be improved. Placing lawbreakers, or suspected lawbreakers, in mental hospitals against their will is not a proper substitute for prison reform."<sup>48</sup> Predictions of future dangerousness are regularly made in probation and parole decisions. Such decisions, while difficult, are not medical.

On the other hand, Szasz rejects the notion that harm to oneself constitutes a legitimate basis for incarceration in a mental institution. The right to do what one wants with one's body is absolute. Whether or not it is deemed "rational" to act in a self-destructive fashion, or even to commit suicide, is an ethical, moral, and religious question to which psychiatrists have no better answers than anyone else. This is the final ethical issue to be examined in light of the views of Thomas Szasz.

#### CRIMES WITHOUT VICTIMS

For Szasz, the category of offenses loosely labelled "crimes without victims" should be called "victims without crimes." The punishing of homosexuality offers an intriguing illustration of the continuing misuse of both criminal law and medicine. On the one hand, the American Psychiatric Association, in 1973, altered its Diagnostic and Statistical Manual to declare that homosexuality is no longer an "illness." Homosexuality is now viewed as "one form of sexual behavior and, like other forms of sexual behavior which are not by themselves psychiatric disorders, is not listed in this nomenclature of mental disorders, *i.e.*, the diagnostic category entitled "sexual orientation disturbance."<sup>49</sup> Such an action supports Szasz' contention that mental "illness" is a myth — medical illnesses cannot be voted out of existence.

On the other hand, efforts to use the criminal law to punish consenting adults for deviant sexual practices have often been met successfully with the argument that it is unconstitutional to punish someone for having a "condition" or an "illness." This very argument provided the rationale for the Supreme Court decision in *Robinson v. California*<sup>50</sup> which invalidated a California statute mak-

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48. *Psychiatrist*, *supra* note 41, at 237.

49. AMERICAN PSYCHIATRIC ASSOCIATION DIAGNOSTIC AND STATISTICAL MANUAL 44 (6th ed. 1973).

50. 370 U.S. 660 (1962).

ing it a criminal offense to be "addicted" to narcotics. The Court reasoned: "It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill . . . ."<sup>51</sup> Mental illness and addiction, then, are seen as medical conditions to which the criminal law may not be constitutionally applied.

Thus, for Szasz, whether one chooses to engage in homosexual behavior or to take drugs is neither a matter of medicine, nor a matter of criminal law; it is a matter of personal choice and personal morality. In addition, Szasz rejects the concept of drug "addiction" itself. He maintains that "while addiction is ostensibly a medical and pharmacological problem, actually it is a moral and political problem."<sup>52</sup> He rejects the position that "drug addiction is a disease, 'like any other,' which has now reached 'epidemic' proportions, and whose 'medical' containment justifies the limitless expenditures of tax monies and the corresponding aggrandizement and enrichment of noble medical warriors against this 'plague'.<sup>53</sup> The fact that it is possible to kill oneself by abusive injection of drugs does not justify their prohibition. The fact that people *will not* stop taking drugs does not demonstrate their *inability* to stop — only their *unwillingness*. The increased tolerance which can be biologically *learned* can be biologically *forgotten*.

#### SUMMARY AND CONCLUSIONS

We have sought in this article to present a summary of the ideas contained in the prolific works of Thomas Szasz, and to explore their implications for a series of issues confronting the criminal justice system. As is evident, the adoption of Szasz' perspective would result in a rethinking of the role of medicine in the criminal justice system, the role of the criminal law and the civil law in reducing human freedom, and, ultimately, in the definition of what it means to be free. While not frequently discussed in criminal justice literature to date, Thomas Szasz poses an intellectual challenge which will, sooner or later, have to be met by scholars in our field, as well as in the other social sciences, law, and medicine. While

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51. *Id.* at 666.

52. Szasz, *The Ethics of Addiction*, in *THE RHETORIC OF NO.* 195 (2d ed. 1974).

53. *Id.* at 188.

having only initiated the discussion of the views of Thomas Szasz among students of the criminal justice system, it is our hope that further analysis will be stimulated by our efforts.