The psychiatric protection order for the "battered mental patient"

Thomas Szasz

Psychiatric patients are routinely treated against their will. Legally enforceable psychiatric protection orders would protect patients from coercive psychiatric interventions

Department of Psychiatry, Upstate Medical University, State University of New York, Syracuse, NY 13210, USA
Thomas Szasz
emeritus professor of psychiatry

Correspondence to: 4739 Limberlost Lane, Manlius, New York, NY 13104, USA
tszasz@aol.com

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The avowed desires of patients and doctors conflict more often in psychiatry than in any other branch of medicine. People known as "mental patients" are routinely subjected to "diagnostic" and "therapeutic" interventions against their will. Many such people see being committed (sectioned) and treated against their will as a personal violation—a "psychiatric abuse"—and want to protect themselves from future involuntary psychiatric hospitalisation and treatment. At present former psychiatric patients, even when legally competent, have no means to defend themselves from such a contingency.

Mental health laws—reflecting the point of view of psychiatrists and society—protect (or are said to protect) mentally ill patients from the dangers they pose, because of their illness, to themselves and others. Many mental patients view—and have always viewed—psychiatrists as posing a danger to them. Respect for the self defined interests of such patients requires that the law protect them from further unwanted psychiatric interventions.

The psychiatric protection order

Courts recognise the validity of "psychiatric wills" (psychiatric advance directives) only when they prospectively authorise treatment; courts do not recognise them when the "psychiatric testator" rejects psychiatric "help."[1] To remedy this defect, especially when patients are released into the community after a period of involuntary treatment for mental illness, I propose a new legal safeguard: the psychiatric protection order. Such an order, similar to the protection order used in domestic conflicts, would make it a criminal offence to impose involuntary psychiatric interventions on people protected by the order.

In free societies only psychiatric patients are routinely treated against their will. (Public health laws explicitly serve the interests of the public, not the therapeutic needs of particular persons.) Competent patients with uraemia are not treated against their will and can use a "medical will" to protect themselves from undergoing dialysis. If psychiatry were like any other medical specialty competent patients with schizophrenia would not be treated against their will and could protect themselves with a psychiatric will from being treated.[2] But they cannot: neither psychiatrists nor the courts recognise the validity of the psychiatric will. Mental health laws trump psychiatric advance directives.

Not by coincidence the history of psychiatric interventions forcibly imposed on patients is long and depressing. In a letter he wrote to me in 1988 Karl Menninger summarised the history of psychiatry with these sad words: "Added to the beatings and chainings and baths and massages came treatments that were even more ferocious: gouging out parts of the brain, producing convulsions with electric shocks, starving, surgical removal of teeth, tonsils, uteri, etc."[3] To this list Menninger might have added the use of straitjackets, tranquillising chairs, confining chairs, cold baths, emetics, purgatives, Metrazol shock, inhalations of carbon dioxide, and neuroleptic drugs.

Freedom from enforced psychiatry

From the beginnings of the specialty, psychiatric patients have had no opportunity to free themselves from their protective-oppressive relationship with psychiatrists. In this brief paper I focus on a single issue: the desire of some psychiatric patients to free themselves, once and for all, from what they regard as an abusive relationship with the psychiatric profession. The Anglo-American legal system has always denied this option to these patients. This denial resembles the denial of slaves' opportunity, in a slave society, to leave their master; of the wife's opportunity, in traditional marriage, to leave her husband; and of citizens' opportunity, in the modern totalitarian state, to leave their country and its rulers. These people may enjoy all manner of benefits and privileges, but they cannot, without the permission of the repressive authority, leave the system for good.

The English and American legal systems maintain the fiction that the relationship between a family member responsible for committing a "loved one" and the incarcerated individual—as well as that between psychiatrists and involuntarily detained patients—is always one of "care" and "treatment." It can be otherwise only in "unfree," "totalitarian" countries; such was the case in the Soviet Union and is now the case in China. That self serving rationalisation is at the core of the problem facing us.

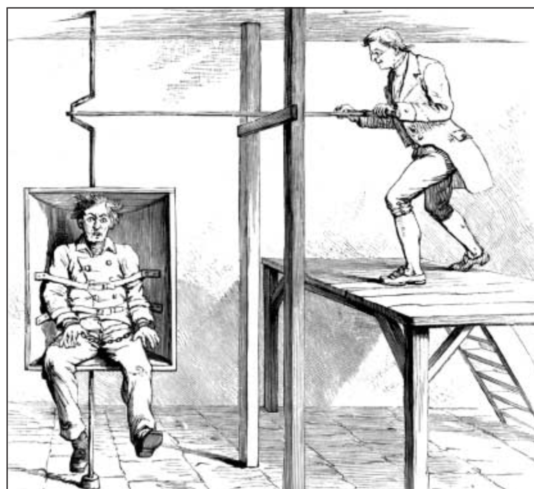
Anglo-American law assumes, as a matter of fact, that the relationship between a person and a legal agent of the state is adversarial. Justice Potter Stewart of the US Supreme Court famously remarked: "To force a lawyer on a defendant can only lead him to believe that the law contrives against him."[4] The law student is taught the duties and roles of both prosecuting attorney and defence attorney. Both jobs are legitimate and proper.

In contrast Anglo-American psychiatry assumes, as a matter of law and psychiatry, that the relationship between a person and a psychiatric agent of the state is therapeutic. Forcing psychiatrists on mental patients is routine practice, and the patient who protests is likely to be given a diagnosis of paranoia. The medical student is taught only the duties and roles of the psychiatrist making diagnoses and providing treatment. The psychiatrist has no other legitimate duties or roles; only the job of the coercive psychiatrist is legitimate and proper. The psychiatrist who tries to help the coerced "patient" to reject the patient role is ostracised, or worse.

The gatekeepers: the family

We are hypocrites if we ignore who the parties are that support the enactment of mental health laws and deny patients the option of rejecting psychiatric services. Everywhere the supporters of mental health laws are psychiatrists and the relatives of so called mental patients. In the United States the relatives are now also in control of a powerful lobby, the National Alliance of the Mentally Ill, that legitimises the abuse of family members (mainly adult children) as the care of "loved ones." Organisations of former psychiatric patients—who call themselves "victims of psychiatric abuse"—are not among the parties clamouring for more psychiatric coercions or "services."

People subjected to involuntary psychiatric hospitalisation and treatment often feel victimised in much the same way as do wives (less often husbands) who are abused by their spouses. Until recent times women had no effective protection from their abusers, whom the law defined as their protectors. In many parts of the world women are still in that situation. Similarly, in the days of Dickens children were not protected from abuse by their parents.



Specific treatments may have changed since this 1818 drawing, but psychiatric patients are still forced to undergo unwanted interventions

We in the West now recognise that the family is not just the primary locus of affection, care, and security for its members: it is all too often also the source of the most insidious danger to their physical and spiritual wellbeing. We acknowledge this unhappy fact and accordingly speak of "battered" children, spouses, parents, and grandparents. In the conflicts that often arise between adults living together as married couples or lovers, legal separation, divorce, and the so called protection order exemplify the legal system's acknowledgment of the problem and the need for legally sanctioned and enforceable mechanisms to remedy it. A protection order mandates physical separation between the parties and makes it a criminal offence for the denominated threatener to impose their mere presence on the threatened person. I suggest that we similarly acknowledge the unhappy fact of "battered mental patients" and the need to protect them from their batterers. In the absence of a protection order the power relations between psychiatrist and involuntary patient will continue to generate "psychiatric abuse," rationalised as protection and treatment. Indeed, it is precisely because psychiatrists reject advance psychiatric directives authorising abstinence from further treatment (a request that non-psychiatric doctors accept) that makes a legal mechanism such as the psychiatric protection order necessary.

Legalise "divorce" between psychiatrists and patients

Psychiatrists object to efforts to treat patients as responsible moral agents and cite the prevention of harm as a basic social mandate of psychiatry. Typically, they argue that people who would have committed suicide but for their involuntary detention would thereby have been deprived of the option of changing their minds once they had recovered from depression. A similar argument could be made against last wills or, indeed, any decision that profoundly affects one's future, such as marriage or having children. The standard psychiatric justification for "therapeutic" coercion either ignores the familiar conflict between liberty and security or, more often, equates (involuntary) psychiatric treatment with ("true") freedom.[5] Elsewhere I have examined and discussed this and related problems in great detail and proposed reconciling psychiatry with liberty.[6 7]

Human memory is notoriously short and selective. We have forgotten that until recently—even in the United Kingdom and the United States—people could not divorce. In some countries women still cannot divorce their husbands. For a long time the law, supported by religion, ranked the sanctity of marriage more highly than the need to protect the wife from her abusive husband and so prohibited divorce. To make matters worse, the law deprived her of her voice.

The history of the "marriage" between mad people and their doctors shows a similar pattern. Since the beginning of mad doctoring in the 18th century, the law, supported by medicine (psychiatry), has ranked the "health" of mad people more highly than the need to protect them from the abusive psychiatrist and prohibited them from divorcing their psychiatrist. This is still the case. (The psychiatrist is free to leave the patient,

Summary points

Many psychiatric patients are denied the right to refuse treatment they don't want

"Psychiatric wills" are recognised by courts only when patients use them to authorise treatment, not when they use them to reject the possibility of treatment

Like protection orders that protect wives from abusive husbands, "psychiatric protection orders" would protect patients from coercive psychiatric interventions

typically by forcibly "marrying" the patient to another psychiatrist.) And again the law deprived, and still deprives, the victim of his or her voice. Only writers were, and are, willing to face the realities of psychiatry, illustrated for example by James Thurber's miniature masterpiece, *The Unicorn in the Garden*.[8]

Doctors, politicians, and journalists assert that mental illnesses are real diseases and that psychiatrists are regular doctors. If that were true there would be no need for psychiatric protective orders.

Competing interests: None declared.

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3 Menninger, K. Reading notes. *Bull Menninger Clin* 1989;53:350-1.
4 Stewart, P Faretta *v* California, 422 US 806 (1975), p 834.
5 Satel S. For addicts, force is the best medicine. *Wall Street Journal*, 1998 January 7: 6.
6 Szasz T. *Insanity: the idea and its consequences*. New York: Wiley, 1987.
7 Szasz T. *Pharmacracy: medicine and politics in America*. Westport, CT: Praeger/Greenwood, 2001.
8 Thurber J. The unicorn in the garden [1940]. In: *Fables for our time*. New York: Harper & Row, 1968.

Of Struldbruggs, sugar, and gatekeepers: a tale of our times

David Kerr

Socially isolated, depressed old patients most often end up on the diabetes wards after someone notices their blood sugar is low and all other specialists have lost interest

Bournemouth Diabetes and Endocrine Centre, Royal Bournemouth Hospital, Bournemouth BH7 7DW

David Kerr
consultant physician

david.kerr@rbch-tr.swest.nhs.uk

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At the beginning of November Gladys noticed a mild ache in the left side of her chest when she got up to go to the toilet in the middle of the night. The nursing home dialled 999 and she was whisked off to hospital. After six hours of processing in the emergency department, she ended up on the acute admission unit where, despite 72 hours of tests, no cause was found for her pain. Gladys was moved to the cardiology ward but again, despite a further battery of tests (including repeating earlier ones) no one could say for sure what caused her pain. Throughout, Gladys remained befuddled, relatively immobile, occasionally incontinent, and "uncooperative." She didn't like taking the 16 prescribed tablets each morning. The medicine for the elderly team felt that attempting rehabilitation was inappropriate. Due to pressure of beds Gladys was transferred at midnight to an orthopaedic ward, but because of the need to free up the bed for the next day's waiting list initiative patient, she was moved to urology. After three days it was noted that her blood sugar at the time of admission was 15 mmol/l, so the bed manager felt it appropriate that Gladys should be transferred to the diabetic ward, which had two bays closed because of Norwalk virus. At some stage Gladys lost her specs and bottom set of dentures. She will be having turkey on the diabetes ward on Christmas day.

In the diabetes ward

"Old age is not so bad when you consider the alternatives," said Maurice Chevalier. It is difficult to share his optimism after completing a general medical ward round, particularly if you are a doctor with an "interest" in diabetes. Nowadays, it is extremely rare to find a youthful inpatient with a diabetes related problem as, apart from an occasional patient with a foot ulcer, beds on the diabetes ward are most often occupied by Struldbruggs.

In Swift's *Gulliver's Travels*, Gulliver meets the Luggnaggians, among whom lives the immortal race of Struldbruggs. These individuals are destined never to die but continue to suffer the ravages of age and infirmity. Gulliver assumed these people must be particularly wise, given their decades of accumulated wisdom. What he saw was the exact opposite: a most miserable group of socially isolated and depressed ancients suffering from the most awful consequences of extreme senescence.

"They commonly acted like mortals … after which by degrees they grew melancholy and dejected, increasing in both until they came to four score … which is reckoned the extremity of living in this country, they had not only all the follies and infirmities of other old men, but many more which arose from the dreadful prospect of never dying. They were not only opinionative, peevish, covetous, morose, vain, talkative; but incapable of friendship, and dead to all natural affection, which never descended below their grandchildren. Envy and impotent desires, are their prevailing passions … They have no remembrance of anything but what they learned and observed in their youth and middle age, and even that is very imperfect … The least miserable amongst them, appear to be those who turn to dotage, and entirely lose their memories; these meet with more pity and assistance, because they want many bad qualities which abound in the others."[1]

Invariably, in my experience, such individuals are also hyperglycaemic.