

# “Idiots, Infants, and the Insane”: Mental Illness and Legal Incompetence

BY THOMAS SZASZ



In principle, mental patients are considered competent, free to accept or refuse treatment. In practice, they are often treated as if they were incompetent, forced to submit to treatment in their own best interest. This conflation of mental illness and legal incompetence—and the concomitant transformation of the mental patient in the community into the (potential or actual) ward of his psychiatrist—are relatively recent phenomena.

Prior to World War II, only legally incompetent persons were incarcerated in state mental hospitals. In the aftermath of the war, social attitudes toward mental hospitalization began to change. Journalists compared state mental hospitals to Nazi concentration camps and called them “snake pits.” Erving Goffman’s book *Asylums* and my book *The Myth of Mental Illness* challenged the moral and legal legitimacy of psychiatric coercions, epitomized by involuntary confinement in a mental hospital. Presidents of the American Psychiatric Association and editors of psychiatric journals acknowledged the problem of hospitalized mental patients becoming “institutionalized.”

At this critical moment, the psychiatrist’s drugs *ex machina*—like the Roman dramatist’s *dei ex machina*—appeared and saved the profession. Politicians and the public quickly accepted the doctrinaire psychiatric claim that mental illnesses are brain diseases, and that neuroleptic drugs are effective treatments for them. Psychiatrists used the fictions of “chemical imbalance” and “neuroleptic drug treatment” as the pegs on which to hang the complexly motivated program of emptying the state mental hospitals, misleadingly called “deinstitutionalization.” Thus arose the three mutually reinforcing characteristics of modern psychiatry: psychiatric drugs,

deinstitutionalization, and the conflation of mental illness and legal incompetence.

The much-celebrated “deinstitutionalization” of mental patients was a hoax. Some mental hospital inmates were “transinstitutionalized”—rehoused in parapsychiatric facilities, such as group homes and nursing homes. Others were imprisoned for offenses they were prone to commit, transforming jails into the nation’s largest mental hospitals. Still others became “street persons,” living off their Social Security Disability benefits.

Today, more people than ever are being committed to mental hospitals. The powers of courts and mental-health professionals over persons called “mentally ill” have been vastly expanded. Before World War II psychiatrists could forcibly “treat” only persons housed in mental hospitals. Today, armed with “outpatient commitment” laws, they can forcibly “treat” persons living in the community.

Medical practice rests on consent.

Psychiatric practice rests on coercion, actual or potential. It is the duty and power to coerce the mental patient—to protect him from himself and to protect society from the patient—that has always set, and continues to set, psychiatrists apart from other medical practitioners. Nevertheless, the conflation of mental illness and legal incompetence—defined as “protection of the patient’s best interest” or even as “protection of the patient’s right to autonomy”—is widely regarded as an important advance in medical and psychiatric ethics.

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## Obscuring the Distinction Between Mental Illness and Incompetence

In the days of asylum psychiatry, the distinction between mental illness and legal incompetence was unambiguous. If a person was mad enough to merit confinement in a madhouse, then he was manifestly incompetent. Whereas if he was competent, then he was manifestly not a fit subject for incarceration in an insane asylum. To this day, a history of psychiatric commitment remains the most incontrovertible evidence that the subject "has a mental illness."

After World War II psychoanalysis and psychotherapy achieved sudden popularity. A new class of mental patients thus came into being: like medical patients, these persons sought help, paid for the services they received, and were regarded as legally competent. This development greatly enlarged the number of persons classified as mentally ill, contributed to the false belief that legal competence is a psychiatric issue, and confused legal relations between psychiatrist and mental patient. The confusion was compounded by the introduction of neuroleptic drugs into psychiatry and the exchange of doubt about the therapeutic benefits of long-term mental hospitalization with confidence in the therapeutic effectiveness of outpatient chemotherapy for mental illness. The result is that psychiatrists sometimes view mental patients as competent, sometimes as incompetent. Neither party can be certain of the law's expectations of him.

Just as there is no objective test for mental illness, there is none for competence. How, then, do psychiatrists know when a mental patient is competent and when he is not? They never know it. Legal competence is not an attribute; it is an attribution. As a general rule, the patient who behaves properly and cooperates with the psychiatrist is considered competent, and the patient who misbehaves and refuses to cooperate with the psychiatrist is considered incompetent. These novel legal presumptions have novel psychiatric consequences. For example, if the patient kills himself or someone else, then, ex post facto, he is considered incompetent and his psychiatrist's treatment of him is judged to be "medically negligent." Viewed as the patient's guardian, the psy-

chiatrist is considered to have failed to fulfill his "duty to protect" his ward.

We are proud of our criminal-justice system, because it protects the accused from the power of the state—a power we distrust because its avowed aim is to harm the individual. We are also proud of our mental-health system, because it protects the mentally ill person from the dangers he poses to himself and others, a power we trust because its avowed aim is to help the individual.

Ironically, it is precisely because the American system of criminal justice is so intensely concerned with protecting innocent persons from punishment that it is especially vulnerable to corruption by excuses couched in terms of psychiatric disabilities and coercions justified as psychiatric treatments. The root of the problem lies largely in the concepts of mental illness and dangerousness, and partly in the doctrine of *mens rea*.

## On Psychiatric "Reform"

The use of certain psychiatric coercions—such as beatings, cold showers, and mechanical straitjackets—are no longer fashionable. However, changes in mental-health policy have failed to increase the mental patients' responsibility to care for himself and be legally answerable for his criminal conduct. On the contrary, more people than ever are now defined as mental patients and are treated paternalistically, without their consent, as if they were incompetent. Moreover, the practice of commitment, formerly confined to the mental hospital, has metastasized: outpatient commitment has turned all of society into a kind of mental hospital.

We cannot make progress in mental-health-care policy until we agree on what we mean by progress. Psychiatrists and politicians mean making more and better mental-health services available to more and more people. I consider this not progress, but a plan to turn more people into "consumers of mental health services." There can be only one humane goal for mental-health-care policy, namely, reducing and ultimately eliminating the number of persons in the population treated as mentally ill. This goal will remain unattainable as long as we cling to the notion that "mental illness" is a disease that the patient "has." 