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ABSTRACT

Court decisions stressing the rights of mental patients have necessitated a radical revision in the management of behavioral treatment programs. The client's rights to the least intrusive procedures to achieve treatment goals have become important in case law. Factors which identify intrusiveness include: (1) the extent to which the "new mental state is foreign or unnatural" to the patient; (2) the extent to which the effects of therapy are reversible; (3) the rapidity with which effects occur; (4) the duration of change; (5) the extent of bodily invasion; (6) the nature of side effects; and (7) the extent to which an uncooperative patient can avoid the effects of treatment. A prominent attorney has ranked treatments from least to most intrusive: milieu therapy, psychotherapy, drug therapy, behavioral modification, aversion therapy, ECT, brain stimulation, lobotomy, and stereotactic psychosurgery. The psychological treatments of milieu therapy, psychotherapy, behavior modification, and aversion therapy vary widely and cannot reasonably be ranked in such a manner. Psychologists must be prepared to answer questions about their therapies, to enlighten legal professionals about the distinctions among therapies, and to encourage the courts to specify particular therapy procedures for involuntary clients. (Author/NRB)

# LEGAL VS. PSYCHOLOGICAL ASPECTS OF INTRUSIVENESS

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Legal vs. Psychological Aspects of Intrusiveness

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For the first half of this century, mental health professionals--psychiatrists in particular--went unchallenged in their ability to make wise and informed decisions about the lives of institutionalized patients. The late 1960's and early 70's saw this state of affairs reversed by court interventions which have come to be known as court decisions on patients' rights. Two landmark cases, Donaldson v. O'Connor[1] and Wyatt v. Stickney[2] granting freedom and/or the right to treatment, have received publicity and acclaim as much needed reforms in this country's mental health process. While few psychologists would object to a shift from psychiatric dominance and omnipotence in the field of mental health to policies supportive of the mental patient, I wonder whether they would feel any more comfortable allowing the judges of the U.S. to decide the fate of mental patients if they were aware of the bases on which such decisions are made.

The court seems to rely on three main sources of data--the expert witness, the amicus curae (friend of the court) brief, and commentaries in law reviews. In the situation where the expert witness is called, we have only to look at the biased nature of any expert witness (Morse, 1978) and the inferior status of data-based psychologists relative to their tradition-based colleagues, the psychiatrists (Schwitzgebel & Schwitzgebel, 1980) to sound the first alarm. A second alarm is sounded when one realizes that the

American Psychiatric Association and the American Medical Association are far more active and experienced politically than the American Psychological Association regarding involvement in the preparation of briefs. Last, but not least, are the law review commentaries. Informal perusal of discussions in law reviews on mental health and criminal justice topics suggests that judicial decisions often reflect issues and opinions raised in law reviews prior to the court hearing. For example, the decision to extend due process rights to juveniles (in re Gault[3]) followed the discussion of this topic in law reviews over a series of years (Faust and Brantingham, 1979). Even the legislature can be influenced by a timely law review article (Pizzulli, 1980). While it is comforting to note that the judiciary is well read, it is also discomforting to realize that commentaries on psychological issues are screened by legal editors (usually advanced law students), not by psychological referees. Furthermore, few psychologists consider the law reviews as avenues for publication (Tanke and Tanke, 1979).

Let us examine one of the newly emerging patients' rights and look at the information available to the court for decision-making. The right in question is the right to the least intrusive treatment necessary to achieve the goals of incarceration (Kaimowitz v. Michigan Dept. of Mental Health[4]). Mental health still functions largely from a medical model perspective (Chu and Trotter, 1974; Snow and Newton, 1976; Szasz, 1974) so it should come as no surprise that intrusiveness is often discussed in the

context of medical invasion of the body. Such a definition may be appropriate when the treatment procedures are medically oriented as is the case with drugs, lobotomy and ECT. However, the bulk of mental health treatments are not medical and it is these non-medical treatments which will be discussed here.

First, let us look more closely at the definition of intrusiveness. Several authors (Friedman, 1975; Shapiro, 1974; Spece, 1972) have attempted to spell out criteria for intrusiveness and there seems to be considerable overlap among the authors. An integration of these views would provide a list which includes:

a) the extent to which the "new mental state is foreign or unnatural" to the person in question,

b) the extent to which the effects of the therapy are reversible,

c) duration of change,

d) the rapidity with which the effects occur,

e) the extent of bodily invasion,

f) the nature of side effects,

g) the extent to which an "uncooperative" patient can avoid the effects of the treatment.

Spece (1972) goes a step further and attempts to classify mental health treatments along a continuum from least to most intrusive resulting in the following listing: milieu therapy, psychotherapy, drug therapy, behavior modification, aversion therapy, ECT, brain stimulation, lobotomy, and stereotactic psychosurgery. Such a ranking suggests that, as case law

develops, behavioral approaches could only be used after psychotherapy had been tried and failed. Though the originator of the ranking and others (Friedman, 1975; Shapiro, 1974) have warned that any ranking is subjective and dependent upon theoretical disposition, the classification is nevertheless widely quoted, and even implemented.

I would now like to focus on the psychological treatments of psychotherapy, behavior modification, and aversion therapy and argue that they cannot be easily ranked in the illustrated manner. The first and most important difficulty is the lumping together of many treatments under a single heading. There are hundreds of psychotherapies and they are often as distinct from each other as they are from behavior modification. The same is true of the many procedures used by behavior therapists. To illustrate, the approaches of Carl Rogers, Fritz Perls (Gestalt Therapy) and Arthur Janov (Primal Therapy) are generally classified as psychotherapies, yet few would consider them equivalent. Likewise, the behavioral techniques of systematic desensitization and implosive therapy differ markedly in implementation and general acceptance by the community of mental health professionals. Neither psychotherapy nor behavior modification are terms with agreed-upon definitions. Almost any text in the clinical area gives them a specialized definition. It would appear that the more informed one is about the various therapies, the less likely one would be to readily accept broad classifications.

a) The extent to which the new mental state is "foreign or

unnatural" to the person in question seems to refer to the breadth of change and to the novelty of the change. As psychoanalysis and other dynamic therapies aim for complete renovation of the person, they hardly seem less intrusive in the breadth of their goals than behavioral approaches. In fact, systematic desensitization and aversive conditioning often aim at a specific target problem, and are criticized by the dynamic therapists for treating only the symptom, not the whole person. Regarding the novelty of the changes, the behaviorally-oriented therapies may earn points for intrusiveness. For a homosexual of long standing to find himself repelled by the sight of another male after a series of aversive shocks seems like a drastic shift. However, it is interesting to note that such changes seem to be the least effective of the behaviorists' treatments (Bernstein and Nietzel, 1980).

b) The extent to which the effects of the therapy are reversible seems to be a characteristic most applicable to medical procedures like the lobotomy. None of the psychotherapies or behavior therapies have chalked up much success producing non-reversible changes, and behavioral treatments for habit disturbances like smoking and excessive drinking have particularly poor records. On irreversibility of effects, none of the psychological methods rank high on intrusiveness. It's interesting that drug therapy is ranked as less intrusive than behavioral approaches, and yet on the category of reversibility of effects, its effects may be long lasting even after the medication is discontinued.

c) The duration of change again places the psychological

approaches in a heap at the bottom of the pile on the criteria of intrusiveness. The ultimate follow-up--the 30 year follow-up (McCord, 1978) of the Cambridge-Summerville Youth Study--shows the same pattern as is found in most typical six months or one year follow-ups of psychotherapy--i.e., no lasting change. Likewise, token-economies are widely criticized, even by their proponents (Bellack and Hersen, 1977; Rimm and Masters, 1979) as losing their effectiveness as soon as the patients leave the program.

d) Only the characteristic of the rapidity with which the effects occur, seems to point uniquely to behavior therapy and aversive conditioning as more intrusive than psychotherapy. Countless studies document the speed with which behavioral approaches can work. However, psychoanalysis and its average three to five years duration, need not be the "psychotherapy" chosen for comparison. Primal Therapy promises change within a two week span, and Crisis Intervention is widely noted as a six week procedure.

e) The extent of bodily invasion (another characteristic more medical than psychological) conjures up visions of A Clockwork Orange where the protagonist is strapped to his chair and shocked --the supposed analogy to aversive conditioning. But what about Rolfing, Bioenergetics, and the Gestalt focus on body awareness. Again, "psychotherapies" can be directed at body change, so the categorizations do not fall clearly into place.

f) The nature of the side effects (still another medical analogy) would seem to pinpoint therapies using punishment as

intrusive. Clearly operant therapists have discussed the negative consequences of punishment (Bellack and Hersen, 1977). But other psychologists concern themselves with the psychological casualties of encounter groups (Hartley, Roback and Abramowitz, 1976). Again a behavioral approach is not the sole offender.

g) Finally, the extent to which an "uncooperative" patient can avoid the effects of treatment again brings to mind A Clockwork Orange and would make aversive conditioning the clear loser in this category. But wait--Is it not easier to resist a therapy which is made explicit and described honestly than one in which the therapist claims to be nondirective, but may not be? An interesting recent study (Woolfolk, Woolfolk, and Wilson, 1977) presented an identical behavior change approach described in either humanistic or behavioral terminology. Though the procedure was identical, the words of the humanists effectively convinced an audience that the approach was benign. It is the purpose of this paper to caution against falling into such a misleading trap. Each therapy procedure should be analyzed for intrusiveness on the basis of what actually transpires, not on the basis of flowery theory or a popular stereotype.

In conclusion I would like to suggest that advocates of any therapy system which might be challenged as "intrusive" do their homework and be able to present research to answer questions raised by the intrusiveness issues. For example, Friedman (1975) suggests that those involved in behavior modification should: state the short and long term effects of their treatment, discuss

the extent of intrusiveness upon personal autonomy, note any harms and the probability of harms, describe how experimental a given procedure may be, and note how the procedure compares with other approaches.

Furthermore, psychologists should make more effort to enlighten those in the legal profession about the distinctions (as well as the similarities) among therapies. Behavior modification has a bad press, and obtaining a law degree does not make one less susceptible to the conclusions of the news media. Numerous law articles confuse behavior modification with organic therapies, like psychosurgery, and those which do not typically clarify the misconception in an esoteric discussion in a footnote. Similarly the public impression that all therapy resembles psychoanalysis causes much confusion among consumers.

Finally, psychologists should encourage the courts (or legislators) to specify particular therapy procedures to be used with involuntary clients. Then they should help familiarize the court with the research findings already available on a large number of therapies, thus seeking to avoid overgeneralization on the basis of broad category names. I shudder to think that Primal Scream therapy might be considered preferable (less intrusive) to behavioral modelling in a given case, simply because one is called psychotherapy and the other behavior modification. The interdisciplinary dissemination of research results should clarify immensely the problem of defining the "intrusiveness" of a therapy.

Footnotes

[1]Donaldson v. O'Connor, 493 F. 2d 507, (5th Cir. 1974)

[2]Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972)

[3]In re Gault, 387 U.S. 1, 87 S. Ct. 1428 (1967)

[4]Kaimowitz v. Michigan Dept. of Mental Health, 42 U.S.L.W. 2063 (Mich. Cir. Ct., Wayne Ct., 1973)

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