The Use of Legal Rhetoric in a Clinical Setting: Advocating the Advocates

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The continuing intervention by courts and legislatures in the decisions traditionally reserved to psychiatry is generally perceived by mental health professionals as a threat to their practice. As jurists insist upon supervising therapists' decisions to medicate,[1] to hospitalize patients,[2] and, indeed, to discharge them,[3] clinicians, as might reasonably be expected, retreat into a "siege mentality"[4] as their expertise is called into question: Commentators remark that "legal developments . . . presage a depressing future for psychiatry";[5] and the law is portrayed as hindering effective patient care, rather than as protecting the rights of the neglected and underprivileged.

In view of the uncomfortable liaison between law and psychiatry, it would seem odd indeed were practitioners to be assisting the efforts of those whom they see as the intruders while, at the same time, complaining of that intrusion. Yet this very phenomenon may be occurring. Ironically, clinicians are unwittingly encouraging the expansion of legal influence by adopting legal rhetoric in the treatment setting. Legal rhetoric appears more frequently in the daily dialogue between therapists and the severely disturbed patient. In that dialogue, it promotes antagonism between the treatment team and the patient and among members of the team themselves. The psychiatric community believes that the lawyers have introduced this antagonism. Yet therapists' own use of legal rhetoric in the context of psychiatric treatment may, paradoxically, lead to advocacy of the advocates and away from the invaluable task of further developing psychiatric expertise and defining more closely the parameters of decent care for the severely disturbed.

Case Examples

These case examples may prove to be illustrative.

Case 1 N. is a 26-year-old single male patient at a state-sponsored center providing intensive day treatment for those suffering from various schizophrenic disorders. His treatment includes individual psychotherapy, extensive milieu and group activities, family treatment, and medication. After several months of treatment, it became known that N. made it his regular practice to visit several nonaffiliated emergency services in the area where

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he would receive prescriptions for numerous psychotropic agents and antiparkinsonian drugs. His half-way house, moreover, reported that N. had been abusing alcohol. The center, having attained the agreement of the catchment area state hospital, drew up a plan wherein N. would be admitted to that hospital's special treatment unit for detoxification and would make a gradual transition back into full-time day treatment. N. himself acquiesced in the plan. On a Friday, one week after hospitalization, he submitted a three-day notice, announcing his intention to leave the unit. The state hospital was permitted by statute to detain him on the unit until the following Tuesday.[6] Nonetheless, N. was immediately discharged. On Sunday, he overdosed and was hospitalized on the psychiatric unit of a general hospital, returning to day treatment one week later. A "patient at risk" committee of the Community Mental Health Center investigated the incident. The state hospital staff justified their decision to discharge N. when they did, on the sole ground that they were unwilling to "interfere with his civil liberties."

Case 2 B., a 38-year-old woman, was also receiving intensive treatment at the day center for a schizophrenic illness. B. had been referred to the center by her psychotherapist who worked at a neighborhood clinic, affiliated with the day center and part of the same Community Mental Health Center. B.'s therapist had expressed the wish to continue seeing B. in individual psychotherapy while other treatment modalities were provided by the day center. Thus, B. participated in the center's group program and received her medication there, while she saw her psychotherapist for 15 minutes every two weeks. Day center staff voiced concern over B.'s persistent withdrawal and reticence. Because B. was foreign-born, the staff considered the possibility of a language barrier or culture gap. B.'s family refused to participate in the treatment program.

About one year after admission, B. precipitously announced that she was going away on vacation for a week. When she failed to return on schedule, the staff phoned her family who said that B. was still away. In the meantime, B.'s psychotherapist, who had been contacted by staff about an unrelated matter, admitted knowing a "secret" which she felt she might convey to the center staff at this point, namely, that B. had not gone on vacation but had terminated treatment and taken a job at a local department store. When challenged by the day center staff, the therapist argued that she had to keep the secret for as long as she had, in order to "advocate for" B. and her family; the therapist and B. had feared that the center would try to dissuade B. from pursuing employment. Sadly, B. was unable to maintain the job. She applied for readmission to the day program two and one-half weeks after her departure.

The Failure of Clinical Understanding In both of these cases, the use of legal rhetoric signaled the failure of clinical understanding: The concepts of "liberties" and "advocacy"—once raised—seemed to assume lives of their own, dictating outcomes not in keeping with a common sense appraisal of the instant, clinical pictures. In Case 1, the state hospital staff had the legal right, pursuant to applicable statute, to keep N. on the unit for at least three days, in which time they might have thoroughly evaluated his potential for suicide. Furthermore, within the statutorily allowed period, they could have conferred with the day center staff who probably had a considerably broader knowledge of the patient. They might, as a matter of initial import, have utilized the time to explore with N. the reasons behind his sudden wish to leave; N. might have been persuaded to change his mind. The staff, in any case, was not confronted with a draconian choice between discharging N. on the spot and immediate resort to formal commitment procedures.[7] However, the staff, in Case 1, failed to see the extant law as supporting their right, if not their duty, to exercise a deliberate and reasoned clinical judgment.

Similarly, in Case 2, routine clinical judgment would have mandated that B.'s psychotherapist not rely on her minimal contact (fifteen minutes every two weeks) with B. in order to determine the relevant interests to be "advocated." Treatment of the severely ill usually requires the participation of a multidisciplinary team, whose collaboration and collective judgment yield optimal results.[8] Had the therapist not been distracted by her own ideas of the law, she might have inquired into the psychodynamic constellation at play in B.'s "fear" that the extended treatment team would "discourage" her, a fear possibly shared by B.'s family who refused treatment. Collaborative discourse might have clarified the nature of B.'s reticence as well as that of the family's apparent resistance to treatment. Nevertheless, the therapist, I believe, wrongly concluded, albeit in good faith, that her silence was legally, if not clinically, indicated.

In both of these examples, experienced clinicians were somehow misled through legalistic notions into pursuing courses of action that contravened the most basic clinical considerations. Perhaps the phrase "course of action" warrants emphasis in that, in these two cases, legalistic notions furnished the impetus for *action* rather than discussion. One would typically expect the veteran clinician to choose talk above action; but in these examples, the exception seems to have become the rule.[9]

Because of the increasing significance of the law to the practice of psychiatry, the question of how the law is being received in daily practice must be addressed. It is my hypothesis that in the daily practice of psychiatry, clinicians misperceive the law, recreate it based on their misperceptions, and conjure up "legalisms" for disturbing reasons.

Why the Failure? The clinical decisions in these cases, I maintain, represent failures in clinical understanding concealed behind the language of the law. The clinicians described violated the most elementary among therapeutic principles; they seemingly forgot the concepts of ambivalence and acting out, *inter alia*, concepts most certainly inculcated in them at an early stage of their training. Rather than turning toward these concepts, they reached for the less familiar idioms of "civil liberties" and "advocacy" in entering into commonplace, clinical interactions.

One possible explanation for their abandonment of the familiar for the foreign is that clinicians do not understand the law; that they are, therefore, intimidated by it and thus try to elude it by anticipating any conceivable legal difficulty which could arise, even if such anticipation entails the abandonment of zealously guarded clinical tenets. Not only may clinicians attempt to avoid the concrete possibilities of litigation but they may, on a broader scale, try to second-guess courts and regulators. In Case 1, perhaps the staff immediately discharged N. for fear that, absent a clear demonstration of his suicidal potential, N. might have cause to sue the hospital if they chose to detain him. Perhaps this was an instance in which a little knowledge of the law was misleading. Staff members who have done some reading in the law might imagine N.'s bringing an action on a theory of deprivation of liberty, cruel and unusual punishment, maybe even lack of procedural due process. But it is less likely that staff, having gone this far, would know quite enough about the law to console themselves with the thought that, absent "bad faith," they are unlikely to be held liable in any event for exercising reasonable clinical judgment.[10] Thus, arguably, a modicum of legal information could frighten staff into going against their best clinical judgment.

Their concern might be moderately compelling were it not for two factors which it fails to embrace. First, N., in Case 1, gave no hint that his wish to leave the detoxification unit was founded on any concern for his civil liberties. He simply stated that he wished to leave; his motivation to leave was never revealed. The staff proferred the language of "liberties"—not the patient. In short, there was no realistic basis here on which the staff could conclude that N. was predisposed either to view his situation in terms of a loss of liberty or to seek legal assistance were his request to leave denied.

Of course, the fear of litigation need not be grounded in reality. But it is highly doubtful that an experienced staff of a state hospital would be ignorant of the extent of and limits on its power.[11] N. could hardly have been the first patient to have presented this particular clinical dilemma. The staff, on numerous occasions, had both held patients like N. (although perhaps patients more overtly at risk) beyond the statutory period as well as gone on to petition the court for commitment. Yet, in N.'s case, *they*

asserted *his* civil liberties as standing in their way of being able to effectuate the agreed upon treatment plan.

An "ignorance of the law" theory might be more applicable in Case 2. The therapist who decided to withhold a significant, clinical datum from B.'s treatment team may have been moved by considerations of patient confidentiality or B.'s right to privacy. Certainly, these are areas of the law which plead for definition, especially in the context of the public mental health system.[12] Generally, "[i]t is not considered a breach of confidentiality to disclose information to those who are assisting the primary caregiver's efforts. This includes supervisors, members of a hospital's milieu staff, and colleagues who are involved directly in the patient's treatment".[13] But statutory provisions might be unclear and the concepts of privilege, confidentiality, and right to privacy difficult to distinguish. B.'s therapist may have preferred to err in the direction of confidentiality rather than risk a lawsuit.

And also, in Case 2, the clinical picture offers a slightly more substantial basis for the therapist's fear of the possibility of litigation. Although there was no mention of litigation, the clinical picture could be read to imply that there was already disagreement between B.'s family and the day treatment center. It is possible that B.'s silence at the day center concealed a measure of hostility toward day care personnel. After all, B. and her family chose to inform only the psychotherapist of their plan for B. Taken at face value, these several observations and inferences could justify a therapist's being more than ordinarily mindful of legal guidelines.

Again, however, this explanation is unsatisfactory on two grounds. First, B's psychotherapist had participated fully in at least two treatment conferences with the extended treatment team, in which she had reasonably shared "confidences" regarding B.'s psychotherapy. The ignorance of the law theory—to be truly satisfactory—would have to include some explanation of the therapist's sudden crisis of legal conscience at that particular juncture in the treatment and about that particular treatment issue. Such explanation is not apparent.

Second, B's therapist did not articulate concerns of "confidentiality" as responsible for her decision to keep silent. While one might, as a matter of hindsight, read such concerns into the clinical picture, the therapist specifically stated that she saw her role as that of B.'s advocate. She believed that she was advocating for B. by guarding B.'s secret.

The conclusion to which one is led is that fear and ignorance of the law, in themselves, cannot account for the clinicians' use of legal rhetoric in the absence of some realistic threat of litigation. In neither case example did the patient raise the specter of the law; in both examples, it was the treaters who first introduced legal concerns as referents in the clinical dialogue.[14]

The inescapable implication is that these clinicians, for reasons entirely of their own and for benefits which would inure only to them, donned the clothing of the legal wolf.

So the inquiry devolves, in the end, to an examination of those benefits which the clinician may stand to attain through the use of legal rhetoric. In standing back from the case examples for a moment and regarding them only with a view toward the result achieved in each instance, a curious similarity between them emerges. In Case 1, the clinician's use of legal rhetoric resulted in N.'s discharge from the hospital. In Case 2, the result was an interruption in B.'s treatment. In both cases legal rhetoric was used to distance the treaters from the treated. In neither case did the law actually require withdrawal of treatment.

That legal rhetoric should be used to end treatment rather than promote it should hardly be surprising: "The awesomeness of [schizophrenia] causes us to distance ourselves from those who manifest it."[15] The simple fact of being a clinician does not immunize against the urge to "avoid[ ] the extreme aberrations of schizophrenic behavior."[16] The use of "legalisms" as a defense against "the well-known psychic strains of empathic engagement with the mentally ill" has received trenchant comment.[17] Thus, for example, the "inappropriate failure to petition" for commitment, as demonstrated in Case 1, may derive not only "from wishes to be rid of the troublesome patient but may derive as well from defensive denial of the seriousness, dangerousness or lethality of the patient's clinical state."[18] From a more cynical perspective, in the specific contexts of the overcrowded, underfunded state hospital and the neighborhood clinic where therapists struggle to keep up with burgeoning caseloads, legalisms may furnish no more than ready excuses for reducing patient census and, consequently, the clinicans' workload. In other words, if there is no good clinical justification for discharging a patient, maybe a legal one will do.[19]

But why a *legal* excuse, rather than an ethical excuse, a philosophical excuse or a therapeutic excuse? Where is the power which, even in its absence, the law exerts on clinicians such that the talk of liberties and advocacy permeates the therapeutic dialectic? The answer is to be found not in the reality of contemporary jurisprudence, but rather in its symbolic value. For those who labor outside the legal arena proper, the law may be perceived as a source of certainty, solidity, and finality and the rhetoric of liberties and advocacy comes to represent the decisiveness of those in power. One performs certain acts and refrains from others because "that is the law" and, despite instances in which one may entertain doubts about the law's being quite what it is, it continues to exert an almost mystical appeal as the final arbiter of human affairs.

The dissonance between legal and psychiatric modes of reasoning has been commented upon.[20] Yet the dissonance, I believe, does not necessarily imply that psychiatric practitioners are, as a result, immune to fascination with the law as the emblem of certainty. One might expect, moreover, that the symbolic influence of the law on clinicians will be strongest in those specific clinical areas wherein clinicians feel themselves least secure; that clinicians may be most prone to reaching to legal concepts as providing "the answers" in situations in which psychiatric science has foundered. It may well be, in other words, that clinicians succumb to legal influence not simply because of ambivalence,[21] but because of the limitations on their own expertise. Clinicians may be trying not simply to rid themselves of troublesome patients, but to find answers in situations where they are at a loss as to what to do.

And where is one most apt to encounter such situations? They are to be found in the state hospitals and community clinics, where clinicians are daily admitting chronic patients who are likely to have already exhausted the gamut of available therapies[22]—chronic patients for whom advances in psychopharmacology may mildly ameliorate symptoms but do not effect a cure. Clinicians are being called upon by patients, families, referring agencies, and the courts to "do something"—to "take care of" a burgeoning population for whose ills there are no simple solutions. Thus, the care of the chronic patient is precisely the area in which clinical certainty is lacking; for after the patient has uhdergone trials of antipsychotic medications, antidepressants, antianxiety agents, lithium carbonate, behavioral therapies, vocational counseling, and the like, the question of what to do next insistently presses for an answer.[23] In Case 1, the state hospital staff likely knew very well how to talk with N. to persuade him to withdraw his three-day notice. B.'s psychotherapist, in Case 2, likely knew as well how to draw on the support of the treatment team to convince B. to continue her program. But by choosing not to use routine, therapeutic skills to maintain the therapeutic relationship, these clinicians managed to escape their own sense of hopelessness about the future of two severely disturbed patients. At the heart of the treatment of the chronic psychosis lies a void that has yet to be filled with concrete guidelines for a demonstrably meaningful dialogue between patient and therapist.[24]

To fill that void, then, the therapist borrows from that perceived source of certainty, the law. The language of liberties and advocacy, with its aura of finality, is used to answer the unanswerable. Notwithstanding the inappropriateness of such language to the clinical occasion, the clinician, in a search for definition, stretches the meaning of the law in applying it to the situation before him in order to, at least, do something. This distortion of

the law, in turn, makes the clinician appear naive in the eyes of the lawyers. Furthermore, the clinician fails to recognize those instances in which the law in actuality protects his decision-making power.[25]

Appreciating this argument in its most exaggerated form may serve to highlight the dangers inherent in imitating the lawyers. The dangers which clinicians face in so doing are three: the danger of relying on the law to furnish solutions to *clinical* problems (borrowing the "emperor's clothes"); the danger of importing an adversarial language into the therapeutic sphere; and the danger of furthering the intrusion of the law into territory where it does not belong and where its presence is lamented.

The Emperor's Clothes To the outsider, the law may represent all that is certain, but those inside the law are all too familiar with the insecurity of the law. The legal realist movement[26] and its successor, the critical legal studies movement, have come to recognize the essential indeterminacy of every legal debate.[27] The grand scheme of 19th century law has failed; legal categorization has collapsed[28] and contemporary scholars acknowledge that the law is molded to reflect the wishes of the powerful and to reproduce extant hierarchies.[29] Thus, not only are legal principles fluid but they also serve as a method of manipulation. Radical commentators portray the "science of law," propounded by Christopher Columbus Langdell, as a tool with which classism, racism, and sexism have been perpetuated, while deceiving those oppressed into believing that justice is being served.[30] Even the most moderate among jurists have noted the void at the heart of the law, where conflict remains as conflict and where overarching principles are unavailable to provide the much desired sense of finality and repose.[31]

Thus, those who seek answers in the provinces of the law for the problems of the chronic patient are bound to be disappointed. The task of developing a meaningful dialogue with patients who have been left behind by clinical science cannot be passed on to lawyers, themselves coping with the vagueness at the heart of the law. Legal certainty is a facade, and, moreover, lawyers whose practice bears on mental health must deal with the twin uncertainties of law and psychiatry. They confront the same concerns as clinicians face in their work with the severely disturbed: how to define irrationality and how, once the boundary is delineated, to bridge the gap between madness and sanity.

Importing the Adversarial Stance into the Clinical Arena Not only are the answers to these problems not to be found in the law, but the very use of legal rhetoric in an attempt to find those answers introduces a noxious, foreign element into clinical dialogue. Notions of advocacy with their implications of a "zero-sum game"[32] are at odds with the basic premises of the therapeutic encounter. For the clinician to call herself an advocate, in the legal sense, of her patient is to place herself in a position of antagonism

vis-à-vis her fellow clinicians. In a clinical situation which demands a collaborative effort—again, most typically, in the case of the severely disturbed—the use of such language is susceptible to being interpreted as an insinuation that the "clinician/advocate" is the only individual on the team who is taking it upon herself to support the patient's best interests, in the face of *opposition* from other team members. It would hardly be surprising, therefore, were legal rhetoric, however innocently used, to increase friction among those who should be working together in the interest of the patient.

Similarly, the invocation of the language of liberties implies a struggle between therapist and patient. It is not a foregone conclusion, e.g., that a patient like N. who submits a three-day notice really means to gain his release from the hospital.[33] The act of submitting the notice may be an invitation to the staff to enter into a dialogue with the patient about the significance of the hospitalization, its goals, and anticipated duration or it may be merely an attempt by the patient to express some disappointment in the direction that his hospital stay has taken up to that point. When the treatment team responds with talk of civil liberties, staff members are declining the invitation to enter into a dialogue of clarification. Instead, they are squaring up to the patient, countering his inarticulate invitation to engage in a dialogue with their own offer to engage in confrontation. The original meaning of the three-day notice is lost in the ensuing exchange. In this way, legalisms take the place of therapeutic colloquy and clinicians lose an opportunity to enlarge upon our understanding of psychotic phenomena.

Welcoming the Invader The incorporation of legal rhetoric—however it may be altered from its original, contextual meaning—into the clinical setting seems to signal psychiatry's acknowledgment of defeat. Psychiatry is giving in to the perceived aggressor and adopting its language in the process.[34] The true danger lies not so much in psychiatry's cloaking itself in the language of the law as it does in the fact that this exercise diverts energy away from the far more important task of developing a language from within the psychiatric community—a language with which to contend with the needs of the chronic patient population. Absent such a language, the psychiatric community may be preserving a vacuum which the law will seek to fill.[35] Psychiatry's mimicry of the law is a temporizing measure. It forestalls the inevitable encounter with the problem of the unremittingly psychotic patient.

The act of mimicry will bring no rewards. Unsolved problems of the chronic patient cannot be solved, but only masked, by borrowed legal rhetoric. I suggest that, in lieu of borrowing from the troubled purview of the law, helping professionals once again undertake the painful work of introspection. Provocative suggestions for new visions have been made.[36]

Alternative approaches to the psychotherapy of psychosis merit consideration after years of neglect.[37] Until a new and relevant language is forthcoming, those who purport to advocate for the patient may, in fact, be advocating the advocates.

References

1. *Rogers v. Commissioner of the Department of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983)
2. *O'Connor v. Donaldson*, 422 U.S. 563 (1975)
3. *Durflinger v. Artiles*, 234 Kan. 484, 673 P.2d 86 (1983)
4. Talbott JA: *Viewpoint: what on earth can be done to save us from all this trouble?* Psychiatr News, Sept. 21, 1984, at 2, Col. 1
5. *Id*
6. See Mass. Ann. Laws ch. 123, § 11 (Michie/Law Co-op. 1981)
7. The statutory scheme takes into account precisely the situation wherein a psychiatric staff is not fully comfortable with the premature discharge of a voluntarily admitted patient whose safety is in question. Mass. Ann. Laws ch. 123, § 11 (Michie/Law Co-op. 1981) provides, in relevant part: "Where persons or their parents or guardians are required to give three days notice of intention to leave or withdraw, an examination of such persons may be conducted to determine their clinical progress, their suitability for discharge and to investigate other aspects of their case . . . . Such person may be retained at the facility beyond the expiration of the three-day notice period if, prior to the expiration of the said three-day notice period, the superintendent files with the district court a petition for the commitment of such person at the said facility."
8. Bachrach LL: *Asylum and chronically ill psychiatric patients*. Am J Psychiatry 141:975, 1984
9. "Action as Defense. In common with other aspects of care, the procedures of the law provide the trainee with opportunity to discharge anxiety through such activity as consulting lawyers, forensic psychiatrists, court clerks, legal officers, and so on. Such consultations may, of course, represent valid and necessary researches as well as symptomatic acts." Gutheil, *Legal defense as ego defense: a special form of resistance to the therapeutic process*. Psychiatr Q 51:251, 255, 1979. Dr. Gutheil's penetrating observations of the "excesses of legalistic zeal" in psychiatric trainees are further commented on in this paper. See *infra* text accompanying notes 17-19
10. *Rogers v. Okin*, 478 F. Supp. 1342, 1380–1383 (D. Mass. 1979)
11. Gutheil TG, Magraw R: Ambivalence, alliance, and advocacy: misunderstood dualities in psychiatry and law. Bull Am Acad Psychiatry Law 12:51, 55, 1984
12. Miller RD: Confidentiality or communication in the treatment of the mentally ill. Bull Am Acad Psychiatry Law 9:54, 1981
13. Gutheil T, Appelbaum P: Clinical Handbook of Psychiatry and the Law 9, 1982. See also Slovenko R: Psychiatry and Law 437, 1973. ("[I]t is only the promiscuous nontestimonial disclosure of information which leads to liability.")
14. These examples are to be distinguished from the case where the patient's lawyer is actually present on the ward, engaged in a confrontation with an ambivalent clinician. See Gutheil and Magraw, *supra* note 11, at 56. In the latter case, it is easy to see how the clinician could feel overwhelmed by the attorney. But in the case examples discussed in this paper, the struggle appears to lie totally within the mind of the treating clinician.
15. Day M, Semrad EV: Schizophrenic reactions, in Harvard Guide to Modern Psychiatry. Edited by Nicholi A Jr. Cambridge, MA, Harvard University Press, 1978, p. 199
16. *Id* See also Minow and Kraft, Deinstitutionalization: professional prescriptions and ideologies, paper presented at the conference on Chronic Mental Patients in the Community, Harvard University Division on Health Policy, Stanford University Department of Psychiatry, December 3, 1982 (unpublished manuscript) (lawyers and psychiatrists alike develop forms of rhetoric which, in order to avoid "professional pain," serve to distance the professional from the patient)
17. Gutheil TG, *supra* note 9, at 252
18. *Id* at 253
19. Gutheil also remarks that "[i]n certain situations relating to gathering important data about a new patient (from other agencies or institutions, relatives, outside physicians and so on), the issue of confidentiality may be inappropriately invoked quite simply to avoid doing this work which, though necessary, is often tedious and time-consuming." *Id* at 252
20. Gutheil TG, Magraw R, *supra* note 11. See also Gutheil and Mills: Legal conceptualizations, legal fictions, and the manipulation of reality: conflict between models of decision making in psychiatry and law. Bull Am Acad Psychiatry Law 10:17, 1982 (law and psychiatry operate through differing models of reasoning)
21. Gutheil TG, Magraw R, *supra* note 11, at 56

22. Bachrach LL: Young adult chronic patients: an analytical review of the literature. Hosp Community Psychiatry 33:189, 1982
23. "[I]t is clear that the biological and behavorial approaches to psychiatry, though promising, have not yet solved all the problems of either serious mental disorders or less severe disturbances." Stone, The new paradox of psychiatric malpractice. New Engl J Med 311:1384, 1385, 1984
24. Bellak The schizophrenic syndrome: what the clinician can do until the scientist comes, in Disorders of the Schizophrenic Syndrome. New York, Basic Books, 1979, p. 585
25. See *supra* note 7
26. Mensch E: The history of mainstream legal thought, in The Politics of Law. Edited by Kairys D. New York, Pantheon 1982, pp. 26–29
27. See generally Dalton, Book Review, Harv. Women's L.J. 6:229 (1983) (reviewing the Politics of Law (D. Kairys, ed., 1982))
28. Gilmore, G: The Death of Contract, Columbus, OH, Ohio State University Press, 1974
29. Rabinowitz V: The radical tradition in the law, in The Politics of Law. Edited by Kairys D. New York, Pantheon 1982, p. 310
30. "In a broader sense, the ideological role of concepts like legal reasoning is but one aspect of a larger social phenomenon. In many areas of our lives, essentially social and political judgments gain legitimacy from notions of expertise and analysis that falsely purport to be objective, neutral, and quasi-scientific. . . . If religion is the opiate of the masses, it seems that objectivity, expertise, and science have become the tranquilizers." Kairys, *Legal Reasoning*, in The Politics of Law 11, 17 (D. Kairys ed. 1982).
31. "The true grounds of decision are considerations of policy and of social advantage, and it is vain to suppose that solutions can be attained merely by logic and the general propositions of law which nobody disputes. Propositions as to public policy rarely are unanimously accepted, and still more rarely, if ever, are capable of unanswered proof." *Vegelahn v. Guntner*, 167 Mass. 92, 106, 44 N.E. 1077, 1080, 1896 (Holmes J, dissenting)
32. Gutheil TG, Magraw R, *supra* note 11, at 57
33. *Id* at 52–53
34. Ironically, at the same time, the law seems to be embroiled in a struggle to limit psychiatric intrusions by reforming the insanity defense, for instance. See Insanity Defense Overhaul Moves Ahead. American Bar Association Journal, Feb. 1984, at 25
35. Kraft P: The right to refuse psychiatric treatment: professional self esteem and hopelessness, in Psychology, Psychiatry and Criminal Law: A Clinical and Forensic Handbook. Edited by Ewing C. In press
36. Unger RM: A program for late twentieth-century psychiatry. Am J Psychiatry 139:155, 1982
37. Federn P: Ego Psychology and the Psychoses, London, H. Karnak, 1977