

HOSPITALIZED PATIENTS AND THE RIGHT TO SEXUAL INTERACTION: BEYOND THE LAST FRONTIER?

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INTRODUCTION

We are obsessed with sex. Questions of sexual morality, often couched in phrases such as "family values," dominate national elections; a judicial candidate's position on reproductive rights and autonomy overwhelms all other issues as a litmus test for approval (or disapproval, depending on the voter's perspective); the President's decision to rescind an executive order barring gay persons from serving in the military spawns a firestorm of controversy. We appear eager to discuss any sort of sexual behavior, whether or not we personally practice it, and our endless speculation about the sex lives of public and political figures has become a national—perhaps the national—hobby.

Television inundates us with talk shows, soap operas, sitcoms, and music videos in which the central theme is sex. "Confession lines" are common on call-in radio shows in most metropolitan areas. The limits of eroticism/pornography/obscenity are constantly being tested in television, film, and other visual media. Supermarket check out lines reveal a treasure trove of publications devoted to celebrities' sexual behavior. And then there is Madonna.¹

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1. I have successfully resisted the temptation to footnote—in deadpan law review style—each of the propositions asserted in these two paragraphs. I refuse to acknowledge even the

In their private lives, law professors are probably neither more nor less preoccupied with sex than any other segment of society.² More importantly, in their professional roles, law professors generally appear to be comfortable writing about sex. The past few years have seen a proliferation of law review literature about sex, sexuality, the regulation of sexuality, and the meaning of sexuality in its countless permutations.³ A law professor has discussed her own sexual life and the meaning of erotic pleasure as part of her inquiry into whether there is a distinctly female jurisprudential voice.⁴ Even law professors write about Madonna, although somewhat less frequently than do authors in the popular press.⁵

possibility that *any* reader of this Article would ever need to verify *any* of these observations via an examination of the original sources from which I draw my conclusions.

On the other hand, the excuse to do a computerized Madonna search was too much to pass up. Enquiring minds will thus be fascinated to learn that, in 1992 alone, there were 11,962 references to Madonna in the NEXIS, CURRNT database and a total of 29,638 references in the entire NEXIS database, which dates back to January 1, 1990. Since some of these references may have been to other Madonnas, a more refined search ("Madonna w/5 sex") revealed 1,443 stories in 1992 and a total of 3,490 since January 1, 1990. Search of LEXIS, Nexis Library (Sept. 23, 1993). On the frequency of Madonna references in legal databases, see *infra* note 5.

2. I have absolutely no empirical support for this proposition. On the other hand, a poll of law students forced to tolerate endless sexually-tinged hypotheticals in virtually all law school classes might prove to be illuminating.

3. On sex and modernism, see, for example, Mary Joe Frug, *A Postmodern Feminist Legal Manifesto*, 105 HARV. L. REV. 1045 (1992); Dennis Patterson, *Postmodernism/Feminism/Law*, 77 CORNELL L. REV. 254 (1992). On sexual autonomy and reproductive freedom, see, for example, Stephanie Ridder & Lisa Woll, *Transforming the Grounds: Autonomy and Reproductive Freedom*, 2 YALE J.L. & FEMINISM 75 (1989). On the legal implications of sexual imagery in popular music, see, for example, Peter A. Block, *Modern-Day Sirens: Rock Lyrics and the First Amendment*, 63 S. CAL. L. REV. 777 (1990); Emily Campbell, *Obscenity, Music and the First Amendment: Was the Crew 2 Lively?*, 15 NOVA L. REV. 159 (1991). On the political value of sexual fantasy, see Keith S. Furer, "Warning: Explicit Language Contained" *Obscenity and Music*, 9 N.Y.L. SCH. J. HUM. RTS. 461 (1992); Robert T. Perry & Carlton Long, *Obscenity Law, Hip Hop Music and 2 Live Crew* (pts. 1 & 2), N.Y. L.J., July 13, 1990, at 5, July 20, 1990, at 5. On the legal regulation of sexually explicit literature, see, for example, Catharine A. MacKinnon, *Pornography as Defamation and Discrimination*, 71 B.U. L. REV. 793 (1991); Nadine Strossen, *The Convergence of Feminist and Civil Liberties Principles in the Pornography Debate*, 62 N.Y.U. L. REV. 201 (1987) (reviewing Varda Burstyn, *WOMEN AGAINST CENSORSHIP* (1985)). On sexual desire, see Joanna Calne, *In Defense of Desire*, 23 RUTGERS L.J. 305 (1992) (critiquing CATHARINE A. MACKINNON, *TOWARD A FEMINIST THEORY OF THE STATE* (1989)). On "sexy dressing," see Duncan Kennedy, *Sexual Abuse, Sexy Dressing and the Eroticization of Domination*, 26 NEW ENG. L. REV. 1309 (1992). On the need to legalize and regulate prostitution, see Kenneth Shuster, *On The "Oldest Profession": A Proposal in Favor of Legalized But Regulated Prostitution*, 5 U. FLA. J.L. & PUB. POL'Y 1 (1992).

4. Robin L. West, *The Difference in Women's Hedonic Lives: A Phenomenological Critique of Feminist Legal Theory*, 3 WIS. WOMEN'S L.J. 81 (1987); cf. SUSAN ESTRICH, *REAL RAPE* 1-7 (1987) (providing law professor's account of being raped). Professor West's work in this area has been widely recognized. See, e.g., Drucilla Cornell, *The Doubly-Prized World: Myth, Allegory, and the Feminine*, 75 CORNELL L. REV. 644, 649 (1990); Jeanne L. Schroeder, *Feminism Historicized: Medieval Misogynist Stereotypes in Contemporary Feminist Jurisprudence*, 75 IOWA L. REV. 1135, 1138 (1990); Lucinda M. Finley, *The Nature of Domination and the Nature of Women: Reflections on Feminism Unmodified*, 82 NW. U. L. REV. 352, 407 (1988) (reviewing CATHARINE A. MACKINNON, *FEMINISM UNMODIFIED: DISCOURSES ON LIFE AND LAW* (1987)).

5. A search for "Madonna w/200 sex!" revealed but twenty-seven law review articles.

At the same time, the literature on mental disability law has grown exponentially. (Almost) every mental health-related question that has come before the courts in the past twenty years has been extensively analyzed, critiqued, and deconstructed in the scholarly literature.⁶ And when it has appeared that this scholarship was in danger of failing to provide an adequate basis upon which to address core policy and practice issues,⁷ fresh scholarly approaches have infused new life into this enterprise.⁸ For example, within the past two years, such topics as voluntary hospitalization, the right to refuse treatment, the interplay between mental disability and the criminal justice system, and the basis for tort liability in cases involving persons with mental disabilities have all been reexamined through the lens of therapeutic jurisprudence.⁹

Yet one issue remains virtually undiscussed—the right of institutionalized persons with mental disabilities to engage in consensual sexual activity.

Search of Westlaw, JLR database (Sept. 25, 1993); see, e.g., Scot A. Duvall, *A Call for Obscenity Law Reform*, 1 WM. & MARY BILL RTS. J. 75, 76 n.6 (1992) (detailing Madonna's description of how her banned video, "Justify My Love," dealt with her sexual fantasies); cf. Joel Chineson, *Psst . . . Wanna See Madonna Naked?*, LEGAL TIMES, Jan. 18, 1993, at 66 (reviewing movie, BODY OF EVIDENCE (Metro-Goldwyn-Mayer/United Artists 1992)) ("Madonna's work . . . is more graphic than anything she has ever done on film before. She displays her finely tuned body unashamedly.").

6. See generally David B. Wexler, *Therapeutic Jurisprudence and Changing Conceptions of Legal Scholarship*, 11 BEHAV. SCI. & L. 17 (1993) (discussing the rise of mental disability law scholarship focusing on the therapeutic or anti-therapeutic effects the law has on persons with mental disability); Michael L. Perlin & Deborah A. Dorfman, *The Invisible Renaissance of Mental Disability Law Scholarship: A Case Study of Subordination* 3 & n.10, 7-9 & nn.18-22 (Dec. 2, 1993) (unpublished manuscript in progress, on file with the *New York University Review of Law & Social Change*) (discussing the important contributions that mental health law scholarship has made to criminal law, patients' rights law, penal law, civil rights law, and tort law).

7. See John Petrila, *Redefining Mental Health Law: Thoughts on a New Agenda*, 16 LAW & HUM. BEHAV. 89, 90 (1992).

8. See, e.g., THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (David B. Wexler ed., 1990) [hereinafter THERAPEUTIC JURISPRUDENCE]; David B. Wexler, *Putting Mental Health Into Mental Health Law: Therapeutic Jurisprudence*, in ESSAYS IN THERAPEUTIC JURISPRUDENCE 3, 4-8 (David B. Wexler & Bruce J. Winick eds., 1991) [hereinafter ESSAYS]; Wexler, *supra* note 6.

9. Therapeutic jurisprudence is an interdisciplinary approach to mental disability law that focuses on the extent to which the law affecting people with mental disabilities acts as a therapeutic agent or an anti-therapeutic agent. See, e.g., Michael L. Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 LAW & PSYCHOL. REV. 29 (1992); Norman Poythress & Stanley Brodsky, *In the Wake of a Negligence Release Suit: An Investigation of Professional Consequences and Institutional Impact on a State Psychiatric Hospital*, 16 LAW & HUM. BEHAV. 155 (1992); David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence and Criminal Justice Mental Health Issues*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 225 (1992); Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Consent*, in ESSAYS, *supra* note 8, at 41; Bruce J. Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinermon v. Burch*, in ESSAYS, *supra* note 8, at 83 [hereinafter Winick, *Voluntary Hospitalization*]. For recent surveys, see David B. Wexler, *Justice, Mental Health, and Therapeutic Jurisprudence*, 40 CLEV. ST. L. REV. 517 (1992); David B. Wexler, *New Direction in Therapeutic Jurisprudence: Breaking the Bounds of Conventional Mental Health Law Scholarship*, 10 N.Y.L. SCH. J. HUM. RTS. 759 (1993); David B. Wexler, *An Orientation to Therapeutic Jurisprudence*, 19 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT (forthcoming 1994) [hereinafter Wexler, *Orientation*].

For a variety of reasons that I will explore, this question remains "beyond the last frontier"¹⁰ for law professors, as it does for most of the general public.¹¹

Simply put, the sexuality of persons with mental disabilities is one of the most threatening issues confronting clinicians, line workers, administrators, advocates, and attorneys who are involved in mental health care related work, as well as the families of individuals with mental disabilities. It is "a public policy question as controversial as they get,"¹² since the taboos and stigmas ordinarily associated with sexual behavior are inevitably enhanced when juxtaposed with stereotypes about mental disability.¹³ The subject challenges the traditional liberal position on questions of institutionalization and civil rights enforcement. It forces us to consider the extent to which rules that appear intended to protect individuals with mental disabilities by limiting or subordinating their sexual autonomy are actually the product of a patronizing paternalism toward persons with mental disabilities in institutions. The discomfort with which many respond to this subject itself reflects the massive use of ego defenses, including denial, in the way most of us think about mental disability and hospitalization.¹⁴ Ultimately, our response to these issues serves as a Rorschach test for the degree to which we are willing to punish people, by restricting their ability to exercise civil rights, because they suffer from mental illness.

The cause of this discomfort and the attitudes that motivate such restrictions may be described as *sanism*.¹⁵ Sanism is an irrational prejudice of the same quality and character as other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry.¹⁶ Sanist behavior is thus based upon stereotypes, myths,

10. I have borrowed this phrase from New York Law School Professor Keri Gould's response to my incredulity when I told her of the hostile and astonished responses I received from several other law professors upon telling them that I was researching this topic. Professor Gould (who, like me, represented institutionalized persons with mental disabilities in her prior career) responded, "Michael, why are you surprised? For almost everyone, this really is beyond the last frontier!" Telephone Conversation with Keri Gould, Professor of Law, New York Law School (Nov. 3, 1992).

11. *But cf.* Diana J. Schemo, *Matchmaker's Niche: The Lonely Mentally Ill*, N.Y. TIMES, Dec. 14, 1992, at A1 (discussing new dating service for adults with mental disabilities).

12. Rob Karwath, *Mental Center Sex Rule Studied*, CHI. TRIB., Apr. 9, 1989, at 1.

13. *See generally* SANDER GILMAN, *DIFFERENCE AND PATHOLOGY: STEREOTYPES OF SEXUALITY, RACE, AND MADNESS* (1985) (discussing human need to form stereotypes); David Shelton, *Client Sexual Behavior and Staff Attitudes: Shaping Masturbation in an Individual with a Profound Mental and Secondary Sensory Handicap*, 20 MENTAL HANDICAP 81 (1992) (discussing how male patients with developmental disabilities are discouraged from masturbating based more often on moral judgements and prejudices than on valid clinical considerations).

14. *See* Deborah A. Dorfman, *Through a Therapeutic Jurisprudential Filter: Fear and Pretextuality in Mental Disability Law*, 10 N.Y.L. SCH. J. HUM. RTS. 805 (1994).

15. The term *sanism* was, to the best of my knowledge, coined by Dr. Morton Birnbaum. *See* Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 Hous. L. REV. 63, 92-93 (1991) (discussing Birnbaum's insights).

16. *See generally* GORDON W. ALLPORT, *THE NATURE OF PREJUDICE* (1954); Larry Alexander, *What Makes Wrongful Discrimination Wrong? Biases, Preferences, Stereotypes, and Proxies*, 141 U. PA. L. REV. 149 (1992).

superstitions, and deindividualization in ways that reflect a community's dominant morality.¹⁷ It is, finally, astonishingly underdiscussed¹⁸ (and the fact of this underdiscussion has a special significance here) in light of the fundamentality of sexuality to the human experience.¹⁹

This Article will proceed in the following way. In part I, I will discuss the importance of the perspective (such as legal, clinical, or administrative) from which we analyze this subject. In doing so, I will attempt to raise many of the ancillary questions that must be addressed in formulating a comprehensive response to this issue. In part II, I will discuss the development of the patients' rights movement and analyze the extent to which the right to sexual interaction "fits" into that context. I will also briefly consider the sparse litigation on this issue and offer some thoughts about the potential impact of the Americans with Disabilities Act²⁰ (ADA) on future developments in this area. In part III, I will discuss attitudinal issues and explore how sanism and pretextuality²¹ affect the way many approach this area of the law. In part IV,

17. See generally Michael L. Perlin, *On "Sanism,"* 46 SMU L. REV. 373 (1992) (discussing the historic roots of sanist attitudes in the prevalent association of mental disability with sin and criminal activity); Michael L. Perlin & Deborah A. Dorfman, *Sanism, Social Science, and the Development of Mental Disability Law Jurisprudence*, 11 BEHAV. SCI. & L. 47 (1993) (analyzing the extent to which sanist attitudes dominate recent Supreme Court jurisprudence).

18. Only one major law review article comprehensively addresses the core issues discussed here. See Susan Stefan, *Whose Egg Is It Anyway? Reproductive Rights of Incarcerated, Institutionalized, and Incompetent Women*, 13 NOVA L. REV. 405 (1989) [hereinafter Stefan, *Reproductive Rights*]; see also Susan Stefan, *Silencing the Different Voice: Feminist Theory and Competence*, 47 U. MIAMI L. REV. 763, 791-99 (1993) (discussing the applicability of statutory rape laws to women with mental disabilities) [hereinafter Stefan, *Silencing*]. Other important articles focus on related issues concerning sexuality and persons with mental disabilities. On how persons with mental disabilities are deprived of their parental rights, see Robert L. Haymann, Jr., *Presumptions of Justice: Law, Politics, and the Mentally Retarded Parent*, 103 HARV. L. REV. 1201 (1990). On the rights of a mentally disabled person to resist state-sponsored sterilization, see Edward J. Larson & Leonard J. Nelson III, *Involuntary Sexual Sterilization of Incompetents in Alabama: Past, Present, and Future*, 43 ALA. L. REV. 399 (1992); Julie Marcus, *In re Romero: Sterilization and Competency*, 68 DENV. U. L. REV. 105 (1991); Elizabeth S. Scott, *Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy*, 1986 DUKE L.J. 806. However, the overall area is bereft of structured and organized analysis. This stands in stark contrast to other areas of patients' rights that have spawned cottage industries of commentary (such as the right to refuse the imposition of antipsychotic medication or the meaning of *dangerousness* at an involuntary civil commitment proceeding). See sources cited *supra* notes 6 & 9 (articles discussing this literature).

19. Although the Supreme Court has never expressly held that sexual intercourse is a fundamental right, it has recognized a fundamental right to be free, "except in very limited circumstances, from unwanted governmental intrusions into one's privacy." *Stanley v. Georgia*, 394 U.S. 557, 564 (1969). For a list of areas in which the court has recognized sexual privacy, see *Whisenhunt v. Spradlin*, 464 U.S. 965, 971 (1983) (Brennan, J., dissenting from denial of certiorari).

20. Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified at 42 U.S.C. § 12101 (Supp. III 1991)).

21. By pretextuality, I refer to the way that participants in the legal process (particularly expert witnesses and courts) dishonestly present testimony or reach decisions which conform with their sanist pretexts, under the guise of presenting neutral factual information or simply "applying" the law. See Michael L. Perlin, *Decoding Right to Refuse Treatment Law*, 16 INT'L J.L. & PSYCHIATRY 151, 172 n.168 (1993).

I will attempt to articulate some of the unanswered (and perhaps unanswerable) questions these tensions raise, highlighting the resulting clash of contradictory rights and social values. I will conclude with some modest recommendations on how these issues may be practically addressed as well as some suggestions for future research in this area.

I

PERSPECTIVES ON PATIENTS AND SEX

Before we can analytically approach the question of whether institutionalized persons with mental disabilities have the right to engage in consensual sexual activity, we must attempt some modest deconstruction. No doctrinal or theoretical formulation can be seriously undertaken until we articulate our perspective. Are we looking for a legal answer, a clinical answer, a social answer, an administrative answer, or a behavioral answer (or, as we should, a combination of all of these)? Surely we must consider each of these areas of analysis if we wish to construct a meaningful, multitextured, and comprehensive response.

Let us first consider the legal implications of this subject. To what statutorily or judicially defined civil rights are involuntarily committed mental patients generally entitled? In the articulation of such rights, have the courts or the legislatures specifically considered sexual autonomy or interaction rights?²² Will the ADA force public institutions to change how they treat patients in this context?²³ Is it necessary to inquire initially into an individual patient's competency to make sexual decisions? If so, how would this be determined?²⁴ Do competent institutionalized patients have the same autonomy rights as all other persons, allowing them to engage in the same level of sexual self-determination as noninstitutionalized persons?²⁵ Putting aside inquiries into mental capacities, are all patients to be treated in the same way, or are there differences between voluntarily and involuntarily committed patients that are relevant to this inquiry?²⁶

22. See *infra* notes 69-72 and accompanying text; see also 2 MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* § 11.10A, at 207-11 (Supp. 1993) (discussing the few judicial decisions and state statutes guaranteeing patients the right to reasonable sexual interaction). On how this traditional doctrinal analysis runs the risk of intellectual sterility, see *supra* notes 7-9 and accompanying text.

23. See generally *infra* notes 73-78 and accompanying text. The only major analysis of the ADA focusing on institutionalization is Timothy M. Cook, *The Americans With Disabilities Act: The Move to Integration*, 64 TEMP. L. REV. 393 (1991). I consider the interplay between ADA enforcement and sanist attitudes in Michael L. Perlin, *The ADA and Persons With Mental Disabilities: Can Sanist Attitudes Be Undone?*, 8 J.L. & HEALTH (forthcoming 1994) (on file with the *New York University Review of Law and Social Change*).

24. See *infra* note 60.

25. On autonomy generally, see Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705 (1992). On the question of consent to sexual activity in institutions for the mentally disabled, see David Carson, *Legality of Responding to the Sexuality of a Client with Profound Learning Disabilities*, 20 MENTAL HANDICAP 85, 87 (1992).

26. See generally *Zinerman v. Burch*, 494 U.S. 113, 130-37 (1990) (noting that patient's

Should involuntary commitment implicitly restrict one's freedom to engage in sexual activity?²⁷ Is it justifiable, or even legally required, to place different restrictions on patients who have been committed following their involvement in the criminal justice system than those imposed on civilly committed patients?²⁸ Within the former group, is there a relevant difference between patients awaiting trial, patients determined by a judge to be permanently incompetent,²⁹ and those patients found not guilty by reason of insanity?³⁰ Is there a relevant difference between patients who have been found

voluntary status is often illusory); Perlin & Dorfman, *supra* note 17, at 55-56 (noting that an attempt to voluntarily receive treatment at a psychiatric facility is not dispositive evidence of one's competence to make that decision); Michael L. Perlin, *Understanding Zinermon v. Burch*, in 3 DIRECTIONS IN PSYCHIATRY: PSYCHIATRIC MALPRACTICE RISK MANAGEMENT ch. 6.9-6.11 (1993) (arguing that a reexamination of the voluntary admissions process should be welcomed, given the often illusory distinctions between voluntary patients and involuntary detainees); Winick, *Voluntary Hospitalization*, *supra* note 9 (arguing that persons who consent to voluntary hospitalization should be presumed competent to make such a decision absent strong evidence to the contrary); see also Note, *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1400-01 (1974) (warning that voluntary procedures are "subject to abuse"); David B. Wexler, *Foreword: Mental Health Law and the Movement Toward Voluntary Treatment*, 62 CAL. L. REV. 671, 676 (1974) (noting that procedures to commit persons to mental hospitals "voluntarily" often involve "substantial elements of coercion"). Many psychiatrists believe that voluntary treatment is more effective than involuntary therapy. See *Rennie v. Klein*, 462 F. Supp. 1131, 1144 (D.N.J. 1979) ("The testimony has indicated that involuntary treatment is much less effective than the same treatment voluntarily received."). An important ethical question arises as to whether the benefits of voluntary hospitalization outweigh the dangers that a "voluntary" patient might not be competent to understand the meaning and implications of their institutionalization. See Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, LAW & CONTEMP. PROBS., Summer 1982, at 161, 190 (discussing *Rennie*).

27. For a historical analysis of the rationales for involuntary commitment, see 1 MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* §§ 2.01-22 (1989).

28. Patients transferred to psychiatric hospitals from jails, for instance, are usually under criminal detainer, so that they will generally be returned to pretrial confinement in locked facilities rather than released following their hospitalization. Those patients found not guilty by reason of insanity are sometimes subject to additional restrictions on their liberty by the nature of that verdict. Cf. *Jones v. United States*, 463 U.S. 354, 370 (1983) (affirming the constitutionality of committing a defendant who was found not guilty by reason of insanity to a psychiatric institution, even though the standard of proof necessary to prove mental illness to qualify for the insanity defense was lower than that necessary to prove mental illness in order to be civilly committed). The Supreme Court has explicitly sanctioned prison regulations that give convicted prisoners fewer rights to refuse the administration of antipsychotic drugs than defendants at trial. Compare *Washington v. Harper*, 494 U.S. 210, 228 (1990) (holding that the Fourteenth Amendment Due Process Clause does not entitle a prison inmate with mental illness to judicial review of a doctor's decision to involuntarily medicate the inmate) with *Riggins v. Nevada*, 112 S. Ct. 1810, 1817 (1992) (holding that when the involuntary medication of defendants with mental illness during trial was not necessary to accomplish an essential state policy, there is no basis for justifying the trial prejudice that results from such treatment); see also Perlin, *supra* note 21, at 163-68 (contrasting the results reached in *Harper* and *Riggins*).

29. Cf. *Jackson v. Indiana*, 406 U.S. 715, 737-38 (1972) (holding that patient may not be confined indefinitely in a maximum security forensic facility if it becomes unlikely that she will regain her competence to stand trial within the foreseeable future).

30. On post-acquittal insanity defense commitments, see 3 PERLIN, *supra* note 27, § 15.20, at 343-44. See generally MICHAEL L. PERLIN, *THE JURISPRUDENCE OF THE INSANITY DEFENSE* 198-207 (1994) (discussing how courts' ambivalent treatment of the insanity defense and

to be incompetent (for any reason) and those who have not?³¹

Next, we should turn our attention to clinical questions. For example, has the patient in question ever expressed any wish either to engage in sexual activity or to abstain from it? Is it clinically beneficial or antitherapeutic to allow institutionalized patients autonomy in sexual decision making?³² In answering this question, to what extent ought we consider research on the therapeutic value of touching and physical intimacy?³³ Should the projected length of a patient's hospitalization affect the restrictions placed on their sexual autonomy? If so, how? What is the impact of sexual activity on different methods of treatment? On the overall ward milieu? What correlative responsibilities come with the assertion of rights? Is the potential relationship between sexual repression and neurotic behavior, articulated most vividly by Wilhelm Reich, worth considering?³⁴

Next, we must consider the practical implications of sexual relationships in a closed institution like a psychiatric hospital. Under the best of circumstances, entering into a new sexual relationship can be stressful and confusing. Are these stresses "inappropriately" exacerbated when the universe in question is that of institutionalized mental patients? To what extent should the differing stress management abilities of institutionalized individuals be factored into any policy ultimately adopted? Conversely, can preoccupation with sex systemically distort all matters involving ward behavior? How does this

their rejection of accepted psychoanalytic theory have rendered insanity defense doctrine incoherent).

31. On judges' self-described discomfort with their inability to make this distinction, see Michael L. Perlin, *Are Courts Competent to Decide Competency Questions? Stripping the Facade from United States v. Charters*, 38 U. KAN. L. REV. 957, 991 (1990).

32. The recent development of therapeutic jurisprudence as an academic discipline, see generally ESSAYS, *supra* note 8; THERAPEUTIC JURISPRUDENCE, *supra* note 8, should force us to consider the therapeutic outcomes of different policies about sexual activity. In formulating our analysis, we need to be mindful of Professors Wexler's and Winick's caveat that therapeutic outcomes should not trump civil libertarian values in articulating policy choices. See David B. Wexler & Bruce J. Winick, *Introduction to ESSAYS*, *supra* note 8, at ix, xi; Wexler, *Orientation*, *supra* note 9 (manuscript at 2).

33. See, e.g., ASHLEY MONTAGU, *TOUCHING: THE HUMAN SIGNIFICANCE OF THE SKIN* (1971); Harry F. Harlow, Margaret K. Harlow & Stephen J. Suomi, *From Thought to Therapy*, 59 AM. SCIENTIST 538 (1971). See generally Bill Mossman, *Therapeutic Benefits Correlated with Sexuality* (Apr. 15, 1993) (unpublished manuscript, on file with the *New York University Review of Law & Social Change*).

34. See WILHELM REICH, *CHARACTER-ANALYSIS* 130-33, 158-68 (Theodore P. Wolfe trans., Noonday Press 3d enl. ed. 1961) (1949); WILHELM REICH, *THE INVASION OF COMPULSORY SEX-MORALITY* 4-11 (Werner Grossmann & Doreen Grossmann trans., Farrar, Straus and Giroux 1971) (1935) (suggesting that sexual activity inhibits neuroses and that sexual repression transforms everyday psychic conflicts into neuroses); WILHELM REICH, *SELECTED WRITINGS: AN INTRODUCTION TO ORGONOMY* 184-85 (Farrar, Straus and Giroux 1973) (1948); WILHELM REICH, *SEX-POL: ESSAYS 1929-1934*, at 126-29 (Anna Bostock, Tom Duboser & Lee Baxandall eds., trans., Random House 1972) (1935) [hereinafter *SEX-POL*]. Although Reich was widely discredited at the time of his death, his arguments are still worthy of consideration in this context. See Bertell Ollman, *Introduction to SEX-POL*, *supra*, at xi. For a discussion of Reich's role in the development of post-Freudian psychiatry, see JONAS ROBITSCHER, *THE POWERS OF PSYCHIATRY* 384-92 (1980).

focus affect questions of individual versus group needs? Might an excessive concern with sex blunt the consideration of other related issues, such as self-esteem, the importance of developing a full range of interpersonal relationships, and the ability to deal with intimacy?

A closed institution, by its nature, places substantial limits on individuals' mobility and freedom of action. When people in the "free world" terminate a stormy love affair, frequently they can adjust their lives so as not to have much contact with their former lovers. What happens if that ex-lover lives on the same floor of an inpatient hospital (especially if it is a *locked ward* hospital), and neither patient can leave without a court order? Conversely, what happens when a couple is split up by a court order transferring one patient to another ward or facility for clinical or legal reasons?³⁵

In any event, can patients be stopped from having sex? Are there worthwhile analogies that can be made here to rules that were supposed to govern college dormitories in the 1960s and 1970s, when administrators vainly and futilely tried to suppress sexual activity among undergraduates?³⁶

Is it realistically possible to monitor sexual practices in a facility such as a psychiatric hospital, so that an individual patient's exercise of the right to sexual autonomy does not result in nonconsensual sex, in unwanted pregnancies, or in the spread of sexually transmitted diseases?

This leads to a consideration of these issues from the perspective of hospital officials. Why are hospital administrators resistant to expanded sexual activity on the part of patients?³⁷ Is it more than simple inconvenience, or even the fear of unwanted pregnancies? How much does a fear of a potential hospital-wide AIDS epidemic contribute to this resistance? How realistic is this fear? How much of this fear is inspired by a genuine clinical concern for the patients in their care? Conversely, how will the well-documented fear of many mental health professionals of being sued—what some commentators term "litigaphobia"³⁸—affect the adoption of, or compliance with, any policy that ap-

35. As to clinical considerations, see, for example, *Johnson v. United States*, 409 F. Supp. 1283, 1293 (M.D. Fla. 1976) (enumerating the pros and cons of custodial psychiatric treatment), *rev'd on other grounds*, 576 F.2d 606 (5th Cir. 1978), *cert. denied*, 451 U.S. 1018 (1981); *Predoti v. Bergen Pines County Hosp.*, 463 A.2d 400, 402 (N.J. Super. Ct. App. Div. 1983) (noting that the decision to transfer a person involuntarily detained in a psychiatric facility from a locked ward to an open ward with fewer restrictions is governed by therapeutic as well as legal concerns). Legal considerations include, for example, the possibility that a criminal detainee may be placed in a patient's file, thus necessitating his transfer to a locked ward in spite of contrary clinical considerations.

36. There are self-evidently major differences between a college dorm and a psychiatric hospital. On the other hand, there are remarkable similarities between the *parens patriae* theory that supports danger-to-self commitments, see 1 PERLIN, *supra* note 27, §§ 2.17-2.20, and the *in loco parentis* doctrine that governed campus life until the late 1960s. See, e.g., George L. Stewart II, *Social Host Liability on Campus: Taking the "High" Out of Higher Education*, 92 DICK. L. REV. 665, 672-73 (1988). It is similarly impossible to enforce such rules of behavior in either setting.

37. See, e.g., *infra* text accompanying note 42.

38. To my knowledge, the term *litigaphobia* was coined by Stanley Brodsky. See Stanley Brodsky, *Fear of Litigation in Mental Health Professionals*, 15 CRIM. JUST. & BEHAV. 492, 497

pears to increase the potential for patients' sexual activity (for fear that litigation might quickly follow unwanted births³⁹ or the spread of sexually transmitted diseases)? The expansion of provider liability⁴⁰ is the source of realistic concerns on the part of therapists that an ever-expanding range of clinical decisions may lead to ever-expanding personal liability.⁴¹ One commentator has suggested that the threat of litigation has led hospital administrators to "attempt to minimize the complexity of patient sexuality by focusing on the symbolic, simplistic reassurance of written procedures."⁴² Was this response idiosyncratic to the circumstances at the hospital there discussed, or is this practice more common?

How does the whole question of sexual autonomy in a public institution fit with the resolution of other social/cultural/political issues such as AIDS reporting⁴³ or condom distribution?⁴⁴ Even if policies are promulgated that protect and respect the sexual autonomy of institutionalized individuals, what happens when individual line staff at a hospital, the people to whom the implementation of the policy inevitably falls, simply refuse to cooperate with the policy because their own sense of religious "morality" forbids it? For exam-

(1988) (discussing the overreaction of mental health professionals to the risk of malpractice litigation); *see also* Carson, *supra* note 25, at 85 (discussing what legal liabilities might apply in cases of sexual activity in facilities for the mentally disabled); Ann G. Lawthers, A. Russell Localio, Nan M. Laird, Stuart Lipsitz, Liesi Hebert & Troyen A. Brennan, *Physicians' Perceptions of the Risk of Being Sued*, 17 J. HEALTH POL., POL'Y & L. 463, 468 (1992) (demonstrating that doctors significantly overestimate the risk of being sued); Perlin, *supra* note 21, at 158-59 (discussing the impact of litigaphobia on therapist behavior in cases involving duties to protect third parties).

39. *See, e.g.*, *Foy v. Greenblott*, 141 Cal. App. 3d 1, 13 (1983) (rejecting a claim for wrongful birth of a child conceived and born while the mother was institutionalized).

40. *See, e.g.*, *Schuster v. Altenburg*, 424 N.W.2d 159, 163 (Wis. 1988) (holding that a doctor may be liable for failing to warn her patient of the side effects of medication if those side effects should have led her to caution a patient against driving where it was foreseeable that an accident could result).

41. Telephone conversation with Dr. Robert L. Sadoff, Clinical Professor of Psychiatry, University of Pennsylvania Medical School (Nov. 8, 1992).

42. Terry Holbrook, *Policing Sexuality in a Modern State Hospital*, 40 HOSP. & COMMUNITY PSYCHIATRY 75, 79 (1989) (discussing the results of a psychiatric hospital's failure to notify the police of the sexual assault of one patient by another).

43. *See, e.g.*, IDAHO CODE § 39-602 (1993); N.J. STAT. ANN. § 26:4-15 (West 1987); N.Y. PUB. HEALTH LAW §§ 2101, 2306 (McKinney 1985). *See generally* Julie Edwards, *Controlling the Epidemic: The Texas AIDS Reporting Statute*, 41 BAYLOR L. REV. 399 (1989) (analyzing the Texas Legislature's stated desire to strike a balance between public welfare and individual rights in its enactment of an AIDS reporting statute, TEX. HEALTH & SAFETY CODE ANN. § 18.041 (West 1992)); Donald H.J. Hermann & Rosalind D. Gagliano, *AIDS, Therapeutic Confidentiality, and Warning Third Parties*, 48 MD. L. REV. 55 (1989) (discussing the possible conflict between a mental health professional's duty of confidentiality to her patients and her duty to warn third parties of risk in emergency circumstances); Sharron Rennert, *AIDS/HIV and Confidentiality: Model Policy and Procedures*, 39 KAN. L. REV. 653 (1991) (discussing model guidelines to assist health agencies in formulating confidentiality policies).

44. This is, of course, a controversial topic in non-institutional settings. *See, e.g.*, Nick Chiles, *Judge OKs School Condom Program*, N.Y. NEWSDAY (City Ed.), Apr. 24, 1992, at 8; Gail Collins, *The Board of Education Retreats in Condom Wars*, N.Y. NEWSDAY (City Ed.), May 29, 1992, at 4; Edna Negron, *Condom Issue Revisited*, N.Y. NEWSDAY (City Ed.), Sept. 16, 1992, at 83.

ple, their religion may teach that unmarried persons—of any mental capacity—should not have sex, or that married persons—of any mental capacity—should not have extramarital sex.⁴⁵ Is it justifiable for private facilities that are church-affiliated, or private nonsectarian facilities that retain units specially designated for practitioners of specific religions, to apply different restrictions in these areas?⁴⁶

Finally, we must consider whether any of these answers depends upon our definition of sex. Do we need to consider every possible permutation of sexual behavior? Does it make a difference if we are discussing monogamous heterosexual sex, polygamous heterosexual sex, monogamous homosexual sex, polygamous homosexual sex, or bisexual sex?⁴⁷ Does sex mean intercourse? What about oral sex? Anal sex? Masturbation? Voyeurism? Exhibitionism? Should erotic or pornographic material be made available to patients? If so, what sorts—magazines of the kind often available at convenience stores or “hard core” magazines generally thought of as “42d Street fare”? What about sexually explicit literature that might appear to involve, condone, or encourage violence? Should sexually explicit videos or movies be available for patients to see? If so, should they view them communally or individually? What if a patient’s prehospitalization behavior involved significant “sexual acting out” in what had been seen as inappropriate ways? Should a patient’s decision to engage in what is sometimes perceived as “deviant”⁴⁸ sexual behavior subsequently be used as evidence of their danger either to self or others⁴⁹ or of “grave disability”?⁵⁰

45. On the ways that “morality” issues are especially complex in mental disability cases in a broad variety of factual settings, see, for example, Michael L. Perlin, *Morality and Pretextuality, Psychiatry and Law: Of “Ordinary Common Sense,” Heuristic Reasoning, and Cognitive Dissonance*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 131 (1991) [hereinafter Perlin, *Morality*] (examining how prominent forensic psychiatrists have invoked morality as a basis for urging witnesses to ignore restrictive civil commitment criteria if they “really believe” patient should be hospitalized); Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625 (1993) [hereinafter Perlin, *Pretexts*] (same); see also Perlin, *supra* note 23 (manuscript at 22) (discussing Senator Helms’s arguments that an employer’s sense of morality might lead him to refuse to hire a manic-depressive person for a job).

46. This latter practice, abandoned in most states, still continues de facto in some California hospitals. Telephone Conversation with Deborah A. Dorfman, J.D., Patients’ Rights Advocate, Mental Health Advocacy Project of San Jose, Cal. (Nov. 12, 1992).

47. See Michael L. Commons, Judi T. Bohn, Lisa T. Godon, Mark J. Hauser & Thomas G. Gutheil, *Professionals’ Attitudes Towards Sex Between Institutionalized Patients*, 46 AM. J. PSYCHOTHERAPY 571 (1992) (discussing ways that mental health professionals’ attitudes towards sex are influenced by the nature of the sexual activity and the patients’ sexual orientation).

48. For a traditional reading on “sexual deviance” in this context, see JAMES D. PAGE, PSYCHOPATHOLOGY 367-79 (1971).

49. See, e.g., Virginia A. Hiday & Lynn N. Smith, *Effects of the Dangerousness Standard in Civil Commitment*, 15 J. PSYCHIATRY & L. 433, 499 (1987).

50. A person may only be subjected to involuntary psychiatric treatment if she (1) has a mental illness or disorder and (2) is a danger to herself or others as a result of that mental illness or disorder. *O’Connor v. Donaldson*, 422 U.S. 563, 575 (1975); see also *Foucha v. Louisiana*, 112 S. Ct. 1780, 1783 (1992) (citing *O’Connor*). In some states where “danger to self” has been narrowly defined either statutorily or via judicial construction, state legislatures have passed

This list of questions should underscore the point that this topic is, indeed, a complex one. Its complexity is compounded by society's generally irrational attitudes towards persons with mental disabilities. Notwithstanding the passage of the ADA and two decades of litigation on behalf of institutionalized persons with mental disabilities, few advances have been made in this area.⁵¹ The patients' rights movement has been substantially geared to ask simply whether mental patients were being treated "as human beings."⁵²

II

DEVELOPMENT OF PATIENTS' RIGHTS⁵³

The history of the development of institutionalized mental patients' substantive constitutional rights begins with *Wyatt v. Stickney*.⁵⁴ In *Wyatt*, Federal District Court Judge Frank Johnson fleshed out the contours of a constitutional right to treatment, by articulating a broad range of civil rights to which all patients are entitled.⁵⁵ These *Wyatt* standards became the inspiration and role model⁵⁶ for other litigation⁵⁷ and for legislation—generally labeled as "Patients' Bills of Rights"—enacted by almost all of the United States⁵⁸ as well as by Congress.⁵⁹ One of the principal guarantees of most of

laws additionally permitting the involuntary commitment of individuals with mental illness or disorders who are "gravely disabled." See, e.g., ALASKA STAT. § 47.30.735 (1993) (setting out hearing procedures for the commitment of persons with mental illness who are gravely disabled); ARIZ. REV. STAT. ANN. §§ 36-529-36-531 (1993) (same); WASH. REV. CODE ANN. § 71.05.240 (West 1993) (same). A person who is gravely disabled may constitute a danger to herself because of an inability to provide for her basic human needs (e.g., her refusal to eat or drink, her failure to provide adequate clothing and shelter from the elements, or unhealthy excretion practices), rather than out of a risk of violence to herself. E.g., ALASKA STAT. § 47.30.915 (1993) (defining the term *gravely disabled*); ARIZ. REV. STAT. ANN. § 36-501 (1993) (same); WASH. REV. CODE ANN. § 71.05.020(1) (West 1993) (same).

51. On the impact of legal change on attitudinal change, see Sheri L. Johnson, *Black Innocence and the White Jury*, 83 MICH. L. REV. 1611, 1650 (1985) ("Where discrimination is not legally or socially approved, social scientists predict it will be practiced only when it is possible to do so covertly and indirectly."); see also Emily Campbell & Alan J. Tomkins, *Gender, Race, Grades, and Law Review Membership as Factors in Law Firm Hiring Decisions: An Empirical Study*, 18 J. CONTEMP. L. 211, 250 n.122 (1992) (reporting empirical evidence suggesting that, in the years since the passage of race-based civil rights legislation, "racial attitudes and stereotypes among white Americans have become more tolerant").

52. See *Falter v. Veterans Admin.*, 502 F. Supp. 1178, 1185 (D.N.J. 1980).

53. The text *infra* accompanying notes 54-72 is generally adapted from Andrew Payne & Michael Perlin, *Sexual Activity Among Psychiatric Inpatients: International Perspectives*, 4 J. FORENSIC PSYCHIATRY 109 (1993).

54. 325 F. Supp. 781 (M.D. Ala.), *amended*, 334 F. Supp. 1341 (M.D. Ala. 1971), *supplemental op.*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd in part and reversed in part sub. nom. by*, *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974); see also 2 PERLIN, *supra* note 27, §§ 4.07-4.17, at 29-75 (discussing *Wyatt* and its impact on the development of patients' rights statutes and case law).

55. *Wyatt*, 344 F. Supp. at 379-83; see 2 PERLIN, *supra* note 27, § 4.08, at 38-41 & n.220.

56. See 2 PERLIN, *supra* note 27, § 11.03, at 954 n.36.

57. See, e.g., *Davis v. Watkins*, 384 F. Supp. 1196 (N.D. Ohio 1974); see also 2 PERLIN, *supra* note 27, § 4.19, at 107-11 (discussing *Wyatt*'s early impact in other jurisdictions).

58. Martha A. Lyon, Martin L. Levine & Jack Zusman, *Patients' Bills of Rights: A Survey of State Statutes*, 6 MENTAL DISABILITY L. REP. 178, 185-200 (1982).

the case law and statutes modeled on the *Wyatt* standards is that an individual will not be considered presumptively incompetent, for any or all purposes, simply because she is institutionalized.⁶⁰

There appears to be a growing consensus among institutional health care providers, behaviorists, other mental health professionals, and legal advocates that the expansion of the civil rights revolution to institutionalized mental patients is both good therapy and good law.⁶¹ Although there is occasional litigation in idiosyncratic cases over the limits of these rights and over such questions as the extent of a patient's right to receive payment for work done,⁶² the area of positive civil rights⁶³ has generally been free of the acrimony that has accompanied debates over the extent of the right to refuse treatment,⁶⁴ the relationship between deinstitutionalization and homelessness,⁶⁵ the extent of state power over an insanity acquittee,⁶⁶ or the ability of a state to medicate a

59. See, e.g., Mental Health Systems Act, 42 U.S.C. § 9501 (1988); Protection and Advocacy for Mentally Ill Individuals Act of 1986, 42 U.S.C. § 10801 (1988 & Supp. III 1991).

60. See, e.g., *Rivers v. Katz*, 495 N.E.2d 337, 344 (N.Y. 1986) (holding that a psychiatric patient's right to refuse medication survives her involuntary institutionalization); *In re LaBelle*, 728 P.2d 138, 142-43 (Wash. 1986) (noting that the mere fact that a person is mentally ill does not render her incompetent to make decisions concerning her need for treatment). For representative statutes, see IOWA CODE ANN. § 4.1(6) (West 1992); N.J. STAT. ANN. § 30:4-24.2 (West 1978). See generally Winick, *Voluntary Hospitalization*, *supra* note 9, at 83 (discussing the Supreme Court's dicta in *Zinerman v. Burch*, 494 U.S. 113, 133 (1990), suggesting that competency is a prerequisite for eligibility for voluntary hospitalization).

61. See Wexler, in *ESSAYS*, *supra* note 8, at 3.

62. Compare *Schindenwolf v. Klein*, No. L-41293-75 P.W. (N.J. Super. Ct. Law Div. 1979) (requiring compensation for institutionalized persons who perform work for which the institution would otherwise have to pay an employee), reprinted in 2 PERLIN, *supra* note 27, § 6.23, at 509-19 with *Bayh v. Sonnenburg*, 573 N.E.2d 398, 421 (Ind. 1991) (holding that institutionalized persons are not entitled to compensation for work performed while confined in hospitals), *cert. denied*, 112 S. Ct. 1170 (1992).

63. On the difference between "sword" rights and "shield" rights in this context, see Marshall B. Kapp, *Residents of State Mental Institutions and Their Money (or, The State Giveth and the State Taketh Away)*, 6 J. PSYCHIATRY & L. 287, 301 (1978). For idiosyncratic litigation over the precise contours of a right that does not fit neatly into any reductive categories, see *Thomas S. v. Flaherty*, 699 F. Supp. 1178, 1203-04 (W.D.N.C. 1988) (holding First Amendment protects freedom of association rights of institutionalized patients), *aff'd*, 902 F.2d 250 (4th Cir.), *cert. denied*, 498 U.S. 951 (1990); *Doe v. Public Health Trust*, 696 F.2d 901, 905 (11th Cir. 1983) (holding that a hospital may constitutionally preclude communication between a minor mental patient and her parents for therapeutic reasons).

64. See generally 2 PERLIN, *supra* note 27, §§ 5.01-.69 (discussing the development of constitutional litigation on an involuntary detainee's right to refuse psychotropic medication and other treatment).

65. Compare H. Richard Lamb, *Will We Save the Homeless Mentally Ill?*, 147 AM. J. PSYCHIATRY 649 (1990) (advocating definitive action to address the needs of homeless persons with mental illness through community outreach, civil commitment, and forcible medication) with Douglas Mossman & Michael L. Perlin, *Psychiatry and the Homeless Mentally Ill: A Reply to Dr. Lamb*, 149 AM. J. PSYCHIATRY 951 (1992) and Perlin, *supra* note 15, at 90 (criticizing Dr. Lamb's suggestions as violative of the rights of homeless persons with mental illness).

66. Compare *Foucha v. Louisiana*, 112 S. Ct. 1780, 1787 (1992) (holding that a Louisiana statute that authorizes the continued confinement of insanity acquittees who are no longer mentally ill violates due process) with *id.* at 1801 (Thomas, J., dissenting) (arguing that insanity acquittee should not be released on the basis of a psychiatric opinion that he is not mentally ill,

defendant either to make the defendant competent to be tried⁶⁷ or executed.⁶⁸

Despite this broad agreement as to the positive civil rights of institutionalized persons with mental disabilities, legislators and litigators have paid astonishingly little attention to one of the most basic and fundamental of all civil and human rights: the right to sexual interaction.⁶⁹ Most of the *Wyatt* standards were simply adopted whole cloth by state legislatures in their subsequent Patients' Bills of Rights enactments, but only six states enacted statutes adopting the portion of the *Wyatt* standards that guaranteed patients the right to reasonable interaction with members of the opposite sex.⁷⁰ There has been no follow-up litigation on any of these statutes, and only a scattering of federal cases seeking to vindicate this right have been litigated.⁷¹ A guarantee of such rights is conspicuously absent from either piece of complementary federal civil rights legislation.⁷²

The ADA⁷³ has been hailed as "the Emancipation Proclamation for

since such opinions are imprecise). This split is discussed in PERLIN, *supra* note 30, at 202-07 and in Perlin & Dorfman, *supra* note 17, at 56-58.

67. Compare *United States v. Charters*, 829 F.2d 479, 493 (4th Cir. 1987) (noting that neither the government's interest in preventing violence nor its interest in trying a defendant could justify the forcible medication of a defendant) with *United States v. Charters*, 863 F.2d 302, 306 (4th Cir. 1988) (en banc) (noting that on remand the *Charters* court allowed forcible medication under limited circumstances), *cert. denied*, 494 U.S. 1016 (1990).

68. Compare *State v. Perry*, 543 So. 2d 487 (La. 1989) (denying review of trial court order to medicate death row inmate), *cert. granted*, 494 U.S. 1015, *vacated and remanded*, 498 U.S. 38 (1990) with *State v. Perry*, 610 So. 2d 746 (La. 1992) (reversing trial court decision on remand to reinstate its order to medicate without consent).

69. Although the Supreme Court has never found sexual interaction per se to be a specifically-protected right, it has found a fundamental right to privacy in a broad array of cases involving reproductive choice, *Roe v. Wade*, 410 U.S. 113, 152 (1973); contraception, *Eisenstadt v. Baird*, 405 U.S. 438, 453-54 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1964); marriage, *Loving v. Virginia*, 388 U.S. 1, 12 (1967); and family relationships, *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977). See also *supra* note 19. For a discussion of how sexual autonomy rights might fall under the aegis of the right to privacy, see Note, *Constitutional Barriers to Civil and Criminal Restrictions on Pre- and Extramarital Sex*, 104 HARV. L. REV. 1660, 1663-71, 1674-77 (1991) (arguing that consensual, heterosexual sex is a constitutionally protected activity); Stephen J. Schulhofer, *Taking Sexual Autonomy Seriously: Rape Law and Beyond*, 11 LAW & PHIL. 35, 35 (1992) (seeing sexual autonomy as "a distinctive constituent of personhood and freedom").

70. See Lyon, Levine & Zusman, *supra* note 58, at 185-200 (listing all state statutes). At the time that Lyon and her colleagues conducted this survey, Kansas, Montana, New Jersey, and Ohio had enacted such laws. Since that time, Kansas has repealed its statute, while similar laws have been enacted in Colorado (on behalf of persons with developmental disabilities) and Louisiana (on behalf of institutionalized minors). See COLO. REV. STAT. § 27-10.5-117(1) (Supp. 1993); KAN. PROB. CODE ANN. § 59-2929(a)(3) (Vernon 1978 and Supp. 1994); LA. STAT. ANN. CHILDREN'S CODE art. 1409(I) (West 1994).

71. See, e.g., *Gary W. v. Louisiana*, 437 F. Supp. 1209, 1228 (E.D. La. 1976) (following sexual interaction rights established in *Wyatt*); *Davis v. Watkins*, 384 F. Supp. 1196, 1205 (N.D. Ohio 1974) (same). But cf. *Davis*, 384 F. Supp. at 1208 ("Patients shall be provided counseling or other treatment for homosexuality.").

72. Mental Health Systems Act, 42 U.S.C. § 9501 (1988); Protection and Advocacy for Mentally Ill Individuals Act of 1986, 42 U.S.C. § 10801 (1988 and Supp. III 1991).

73. 42 U.S.C. §§ 12101-12213 (Supp. III 1991).

those with disabilities”⁷⁴ and promises to be a “national mandate to end discrimination against individuals with disabilities and to bring [them] into the . . . social mainstream of American life.”⁷⁵ However, it is far from clear whether the ADA will have a significant impact on issues affecting disabled persons’ sexual expression.⁷⁶ Little in the ADA’s voluminous congressional history or in its attendant commentary suggests that its drafters gave much thought to what protections it might extend concerning sexual matters. It is thus ironic that ADA opponents largely focused their efforts on excluding certain gender identity- and sexual behavior-related conditions—such as transvestism, transsexualism, exhibitionism, and voyeurism⁷⁷—from the act’s coverage. The floor debate touched on the ADA and sex only in the context of Senator Helms’s insistence that pedophiles, a group he malignantly “twin-
ned” with schizophrenics, should be excluded from the act’s protection.⁷⁸

The general lack of attention, litigation, and commentary on this subject appears anomalous. Institutionalized persons self-evidently do not lose their sexuality or sexual desires when they lose their liberty. There is some added irony to be found in the fact that litigation over antipsychotic medication refusal—the most contentious aspect of institutionalized patients’ rights law—centers on drug side effects, and the loss of sexual desire is one of the most highly-noted amongst them.⁷⁹ Thus, the law acknowledges that sexual desire is a sufficiently important personal trait so that its diminution must be weighed into the formulation of a medication refusal policy. Yet the law simultaneously denies the power and importance of sexual desire with respect to hospital ward life.

Most states do not recognize patients’ right to personal or interpersonal sexual relationships. In practice, a patient’s right to sexual interaction often depends on the whim of line-level staff or on whether such interaction is seen as a feature of the patient’s treatment plan.⁸⁰ It has even been suggested that

74. Bonnie P. Tucker, *The Americans With Disabilities Act of 1990: An Overview*, 22 N.M. L. REV. 13, 16 n.4 (1992); see also Bonnie Milstein, Leonard Rubenstein & Renee Cyr, *The Americans with Disabilities Act: A Breathtaking Promise for Persons with Mental Disabilities*, 24 CLEARINGHOUSE REV. 1240 (1991).

75. H.R. REP. NO. 485, 101st Cong., 2d Sess., pt. 4, at 25 (1990), reprinted in 1990 U.S.C.C.A.N. 512, 512.

76. But see Campbell & Tomkins, *supra* note 51, at 250 n.122 (demonstrating the positive impact of ameliorative civil rights legislation on stereotypes and bias).

77. See 42 U.S.C. § 12208 (Supp. III 1991). On the implications of the congressional debate that led to these exclusions, see Perlin, *supra* note 23 (manuscript at 22-23).

78. See 135 CONG. REC. S10,765-86 (daily ed. Sept. 7, 1989); see Perlin, *supra* note 23 (manuscript at 21-23) (discussing the significance of Helms’s comments). There has not yet been any litigation about these exclusions.

79. See 2 PERLIN, *supra* note 27, § 5.02, at 221 (quoting BARRY FURROW, MALPRACTICE IN PSYCHIATRY 61 (1980)). The loss of sexual desire as a side effect to be considered in determining the scope of patients’ right to refuse treatment is weighed in, *inter alia*, *In re Orr*, 531 N.E.2d 64, 74 (Ill. App. Ct. 1988); *In re Roe*, 421 N.E.2d 40, 54 (Mass. 1981); *Jarvis v. Levine*, 418 N.W.2d 139, 145-46 (Minn. 1988).

80. See Stefan, *Reproductive Rights*, *supra* note 18, at 431 (citing Renée Binder, *Sex Between Psychiatric Inpatients*, 57 PSYCHIATRIC Q. 121, 125 (1985)).

"sexual activity between psychiatric inpatients should be strictly prohibited, and when it occurs patients should be isolated . . . and tranquilized if necessary."⁸¹ One hospital's guidelines counsel patients as follows: "If you develop a relationship with another patient, staff will get together with you to help decide whether this relationship is beneficial or detrimental to you"⁸² Hospital staff is often hostile to the idea that patients may be sexually active in any way.⁸³

However, many institutional mental health professionals and behaviorists now recognize that patients "are and wish to be sexually active,"⁸⁴ and that sexual freedom often has therapeutic value.⁸⁵ Others call attention to our societal obligation to provide family planning assistance to women institutionalized in psychiatric hospitals.⁸⁶ Nonetheless, many hospitals remain reluctant to promulgate such policies.⁸⁷ This is not surprising, given the aforementioned paucity of legal authority requiring them to do so. Moreover, there is a near complete lack of literature generally available to guide hospitals and their staff, should they even desire to formulate such procedures.⁸⁸

Of the few litigated cases, probably the most interesting is *Foy v. Greenblott*.⁸⁹ In *Foy*, an institutionalized patient and her infant child (conceived and born while the mother was a patient in a locked psychiatric ward) sued the mother's treating doctor for his failure to either maintain proper supervision over her so as to prevent her from having sex or to provide her with contra-

81. Binder, *supra* note 80, at 125.

82. Gabor Keitner & Paul Grof, *Sexual and Emotional Intimacy Between Psychiatric Inpatients: Formulating a Policy*, 32 HOSP. & COMMUNITY PSYCHIATRY 188, 193 (1981).

83. See, e.g., *Rogers v. Okin*, 478 F. Supp. 1342, 1373-74 (D. Mass. 1979) (noting that patients are secluded for engaging in sexual behavior); SUSAN SHEEHAN, IS THERE NO PLACE ON EARTH FOR ME? 93 (1982) (describing how staff aides at Creedmoor Psychiatric Hospital refused to fill out "incident reports" on patient sexual activity because they found the subject matter "so unsavory"); Shelton, *supra* note 13, at 81. On the ways that overreporting of sexual activity at a state psychiatric hospital can have negative effects on the patients detained therein, see Holbrook, *supra* note 42, at 78-79.

84. Steven Welch, Joseph Meagher, John Soos & Jaswant Bhopal, *Sexual Behavior of Hospitalized Chronic Psychiatric Patients*, 42 HOSP. & COMMUNITY PSYCHIATRY 855, 855 (1991).

85. Binder, *supra* note 80, at 125.

86. See, e.g., Virginia Abernethy, Henry Grunebaum, Louise Clough, Barbara Hunt & Bonnie Groover, *Family Planning During Psychiatric Hospitalization*, 46 AM. J. ORTHOPSYCHIATRY 154 (1976).

87. For an example of one hospital that has promulgated such policies, see Katherine Bishop, Responding to Sexual Activity Between Clients: Legal and Ethical Dilemmas app. (Aug. 18, 1992) (Sexuality Policy and Procedures, Heritage Center, Erie County, N.Y.) (unpublished conference materials, on file with the *New York University Review of Law & Social Change*).

88. At least one early right-to-treatment case found that, to meet the constitutional predicate of a "trained and qualified staff," a "full range [of] (both professional and nonprofessional) . . . staff training" was mandated. *Davis v. Hubbard*, 506 F. Supp. 915, 921 (N.D. Ohio 1980); see also 2 PERLIN, *supra* note 27, § 4.23, at 120-23 (discussing *Davis* in this context). An argument could be made that training in patient sexuality issues would be explicitly required under this aspect of *Davis*.

89. 190 Cal. Rptr. 84 (Ct. App. 1983).

ceptive devices and/or sexual counseling.⁹⁰

The court rejected the plaintiffs' claims of improper supervision, finding that institutionalized patients had a right to engage in voluntary sexual relations as an aspect of the patient's rights to be placed either in the "least restrictive environment"⁹¹ necessary to serve the purposes of their commitment or at least in "reasonably non-restrictive confinement conditions."⁹² From this, the court held that a patient's right to engage in voluntary sexual relations required that she be afforded suitable opportunities for interactions with members of the opposite sex.⁹³ On the other hand, the court characterized the defendants' failure to provide the mother with contraceptive devices and counseling as a deprivation of her right to reproductive choice.⁹⁴ It also rejected a claim for "wrongful life" by the infant child, concluding that "[o]ur society has repudiated the proposition that mental patients will necessarily beget unhealthy, inferior, or otherwise undesirable children if permitted to reproduce."⁹⁵

Foy has been applauded as "a model exposition of the reproductive rights of institutionalized women,"⁹⁶ but it is an isolated case. Most of the few other recent cases that have been litigated on questions of the sexual rights of institutionalized persons are not so progressive. This cannot be attributed to mere oversight or coincidence. Judges (some of whom continue to endorse Justice Holmes's chilling dictum in *Buck V. Bell*⁹⁷) are excruciatingly uncomfortable deciding these cases.⁹⁸ More troubling, lawyers often fail to provide vigorous advocacy services on behalf of their mentally disabled clients, preferring a "best interests" model that capitulates to institutional power or preference.⁹⁹

90. *Id.* at 87.

91. *Id.* at 90 n.2.

92. *Id.* at 91 n.2.

93. *Id.* at 91. The case arose in the context of a patient's heterosexual activity. The court therefore had no reason or opportunity to consider the possibility that a patient's right to engage in sexual activities might require suitable opportunities for interactions with members of the same sex.

94. *Id.*

95. *Id.* at 93.

96. See Stefan, *Reproductive Rights*, *supra* note 18, at 433.

97. 274 U.S. 200 (1927). In an opinion by Justice Holmes, the *Buck* Court affirmed a lower court's finding that the plaintiff, Carrie Buck, was the "probable potential parent of socially inadequate offspring" and upheld Virginia's law mandating the sterilization of "mental defectives." *Id.* at 207. Though the Court's opinion was styled as a rejection of Buck's substantive due process claim, its true sanist bases were laid bare in Holmes's now infamous epigram: "Three generations of imbeciles are enough." *Id.* On judges' continued endorsement of this dictum, see Kenneth Robertson, *Letter to the Editor*, *DEVS. MENTAL HEALTH L.*, Jan.-June 1991, at 4.

98. See, e.g., *In re Mikulanec*, 356 N.W.2d 683, 687-88 (Minn. 1984) (holding that a conservator may be appointed for a person with mental illness for the limited purpose of approving or disapproving the person's marriage).

99. See generally Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 *LAW & HUM. BEHAV.* 39, 49-52 (1992) (criticizing the level of advocacy generally provided to mentally disabled clients as "substandard"); Perlin, *supra* note 17, at 405 (concluding that legal representation at commitment hearings had im-

These cases frequently are battlefields, with parents pitted against their children over the question of the extent to which institutionalized persons with mental disabilities can enforce their right to sexual interaction.¹⁰⁰ In sum, this is an area in which virtually all participants in the judicial system join with a significant number of hospital staff in wishing that the underlying "problem" would simply go away.

III ATTITUDES TOWARD SEX

A. Introduction

As I have already discussed, we (the general public) appear to be comfortable talking about sexuality (at least *others'* sexuality) in a variety of public and private forums,¹⁰¹ and we (law professors) are comfortable talking and writing about every other aspect of mental disability law.¹⁰² Yet we shy away from any scholarly consideration of the implications of policies that center on patients' sexuality.¹⁰³

Why is this? Is it our fear of our own polymorphous perversity (the desire to seek sexual pleasure without inhibition)?¹⁰⁴ Our denial of our deviant

proved little since the Perlin & Sadoff analysis, *supra* note 26); Perlin & Sadoff, *supra* note 26 (discussing survey data indicating that the legal representation provided to persons at commitment proceedings is largely inadequate).

100. Paul Stavis & Linda Tarantino, *Sexual Activity in the Mentally Disabled Population: Some Standards of the Criminal and Civil Law*, QUALITY OF CARE (N.Y.S. Comm'n on Quality of Care for the Mentally Disabled, Albany, N.Y.), Oct.-Nov. 1986, at 2. The bulk of litigation has come from the applications of parents and guardians seeking to sterilize mentally disabled daughters who they fear will become sexually active. See, e.g., *Ex parte M.K.R.*, 515 S.W.2d 467, 468 (Mo. 1974) (parents seeking sterilization of their "overly friendly" 13 year old institutionalized daughter); *In re Eberhardy*, 307 N.W.2d 881, 882 (Wis. 1981) (parents seeking court authorization to allow them to consent to the surgical sterilization of their 22 year old daughter who they believed had sexual contact with a male camper at a summer program for mentally retarded young adults); see also Stefan, *Reproductive Rights*, *supra* note 18, at 454 (discussing how sterilization may be seen as a perverse "vindication" of the reproductive rights of institutionalized women).

101. See *supra* notes 1-5 and accompanying text.

102. See *supra* notes 6-10 and accompanying text.

103. One anecdote should be illustrative. I teach an advanced seminar in therapeutic jurisprudence. Enrollment is limited to 12 students, each of whom has had the basic mental disability law courses and/or significant experience working in hospitals or in community mental health facilities. In the spring semester of 1992, a student in this course wrote a paper related to the question I am addressing here. When presenting it to the class, she absolutely refused to share portions of it. This was not, I should emphasize, a shy or retiring young woman, yet she felt incapable of discussing with her classmates information she was given by hospital workers describing ward sexual experiences of patients.

104. See SIGMUND FREUD, *CIVILIZATION AND ITS DISCONTENTS* 29 (James Strachey ed. & trans., Norton 1961) (1930). For recent jurisprudential considerations of polymorphous perversity, see David S. Caudill, *Freud & Critical Legal Studies: Contours of a Radical Socio-Legal Psychoanalysis*, 66 IND. L.J. 651, 661 (1991) (discussing Freud's thesis that "normal" sexuality is a result of social repression of infantile sexual impulses); Holbrook, *supra* note 42, at 79 (applying the concept of polymorphous perversity to the question of sexual autonomy of institu-

desires?¹⁰⁵ Our inability to confront the fact that mental patients in their sexuality are much more like us than not like us? To what extent does the personal baggage that each of us brings to our life as a sexual adult impede our ability to discuss the underlying issues?

B. Sanism¹⁰⁶ and Pretextuality

Much like sexism, racism, and other bigotries, sanism¹⁰⁷ infects our jurisprudence and our lawyering practices. It dominates social and legal discourse about persons with mental disabilities (especially *institutionalized* persons with mental disabilities). It infects interpersonal relationships, judicial decisions, legislative enactments, scholarly writings, administrative rulings, litigation strategies, expert testimony, clinical decisions, and social, cultural, and political actions. It is generally socially acceptable and largely unacknowledged. Sanist attitudes operate for the most part on an unconscious (and often invisible) level and are frequently found in the writings and public pronouncements of otherwise liberal or progressive individuals.¹⁰⁸ These attitudes are also rationalized through the nonreflective use of (often misleading) "ordinary common sense."¹⁰⁹ When social science data appear to rebut sanist myths, we simply ignore those data because they do not comport with our a priori views.¹¹⁰

Courts often respond to these sanist devices by condoning or encouraging pretextuality¹¹¹ in both civil and criminal cases involving mentally disabled

tionalized detainees); Pierre Schlag, *Missing Pieces: A Cognitive Approach to Law*, 67 TEX. L. REV. 1195, 1209 (1989) (arguing that nearly all legal texts are polymorphously perverse).

105. See Deborah A. Dorfman, *Deviant Desires and the Need for Punishment* 6-8 (Dec. 20, 1991) (unpublished manuscript, on file with the *New York University Review of Law & Social Change*).

106. The text *infra* accompanying notes 107-12 is largely adapted from Perlin, *supra* note 23 (manuscript at 12-17). See generally Perlin, *Morality*, *supra* note 45 (examining how the legal system condones pretextual decision making and testimony as a way of dealing with cognitively dissonant information); Perlin, *supra* note 17 (examining how sanist attitudes affect the acceptance of testimony in mental disability law jurisprudence); Perlin, *Pretexts*, *supra* note 45 (discussing courts' use of pretexts and their role in perpetuating sanism); Perlin & Dorfman, *supra* note 17 (discussing how sanist attitudes driven by irrational prejudices provide the subtext for pretextual decisions by judges concerning persons with mental disabilities).

107. See *supra* notes 15-17 and accompanying text.

108. See Perlin, *supra* note 15, at 93 n.173 (citing examples of liberal legislators' biases against persons with mental disabilities); Perlin, *supra* note 17, at 373 n.1 (citing examples of legislators' hesitancy to view biases against persons with mental disabilities in the same light as racism and sexism).

109. See Michael L. Perlin, *Psychodynamics and the Insanity Defense: "Ordinary Common Sense" and Heuristic Reasoning*, 69 NEB. L. REV. 3, 22-24 (1990) (discussing how ordinary common sense is used as an unconscious basis for making judgments about disabled defendants in criminal cases). This concept is considered most carefully in Richard K. Sherwin, *Dialects and Dominance: A Study of Rhetorical Fields in Confessions*, 136 U. PA. L. REV. 729, 737 (1988) (characterizing ordinary common sense as the attitude of "what I know is 'self-evident'; it is 'what everybody knows'").

110. See generally Perlin & Dorfman, *supra* note 17, at 49 (describing the different rationales that can be used to reject social science data in favor of sanist views).

111. See *supra* note 21.

litigants. By this I mean that courts accept (either implicitly or explicitly) testimonial dishonesty and engage in similarly dishonest decision making. In the present context, this is principally achieved where witnesses, particularly expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends."¹¹²

The pretexts of the forensic mental health system are reflected both in the testimony of forensic experts and in the decisions of legislators and fact finders.¹¹³ Experts frequently testify in accordance with their own self-referential concepts of "morality"¹¹⁴ and, in the process, openly subvert statutory and case law criteria.¹¹⁵ Their testimony is often further warped by a heuristic¹¹⁶ bias.¹¹⁷ Expert witnesses—like the rest of us—succumb to the meretricious allure of employing simplifying cognitive devices in their thinking and use such heuristic gambits as the *vividness effect*¹¹⁸ or *attribution theory*¹¹⁹ in their

112. Perlin, *Morality*, *supra* note 45, at 133; *see also* Charles Sevilla, *The Exclusionary Rule and Police Perjury*, 11 SAN DIEGO L. REV. 839, 840 (1974).

113. *Cf.* Streicher v. Prescott, 663 F. Supp. 335, 343 (D.D.C. 1987) (finding that, although the District of Columbia Code contained a provision that permitted patients to invoke periodic review of their commitment or to seek independent psychiatric evaluations, in the 22 years since the passage of the relevant statute, not a single patient had exercised her right to statutory review); Arlene S. Kanter, *Abandoned but Not Forgotten: The Illegal Confinement of Elderly People in State Psychiatric Institutions*, 19 N.Y.U. REV. L. & SOC. CHANGE 273, 304-06 (1991-92) (discussing the significance of Streicher).

114. *See, e.g.*, Cassia Spohn & Julia Horney, "The Law's the Law, But Fair Is Fair": Rape Shield Laws and Officials' Assessments of Sexual History Evidence, 29 CRIMINOLOGY 137, 139 (1991) (describing how a legal reform that contradicts deeply held beliefs may result either in open defiance of the law or in a surreptitious attempt to modify it).

115. *See, e.g.*, People v. Doan, 366 N.W.2d 593, 598 (Mich. Ct. App. 1985) (describing expert's testimony that defendant was "out in left field" and "bananas"). *See generally* Perlin, *Pretexts*, *supra* note 45, at 653 (describing how fact finder's sense of "morality" often affects their rulings in incompetency proceedings); Perlin & Dorfman, *supra* note 17, at 50.

116. A *heuristic* is a cognitive psychology construct that refers to implicit thinking devices that individuals use to oversimplify complex, information-processing tasks. *See* Perlin, *supra* note 21, at 169. On heuristics generally, *see* Donald N. Bersoff, *Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law*, 46 SMU L. REV. 329 (1992); Michael J. Saks & Robert F. Kidd, *Human Information Processing and Adjudication: Trial by Heuristics*, 15 LAW & SOC'Y REV. 123 (1980-81).

117. *See* Perlin, *supra* note 23 (manuscript at 25, 30) (describing how expert witnesses and factfinders employ heuristics to reach sanist conclusions not supported by evidence). *See generally* Perlin, *supra* note 15, at 91-93 (discussing how persons with mental illness are victimized by common sanist beliefs); Perlin, *supra* note 17, at 388-91 (discussing how reductionist stereotypes of mental illness reify ubiquitous sanist mythology); Perlin & Dorfman, *supra* note 17 (discussing how sanist thinking dominates much legal discourse and decisionmaking in mental health law); Perlin, *supra* note 109 (examining how the importance of testimony that doesn't "fit" with jurors' predispositions is minimized in jurors' minds). The use of these strategies frequently leads to systematically erroneous decisions through ignorance or misuse of rationally useful information. *See* Perlin, *supra* note 99, at 57 n.115.

118. The vividness heuristic teaches that a single, vivid, memorable case overwhelms the mountains of abstract, colorless data on which rational choices should be made. *See* Perlin, *supra* note 21, at 169; David Rosenhan, *Psychological Realities and Judicial Policy*, 19 STAN. LAW., Fall 1984, at 10, 13.

119. Attribution theory teaches that once a person adopts a stereotype, that individual will see a wide variety of information as reinforcing that stereotype. *See* Perlin, *supra* note 109, at 17-18 & nn.67-68 (citing sources).

testimony.¹²⁰

C. Sanism, Pretextuality, Teleology, and Sex

Sanist myths, based on stereotypes, are the result of rigid categorization and overgeneralization; they are created to "localize our anxiety, to prove to ourselves that what we fear does not lie within."¹²¹ In an earlier paper, I set out what I saw as the primal myth of the mentally ill:

Mentally ill individuals are "different," and, perhaps, less than human. They are erratic, deviant, morally weak, sexually uncontrollable, emotionally unstable, lazy, superstitious, ignorant, and demonstrate a primitive morality. They lack the capacity to show love or affection. They smell different from "normal" individuals, and are somehow worth less.¹²²

Our attitudes toward the sexuality of persons with mental disabilities reflect and reify this myth. Society tends to infantilize the sexual urges, desires, and needs of the mentally disabled.¹²³ Alternatively, they are regarded as possessing an animalistic hypersexuality, which warrants the imposition of special protections and limitations on their sexual behavior to stop them from acting on these "primitive" urges.¹²⁴ By focusing on alleged "differentness,"¹²⁵ we deny their basic humanity and their shared physical, emotional, and spiritual needs. By asserting that theirs is a primitive morality, we allow ourselves to censor their feelings and their actions. By denying their ability to show love and affection, we justify this disparate treatment.

A recent short piece in popular journalist Herb Caen's column is illustrative. The item reads as follows:

120. See generally Bersoff, *supra* note 116 (examining how heuristic biases often distort the underlying facts in expert testimony by mental health professionals); Perlin, *supra* note 109 (observing how heuristic biases infect virtually every phase of the judicial process, including expert testimony, in insanity defense cases); Saks & Kidd, *supra* note 116 (addressing the role of quantitative methods in testimony as a means to avoid heuristic biases in decision making).

121. GILMAN, *supra* note 13, at 240.

122. Perlin, *supra* note 17, at 393-94 (citing, *inter alia*, ALLPORT, *supra* note 16, at 196-98; Peggy C. Davis, *Law as Microaggression*, 98 YALE L.J. 1559, 1561 (1989) (other citations omitted)).

123. See Perlin, *supra* note 17, at 394 (discussing sanist myth that "[a]t the best, the mentally disabled are simple and content, like children"). See generally Mary Romano, *Sex and Disability*, in *DISABLED PERSONS AS SECOND-CLASS CITIZENS* 64, 67 (Myron G. Eisenberg, Richard Duval & Cynthia Griggins eds., 1982) (discussing how persons with disabilities are often stereotyped as asexual, dependent, and childlike).

124. See GILMAN, *supra* note 13, at 24-25, 142-48, 162 (discussing how certain racial and religious minority groups are often viewed in these ways); Holbrook, *supra* note 42, at 79 ("Mental hospitals today are often portrayed by the media as inhabited by sexual deviates, psychopaths and rapists whose uncontrolled sexual impulses and polymorphous sexual perversities require protracted treatment and confinement."); see also Perlin, *supra* note 17, at 394 (discussing sanist myth that "at the worst, [mentally ill persons] are invariably more dangerous than non-mentally ill persons").

125. See generally MARTHA MINOW, *MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW* (1990).

No comment dept. (notice in the Dance Palace Community Center bulletin in Pt. Reyes): "In cooperation with the Pt. Reyes Clinic and with funding from the West Marin Thrift Store, the Dance Palace will be placing a condom machine in the handicapped bathroom."¹²⁶

The idea that physically handicapped individuals might need condoms is apparently too bizarre for Caen to contemplate. One wonders how he would react to the notion of *mentally* disabled persons being sexually active.

Sanist myths lead to pretextual decision making.¹²⁷ As Professor Susan Stefan has perceptively noted, courts routinely find mentally disabled women *incompetent* to engage in sexual intercourse (i.e., to lack sufficient competence to engage knowingly and voluntarily in such behavior), but just as routinely find such individuals *competent* to consent to give their children up for adoption.¹²⁸ In one startling case, a court made both of these findings simultaneously about the same woman.¹²⁹

Other pretextual decision making is regularly present in cases involving criminal prosecutions of men charged with having sex with mentally disabled women.¹³⁰ Professor Stefan's analysis of these cases suggests that courts regularly employ a series of pretexts as to the woman's capacity to consent¹³¹ in cases where, otherwise, a conviction might not be sustainable under traditional rape law standards.¹³² If there is a question concerning whether a particular rape victim "consented," a judicial finding that she lacked mental capacity makes the consent inquiry irrelevant, thus intuitively making a conviction far more likely.

In other contexts, parents with mental disabilities can lose custody of their children because of behavior—such as having a "bad attitude" or being sexually promiscuous—that would rarely (if ever) be invoked if displayed by nondisabled parents.¹³³ In one parental rights termination case, expert testi-

126. Herb Caen, *3-Dot Journalism Survives*, S.F. CHRON., Jan. 6, 1993, at B1.

127. For a court's pretextual treatment of sexual fantasies in a case apparently not involving mentally disabled individuals, see *Meritor Savings Bank v. Vinson*, 477 U.S. 57, 68-69 (1986) (holding that plaintiff's mode of dress, lifestyle, and "expressed sexual fantasies" were all admissible evidence in sexual harassment claim). On the way that sexual fantasies were traditionally seen as characteristic of "unchaste women," see James A. Vaught & Margaret Henning, *Admissibility of a Rape Victim's Prior Sexual Conduct in Texas: A Contemporary Review and Analysis*, 23 ST. MARY'S L.J. 893, 903 (1992).

128. Stefan, *Silencing*, *supra* note 18, at 805.

129. See *State v. Soura*, 796 P.2d 109, 113-15 (Idaho 1990) (holding that a mentally disabled woman was not competent to consent to extramarital sexual intercourse though she was married and had previously had a child), *discussed in* Stefan, *Silencing*, *supra* note 18, at 797; see also *In re Burbanks*, 310 N.W.2d 138, 143-51 (Neb. 1981) (describing social service employees' testimony that parents did not have mental capability to be parents, although the employees willingly assisted the parents in processing papers to authorize the performance of an abortion on, and sterilization of, their daughter), *discussed in* Stefan, *Silencing*, *supra* note 18, at 775.

130. Stefan, *Silencing*, *supra* note 18, at 796.

131. See Carson, *supra* note 25, at 87 (describing pragmatism of judicial decision making).

132. Stefan, *Silencing*, *supra* note 18, at 796-99.

133. Stefan, *Reproductive Rights*, *supra* note 18, at 448 (discussing *In re J.L.P.*, 416 So. 2d

mony that persons with disabilities "cannot show love and affection as well as can persons of normal intelligence" was relied upon to support termination findings.¹³⁴

These pretextual decisions are, at base, teleological. By teleological, I refer to outcome-determinative reasoning; social science that enables judges to satisfy predetermined positions is privileged, while data that would require judges to question such ends are rejected.¹³⁵ As Professor Stefan has noted, courts determine competence "quite blatantly in terms of the *desirability of the outcome*."¹³⁶ Justice Holmes's chilling epigram in *Buck v. Bell*—"three generations of imbeciles is enough"¹³⁷—is a perfect example¹³⁸ and is particularly telling in light of the questions under discussion here. As in many other areas of mental disability law,¹³⁹ the pretexts of trial testimony and judicial decision making, premised on sanist myths, pervade all judicial decision making in this area.¹⁴⁰

IV RIGHTS IN COLLISION

A. Introduction

Let us assume that we can, somehow, identify and eliminate the sanist myths, pretextual decision making, and teleological thinking employed in the

1250, 1251-53 (Fla. Dist. Ct. App. 1982) (upholding a court order committing a mentally retarded woman's child to the custody of the Florida Department of Rehabilitation Services after a finding of abuse and neglect)).

134. *In re McDonald*, 201 N.W.2d 447, 450 (Iowa 1972), discussed in Stefan, *Reproductive Rights*, *supra* note 18, at 449.

135. See generally Perlin & Dorfman, *supra* note 17 (criticizing teleological use of social science in development of mental disability jurisprudence).

136. Stefan, *Silencing*, *supra* note 18, at 774; see also *id.* at 798 (showing how courts "must" find women incompetent in statutory rape prosecutions "in order to circumvent the discontinuity between rape law and women's experiences of forced sex").

137. 274 U.S. 200, 207 (1927).

138. See, e.g., Robert J. Cynkar, *Buck v. Bell: "Felt Necessities" v. Fundamental Values?*, 81 COLUM. L. REV. 1418 (1981); Stephen J. Gould, *Carrie Buck's Daughter*, 2 CONST. COMMENT. 331 (1985); Paul A. Lombardo, *Three Generations, No Imbeciles: New Light on Buck v. Bell*, 60 N.Y.U. L. REV. 30 (1985) (all demonstrating the utter lack of scientific basis for the conclusion that either Carrie Buck or any of her succeeding generations were "mentally defective" or "imbeciles"); see also *supra* note 97.

139. See generally Perlin, *Morality*, *supra* note 45, at 133; Perlin, *Pretexts*, *supra* note 45, at 625.

140. See, e.g., *People v. Stevens*, 761 P.2d 768, 775 n.12 (Colo. 1988) (relying on presumed sexually inappropriate dress and manner—"pos[ing] provocatively in front of a mirror in a [hospital] day room in a tight-fitting leotard"—as sufficient evidence of a patient's danger to self to support his order of commitment); *State v. Hass*, 566 A.2d 1181, 1185 (N.J. Super. Ct. Law Div. 1988) (holding that a patient's sexual fantasies can serve as confirmatory evidence supporting his need for treatment under state Sexual Offenders Act); see also *State v. Murphy*, 760 P.2d 280, 284 (Utah 1988) (discussing how state prosecutor urged that an insanity acquittee's (apparently consensual) sexual contact (e.g., touching of nonerogenous zones and kissing) evidenced his potential risk to the community if he were to be released into a transitional services program).

disposition of these cases. It will still be difficult to resolve these issues because of the likelihood that many of the rights in question may conflict with other rights. Putting aside those cases where a patient's mental illness is closely connected with her sexual or reproductive behavior,¹⁴¹ nonetheless, we will all too frequently confront what have been called "incredible dilemmas."¹⁴² What can or should be done when multiple civil, constitutional, or statutory rights and policies clash?

B. The Presenting Dilemma

Say we assume that there is a baseline right to "meaningful sexual interaction" (whatever content we give to that phrase). First, consider the standard tort law dilemma that confronts contemporary mental hospital administrators: how to reconcile an "open door," or "least restrictive alternative"¹⁴³ policy with the correlative duty to protect?¹⁴⁴ Broken love affairs or bad sexual experiences generally do not improve the mental health of persons who are not mentally disabled. Do we (can we) (may we) (must we) risk scarring the presumably more fragile psyches of institutionalized patients by

141. For example, supposing hypothetically, what happens if a patient with a delusion that she is pregnant with Elvis Presley's love child actually becomes pregnant, or if a patient who is convinced that his sperm contains radioactive poison that can annihilate the world becomes sexually active? Less graphic but more likely examples would include individuals who were sexually abused as children and whose mental illnesses may stem at least partially from those experiences, as well as floridly manic patients with grossly impaired judgment. On the relationship between childhood sexual abuse and subsequent institutionalization, see Susan Stefan, *The Protection Racket: Violence Against Women, Psychiatric Labelling and Law*, 88 NW. U. L. REV. 4 (1994).

142. See Peter Westen, *Incredible Dilemmas: Conditioning One Constitutional Right on the Forfeiture of Another*, 66 IOWA L. REV. 741, 742 (1981) (discussing *Simmons v. United States*, 390 U.S. 377, 391 (1968), in which the Supreme Court held that a defendant's testimony at a suppression hearing may not be used as substantive evidence of his guilt); see also 3 PERLIN, *supra* note 27, § 16.07, at 443 (discussing *Smith v. Murray*, 477 U.S. 527, 533 (1986), in which the Supreme Court held a defendant's tactical decision not to pursue a particular constitutional claim waived his right to raise the claim for the first time in a request for federal habeas corpus).

143. See *Johnson v. United States*, 409 F. Supp. 1283, 1292-93 (M.D. Fla. 1976) (holding that hospital staff was not negligent for releasing a person who subsequently shot the plaintiff and committed suicide, as the release complied with the legislative intent that psychiatric patients be treated "with no more restrictions than good medical practice requires" and the generally accepted "open door" policy emphasizing short term care and outpatient therapy); 3 PERLIN, *supra* note 27, § 12.18 (noting that while the psychiatric community has embraced "open door" and "least restrictive alternative" policies, many courts have insisted that doctors balance benefits to the patient with the risks to the patient and public at large).

144. See generally 3 PERLIN, *supra* note 27, § 12.18, at 53-56 (noting that courts have generally endorsed the open door policy, subject to the limitation that the potential benefits to a patient should be balanced against the likelihood and severity of the concomitant risk to that patient and to the general public); Perlin, *supra* note 15, at 127 n.380 (discussing whether courts should always play a role in decisions to release dangerous patients); Perlin, *supra* note 9, at 45 (arguing that rulings such as that in *Tarasoff v. Regents*, 551 P.2d 334, 360 (Cal. 1976), which imposed on doctors a duty to protect others from the risk of harm from patients in their care with mental illness, may lead doctors to violate the constitutional rights of their patients by inappropriately ordering their involuntary commitment, failing to provide appropriate treatment, and denying them the right to refuse treatment).

not restricting their ability to expose themselves to similar traumas? Or is this presumption that a person with mental disabilities is emotionally frail simply the product of paternalism, infantilization, and sanism? Finally, will a recognition of involuntary detainees' right to sexual intimacy lead to an increase in constitutional tort and state tort claims? How will courts construe such cases?¹⁴⁵

Next, let us consider the right to be left alone. In 1987, the Sixth Circuit Court of Appeals held that there is a fundamental constitutional right to be free from forced exposure to strangers of the opposite sex when it is not reasonably necessary for a legitimate overriding reason.¹⁴⁶ If we remove restrictions on the right of institutionalized patients to be sexually active, the universe of individuals with whom they can be active is fairly limited. How may the rights of institutionalized patients to be free from unwanted sexual attention be safeguarded in this context?

What about AIDS?¹⁴⁷ Should HIV-positive patients be segregated within an institution? Would this conflict with other policies?¹⁴⁸ Can we risk increasing the number of HIV-positive individuals in *any* aspect of society, much less in institutions?

What about reproductive freedom issues? Should (must) birth control devices be supplied to psychiatric patients who are given unescorted hospital leave? This has apparently been a *de facto* policy in at least one New York State psychiatric hospital.¹⁴⁹ In at least one New York City hospital, male patients leaving the facility on unsupervised community leave are given condoms upon request. Female patients, on the other hand, must have their competency (informally) assessed before birth control pills can be prescribed.¹⁵⁰ Certainly this raises arguable equal protection claims.

How will groups opposed to sex education and the distribution of condoms in schools react if condoms are distributed in psychiatric hospitals?¹⁵¹ Will the right to sexual autonomy lead to increased efforts to sterilize institutionalized individuals?

145. See, e.g., *Martin v. City of Eastlake*, 686 F. Supp. 620 (N.D. Ohio 1988) (constitutional tort claim); *Gutierrez v. Thorne*, 537 A.2d 527 (Conn. App. Ct. 1988) (state tort claim).

146. *Kent v. Johnson*, 821 F.2d 1220, 1226 (6th Cir. 1987).

147. See *supra* notes 37-44 and accompanying text.

148. Compare *Nolley v. County of Erie*, 776 F. Supp. 715, 738 (W.D.N.Y. 1991) (holding policy mandating the segregation of HIV-positive inmates unconstitutional) with *Harris v. Thigpen*, 941 F.2d 1495, 1521 (11th Cir. 1991) (holding policy of segregating HIV-positive inmates was not violative of constitutional rights). See generally Ayesha Khan, *The Application of Section 504 of the Rehabilitation Act to the Segregation of HIV-Positive Inmates*, 65 WASH. L. REV. 839 (1990) (discussing related policies that have been implemented in prisons).

149. Telephone Conversation with Keri Gould, Professor of Law, New York Law School and former Senior Trial Attorney with New York Mental Hygiene Legal Services (Nov. 11, 1992).

150. Comment by member of audience at Grand Rounds Presentation at Kirby Forensic Psychiatric Hospital (Nov. 1992). There is apparently no written memorandum or regulation memorializing this policy. *Id.*

151. See *supra* note 44.

What about abortion rights? In what way do institutionalized women's abortion rights differ from those possessed by women in the free world?¹⁵² What about their right to resist an abortion? There is at least one reported example of a suit for damages in response to an unauthorized abortion that was performed on an institutionalized woman with mental disabilities.¹⁵³ Anecdotal evidence suggests that it is not rare for state hospital doctors at certain facilities to attempt to coerce patients into terminating pregnancies.¹⁵⁴ If there is subsequent litigation on this question, how will courts respond?¹⁵⁵

Many antipsychotic medications, as well as other drugs, are contraindicated in cases of pregnancy.¹⁵⁶ Should rules governing a patient's right to refuse antipsychotic medication be reconceptualized if more patients become sexually active and a higher pregnancy rate results?¹⁵⁷

What role do considerations about a patient's "competencies" play in this inquiry? Almost all courts adhere to the catechism that competency is *not* a unitary status and that an individual may be competent for one activity but not for another.¹⁵⁸ However, research shows that clinicians often reject this line of thinking and, for example, regard incompetency to stand trial as co-extensive with incompetency to refuse treatment.¹⁵⁹ Other research suggests,

152. *Cf. In re Doe*, 533 A.2d 523, 526 (R.I. 1987) (holding trial court's authorization of the performance of an abortion on a mentally retarded woman reasonable, based on a finding that the woman would have exercised her right to terminate her pregnancy had she been competent to make such a decision).

153. *McCandless v. State*, 166 N.Y.S.2d 272 (Ct. Cl. 1956), *modified in part & rev'd in part*, 162 N.Y.S.2d 570 (App. Div. 1957), *aff'd*, 149 N.E.2d 530 (N.Y. 1958).

154. Telephone Conversation with Professor Keri Gould, *supra* note 149.

155. *Compare Doe v. General Hosp.*, 434 F.2d 427 (D.C. Cir. 1970) (challenging pre-*Roe v. Wade* hospital regulations which permitted abortions only when necessary to protect pregnant woman's mental health as evidenced by a provable history of mental illness) with *People v. Barksdale*, 503 P.2d 257, 262 (Cal. 1972) (upholding state's pre-*Roe v. Wade* Therapeutic Abortion Act allowing abortions only where a woman's continued pregnancy would create a substantial risk of her experiencing gravely impaired physical or mental health).

156. *See generally* David L. Lourwood & June E. Riedlinger, *The Use and Safety of Drugs in Pregnancy: Trends and Issues in Pharmacy Practice*, DRUG TOPICS, Sept. 4, 1989, at 60 (discussing the utility and safety of various drugs during pregnancy).

157. *Cf. In re K.S.T.*, 578 N.E.2d 306 (Ill. App. Ct. 1991). *K.S.T.* affirmed a lower court's termination of a mother's parental rights as an unfit parent based in part on the fact that the woman stopped taking Prolixin during her pregnancy. *Id.* at 309. Prolixin is a psychotropic medication, the effects of which on fetal development have never been determined. PHYSICIAN'S DESK REFERENCE 520 (Medical Economics Co. ed., 48th ed. 1994); *see also* Lourwood & Riedlinger, *supra* note 156, at 64-66 (discussing the use and effects of psychotropic medication taken during the course of pregnancy).

158. *See* sources cited *supra* note 60; *see also Koehler v. State*, 830 S.W.2d 665, 666 (Tex. Ct. App. 1992) (finding determination that a defendant incompetent to manage his own affairs is not a prima facie showing of incompetency to stand trial). *But see Moran v. Godinez*, 113 S. Ct. 2680, 2685 (1993) (holding that the same standard may be applied in assessing a defendant's competency to stand trial and her competency to waive constitutional rights); *United States v. Charters*, 863 F.2d 302, 310 (4th Cir. 1988) (en banc) (stating that the difference between competency to stand trial and competency to refuse antipsychotic medications is a distinction "of such subtlety and complexity as to tax perception by the most skilled medical or psychiatric professionals"), *cert. denied*, 494 U.S. 1016 (1990).

159. *See generally* Brian Ladds, Antonio Convit, Julie Zito & Joseph Vitrai, *The Dispost-*

just as troublingly, that clinicians are far more likely to find incompetency when a patient disagrees with their conclusions as to what treatment would be in the patient's best interests.¹⁶⁰

How will all of this play out in the context of the sexual interaction of institutionalized patients? Is there one "sexual competency"? What if one person in the relationship is "sexually competent" and the other is not? It is black letter law that, in criminal prosecutions, a "mentally defective" person is deemed incapable of consenting to sexual intercourse.¹⁶¹ Need there be a statutory override here? One court reversed a sexual assault charge that was premised on the complainant's "mental incapacitation" by virtue of her institutionalization.¹⁶² The court held such presumptions invalid and found that the complainant retained the ability to consensually engage in sexual intercourse.¹⁶³ But other courts simply apply statutes proscribing sexual intercourse with individuals with mental illness.¹⁶⁴

Should this version of statutory rape be consigned to the historical scrap heap? Might an acknowledgment of the rights of institutionalized persons with mental disabilities come only at the expense of making it more difficult to prosecute sexual assaults on persons with mental disabilities in the commu-

tion of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial, 38 J. FORENSIC SCI. 1442 (1993); Brian Ladds, Antonio Convit, Julie Zito & Joseph Vitrai, *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review*, 21 BULL. AM. ACAD. PSYCHIATRY L. 529 (1993); Brian Ladds & Antonio Convit, *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Review of Empirical Studies* (unpublished manuscript, on file with the *New York University Review of Law & Social Change*).

160. Stefan, *Silencing*, *supra* note 18, at 784 (citing, *inter alia*, GEORGE J. ANNAS, SYLVIA A. LAW, RAND E. ROSENBLATT & KENNETH R. WING, *AMERICAN HEALTH LAW* 652 (1990); FAY ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* 23 (2d ed. 1990)).

161. *People v. McMullen*, 414 N.E.2d 214, 217 (Ill. App. Ct. 1980) (holding that what the court viewed as an inability to understand "the social and personal costs" of sexual activity rendered a complainant with mental disabilities incapable of consenting to such activity); *Hall v. State*, 504 N.E.2d 298, 300 (Ind. Ct. App. 1987) (finding that the trier of fact could reasonably conclude that a complainant with moderate mental disabilities was incapable of consenting to sexual intercourse).

162. *State v. Green*, No. 01-C-01-9002-CC-00045, 1990 Tenn. Crim. App. LEXIS 653, at *10 (Oct. 3, 1990) (holding that the woman's institutionalizations was not sufficient evidence of the nature and extent of a woman's mental disabilities for the court to legally presume her incapable of consent to sexual activity, as would have been necessary to uphold the defendant's statutory rape conviction).

163. *Id.* at *3; *see also* *People v. Blunt*, 212 N.E.2d 719, 722 (Ill. App. Ct. 1965) (holding that a mentally retarded woman had the capacity to consent to sexual activity).

164. *See* *People v. McMullen*, 414 N.E.2d 214, 217 (Ill. App. Ct. 1980) (noting that the understanding of the physical nature of intercourse does not create the assumption that individual with 45 IQ was capable of forming proper consent to engage in sex with defendant); *Bozarth v. State*, 520 N.E.2d 460, 462 (Ind. Ct. App. 1988) (finding statute not unconstitutionally vague); *Stafford v. State*, 455 N.E.2d 402, 405 (Ind. Ct. App. 1983) (holding that individual who is unable to understand the act of sex, its nature, and its possible consequences was not legally qualified to consent to intercourse with defendant); *State v. Hill*, 406 A.2d 1334, 1335-36 (N.J. Super. Ct. App. Div. 1979) (finding such a statute does not violate either the Equal Protection or Constitution in general).

nity?¹⁶⁵ Is there a difference between prosecutors' attitudes towards sexual crimes in hospitals and those in the community?¹⁶⁶ Will awareness of the underlying issues bring about changes in state administrative policies governing the investigation of criminal sexual assaults in psychiatric hospitals?¹⁶⁷

Is the competency to consent to sexual intercourse the same as the competency to choose a certain method of birth control (or to choose not to use birth control)? Or to have or forego an abortion? Are there different competencies for sexual intercourse and for other forms of sexual interaction?

How do any of these competencies relate to more commonly-confronted competency questions such as the refusal of medication or voluntary admission? In *Zinermon v. Burch*,¹⁶⁸ for example, in the course of holding that a patient could maintain a civil rights suit alleging a right to a due process hearing prior to his "voluntary" admission to a mental health facility, the Supreme Court noted that the "very nature of mental illness" makes it "foreseeable" that such a person "will be unable to understand any proffered 'explanation and disclosure of the subject matter' of the forms that [such a] person is asked to sign, and will be unable 'to make a knowing and willful decision' whether to consent to admission."¹⁶⁹ What impact will this language from *Zinermon*—contrary to virtually all valid and reliable current psychological research¹⁷⁰—have on efforts to expand notions of patient autonomy and competency?¹⁷¹

165. See Karen Houppert, *Boystown: Glen Ridge Circles the Wagons*, VILLAGE VOICE, Nov. 10, 1992, at 11. See generally Hilary Brown & Vicky Turk, *Defining Sexual Abuse as it Affects Adults with Learning Disabilities*, 20 MENTAL HANDICAP 44 (1992) (discussing when sexual activity between a person with mental disabilities and a person without mental disabilities can, is, or should be defined as sexual abuse).

166. In Great Britain, for example, out of 1,000 cases per year of rape and sexual abuse of mentally disabled women, only 10 are prosecuted (resulting in three convictions this past year). Letter from David Carson, Professor of Law, University of Southampton, England, to author (Dec. 7, 1992) (on file with author); see also Linda Lynwander, *Sex Abuse and the Mentally Retarded*, N.Y. TIMES, (N.J. Weekly Desk) Dec. 27, 1992, § 13, at 1 (discussing a recent New Jersey initiative promoting sexual abuse prevention classes for persons with mental retardation). But see Holbrook, *supra* note 42 (discussing the dangers of overreporting sexual abuse in cases involving institutionalized persons with mental disabilities).

167. See *Investigation into Sexual Abuse of Mentally Disabled Woman Prompts Call for State Policy on Reporting Crimes*, QUALITY OF CARE (N.Y. State Comm'n on Quality of Care for the Mentally Disabled, Albany, N.Y.), Sept.-Oct. 1987, at 1; NEW YORK STATE COMM'N ON QUALITY OF CARE FOR THE MENTALLY DISABLED, IN THE MATTER OF LISA COHEN: THE NEED FOR A POLICY IN THE DEVELOPMENTAL DISABILITIES SYSTEM FOR REPORTING APPARENT CRIMES TO LAW ENFORCEMENT AGENCIES (N.Y. State Comm'n on Quality of Care for the Mentally Disabled, Albany, N.Y.) (1987) (on file with the *New York University Review of Law and Social Change*).

168. 494 U.S. 113 (1990).

169. *Id.* at 133 (emphasis added) (quoting FLA. STAT. ch. 394.455(22) (1979), which defines informed consent in this context).

170. See, e.g., Paul Appelbaum & Loren Roth, *Clinical Issues in the Assessment of Competency*, 138 AM. J. PSYCHIATRY 1462, 1465 (1981); Loren H. Roth, Alan Meisel, & Charles W. Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 280-82 (1977).

171. See Perlin & Dorfman, *supra* note 17, at 55-56 (discussing the *Zinermon* Court's troubling failure to use available social science data).

Finally, how does the ADA affect all of this?¹⁷² To what extent does the ADA's bar on discrimination against disabled persons require the reconceptualization of hospital policies prohibiting patients' sexual activity?¹⁷³ If it appears that the ADA might be a tool to attack such policies, might that cause some former ADA supporters to rethink their position on the Act?

In coming to our ultimate conclusions, we must decide not only which rights trump which other rights,¹⁷⁴ but also how we set priorities in defining the underlying question. What do we look at first: autonomy rights,¹⁷⁵ civil libertarian concerns,¹⁷⁶ due process requirements,¹⁷⁷ privacy interests,¹⁷⁸ competency criteria,¹⁷⁹ clinical needs,¹⁸⁰ therapeutic jurisprudential concerns,¹⁸¹ tort liability worries,¹⁸² voluntariness constructs,¹⁸³ or the immutable fact that sexual interaction, by its very description, entails the participation of more than one individual?¹⁸⁴ No resolution of the underlying issues can be contemplated unless we sort out these approaches and carefully articulate their interrelationships, their potential conflicts, and their relative values as competing social choices. In short, this is a very difficult project.

CONCLUSION

I have no definitive or even murky answers to these questions. To make matters worse, the conceptual problem is exacerbated by the way that heuristic reasoning distorts the development of social policy.¹⁸⁵ For example, we know that one vivid case can irrevocably alter the development of the law in

172. See generally Perlin, *supra* note 23 (discussing the ADA's implications for persons with mental disabilities).

173. See, e.g., Cook, *supra* note 23, at 427 (arguing that the ADA, 42 U.S.C. §§ 12101-12213 (Supp. III 1991), should be interpreted as prohibiting gender-segregated institutions for the mentally disabled); see also Stacy E. Seicshnaydre, *Community Mental Health Treatment for the Mentally Ill—When Does Less Restrictive Treatment Become a Right?*, 66 TUL. L. REV. 1971, 1991 (1992) (noting that although the ADA permits different programs and services for persons with mental disabilities, such persons may neither be denied the opportunity to participate in integrated programs nor be required to participate in separate ones).

174. See Michael L. Perlin, *Power Imbalances in Therapeutic and Forensic Relationships*, 9 BEHAV. SCI. & L. 111, 113 n.28 (1991) (discussing the meaning of *trump* in mental disability law).

175. See, e.g., *supra* notes 22, 25, 69 and accompanying text.

176. See *supra* note 32 and accompanying text.

177. Cf. *supra* note 69.

178. See *supra* notes 19, 69, 145-46 and accompanying text.

179. See *supra* notes 31, 60, 128-29, 131-32, 158-71 and accompanying text.

180. See *supra* notes 32-33, 35 and accompanying text.

181. See *supra* notes 8-9, 32 and accompanying text.

182. See *supra* notes 38-42, 143-45 and accompanying text.

183. See *supra* note 26 and accompanying text.

184. But see Shelton, *supra* note 13 (discussing teaching masturbation skills to a seriously mentally disabled institutionalized patient).

185. See generally Perlin, *supra* note 109 (arguing that the use of heuristic and ordinary common sense reasoning have together exerted a marked impact on insanity defense jurisprudence, particularly with respect to the perpetuation of myths concerning the abuse of this defense); Saks & Kidd, *supra* note 116 (advocating that experts should present the mathematical and statistical data and tools they employ in reaching their conclusions to fact finders in order

all facets of mental disability jurisprudence.¹⁸⁶ The Hinckley insanity acquittal is the most obvious example,¹⁸⁷ but there are many others.¹⁸⁸ What impact will the Glen Ridge case¹⁸⁹ have on the resolution of all of these issues? The facts there—a vicious and brutal sexual assault by a group of teenage boys on a young woman with developmental disabilities who apparently had a history of both “voluntary” and coerced sexual activity—are very different from the facts that underlie my discussion of the rights to consensual sexual activity for institutionalized patients. But the fallout from that case may well have a significant impact on any judge, legislator, or administrator who attempts to grapple carefully with any or all of the problems discussed here. This will be particularly true if the laws themselves are restructured so as to change the extent to which a mentally disabled adult will or will not be legally categorized with children and young teenagers in statutory rape laws.

This conclusion is not meant to be nihilistic, but rather serves as a reminder of how our legal system reacts dysfunctionally when the tensile strength of its legal principles is tested to their outermost limits.¹⁹⁰ Because the focus of this Article is a litmus test for such a wide range of social attitudes on so many charged and loaded questions, the chance that the system will

to avoid the otherwise nearly inevitable errors in fact-finding which result from heuristic biases inherent in much intuitive decision making).

186. See *supra* note 118 (discussing the vividness heuristic).

187. United States v. Hinckley, 525 F. Supp. 1342 (D.D.C. 1981), *clarified*, 529 F. Supp. 520 (D.D.C.), *aff'd*, 672 F.2d 115 (D.C. Cir. 1982).

188. See, e.g., Perlin, *supra* note 17, at 400 (noting that, in response to the public outcry over John Hinckley's being found not guilty by reason of insanity for the shooting of President Ronald Reagan, Congress narrowed the criteria for the federal insanity defense); Perlin, *Morality*, *supra* note 45, at 132 (arguing that the popular reaction to the Hinckley acquittal wiped out ‘years of study . . . and reflective inquiry’ into the relationship between the law and the forensic mental health system); Perlin, *Pretexes*, *supra* note 45, at 639 (discussing the popularly held fear that defendants will falsely claim to be insane to escape criminal sanctions despite empirical evidence that this is rare (citing State v. Willard, 234 S.E.2d 587, 591-93 (N.C. 1977)); Perlin & Dorfman, *supra* note 17, at 60-61 (noting how the popular response to the Hinckley insanity acquittal led to increased attacks on the insanity defense).

189. Four former high school football players from Glen Ridge, New Jersey, were convicted of sexually assaulting a young woman with mental disabilities with a broom handle, baseball bat, and a stick. New Jersey *in re* B.G., C.A. and P.A., 589 A.2d 637 (N.J. Super. Ct. App. Div. 1991). Despite the barbarity of the assault itself, much attention was focused on the woman's past sexual experience and the extent of her ability to understand or exercise her right to refuse to engage in sexual acts. For representative press accounts, see Catherine S. Manegold, *Glen Ridge Verdict May Be Milestone for Retarded*, N.Y. TIMES, Mar. 19, 1993, at B16; Sydney Schanberg, *11 Youths Who Disgraced Themselves*, N.Y. NEWSDAY, Nov. 6, 1992, at 51; Laurie Goodstein, *Girl's Low IQ May Determine Outcome of Sexual Assault Trial*, HOUS. CHRON., Nov. 1, 1992, at A15; Bernard Lefkowitz, *Teen Called Sex Obsessed*, N.Y. NEWSDAY, Oct. 17, 1992, at 74.

190. See PERLIN, *supra* note 30, at 377 (discussing Linda C. Fentiman, “Guilty But Mentally Ill”: The Real Verdict Is Guilty, 26 B.C. L. REV. 601, 611 n.63 (1985)); Michael L. Perlin, *Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence*, 40 CASE W. RES. L. REV. 599, 614-15 (1989-90); David B. Wexler, *Redefining the Insanity Problem*, 53 GEO. WASH. L. REV. 528, 537 (1985) (arguing that the various reforms for the insanity defense which were instituted in the wake of the Hinckley acquittal are unlikely to achieve enduring results, because they fail to address the real roots of public dissatisfaction with this defense).

respond dysfunctionally seems particularly high. This puts more responsibility on each of us, as well as on other decision makers in this area, to think carefully, consciously, and reflectively about our values and the choices we make.

In discussing the initial set of considerations that need to be weighed, I raised the baseline question of whether it was clinically beneficial or antitherapeutic to allow patients significant sexual autonomy.¹⁹¹ Legal and behavioral scholars are making exciting progress in articulating and studying therapeutic jurisprudence, in which the law's potential use as a therapeutic agent is critically examined.¹⁹² The issues discussed here pose difficult challenges for therapeutic jurisprudential scholars who must make certain that their focus on therapeutic concerns does not subordinate the civil liberties of persons with disabilities.¹⁹³

It is not enough to ask whether it is therapeutic for institutionalized individuals to have sex. We must also question the therapeutic or antitherapeutic implications of official hospital policies that control the place, manner, and frequency with which such individuals can have sexual interactions. We must consider the implications of these policies on ward life and their implications for patients' post-hospital lives. These questions are difficult ones, but we must ask them nonetheless if we wish to formulate a thoughtful, comprehensive response to the wide range of questions this subject raises.

To do this, both legal and behavioral scholars must add this issue to their research agendas. As I have attempted to demonstrate in this Article, law professors and academics writing in psychology and psychiatry have generally regarded this entire topic off-limits. In an area such as this one, dominated by irrational thought processes, stereotypes, symbolism, and myths, it is particularly essential that scholars confront the underlying questions rigorously and thoughtfully.

In the past three decades, a sexual revolution changed the way we think about gender, sex roles, personal relationships, and sexual expression. The last twenty years have seen a legal civil rights revolution affect the way that we think about persons with mental disabilities, both in institutional and community settings. Perhaps we can now turn our attention to the relationship between these two revolutions. If we can do this, then the ideas raised in this Article will no longer seem to be beyond the last frontier.

191. See *supra* note 32 and accompanying text.

192. See *supra* notes 8-9 and accompanying text.

193. See *supra* note 32 and accompanying text.

