PROTECTING THE RIGHTS, THE PERSON, AND THE PUBLIC:
A BIOLOGICAL BASIS FOR RESPONSIBLE ACTION[1]

E. Fuller Torrey, M.D.

INTRODUCTION

One of the most clearly established functions of government is to protect and provide care for individuals who are physically or mentally disabled. The protection of mentally disabled individuals became incorporated as official policy in the United States in 1766 when Governor Francis Fauquier went before the Virginia House of Burgesses and requested funds to open a public psychiatric hospital. That hospital was utilized by individuals with all three major forms of mental disability: dementia, mental retardation, and serious mental illness.

Dementia is caused by brain diseases which impair cognitive functions and which are usually progressive; Alzheimer's disease is an example. Mental retardation may be caused by chromosomes, genes, birth injuries, infectious agents, metabolic defects, or other brain conditions which impair cognitive functions, usually during pregnancy or early in childhood. Serious mental illness, a category comprised primarily of schizophrenia and manic-depressive illness, is suspected of being caused by many of the same things which cause mental retardation, but differs in having an onset in early adulthood and in having a brain dysfunction predominantly of integrative functions of the limbic system.

It is now possible to measure abnormalities in brain structure and function on all three forms of mental disability: dementia, mental retardation, and serious mental illness. In schizophrenia, for example, one of the most commonly observed structural abnormalities is mild to moderate dilatation of the lateral and third ventricles on CT or MRI scans, which has been reported in over 100 controlled studies.[2]

---

[2] *See generally* T.M. Hyde et al., *Neuroanatomical and Neurochemical Pathology in Schizophrenia*, 10 REVIEW OF PSYCHOL. (1991).

When patients who had never received medication were included in these studies, the results were the same, thereby proving that the dilatation is not a medication effect. Another structural abnormality which is commonly found in schizophrenia is a moderately decreased size of the hippocampus and amygdala, structures which are part of the limbic system. In one recently completed study of identical twins in which one has schizophrenia and the other is well, it was possible to identify correctly the twin with schizophrenia 80 percent of the time on the basis of hippocampus-amygdala size alone.[3] Changes in brain function are equally well established in schizophrenia, including metabolic function (e.g., as measured by PET scans), neuropsychological function (e.g., problem solving, abstract thinking), and neurological function (e.g., "soft" neurological signs); abnormalities in the last, for example, have been demonstrated in 25 separate studies, some of which included patients who had never been medicated.

It is now clear, therefore, that schizophrenia and manic-depressive illness are brain diseases in exactly the same way that multiple sclerosis, Parkinson's disease, and Alzheimer's disease are brain diseases. And it is our failure to fully realize and acknowledge this fact which has led to much confusion regarding choice and responsibility. For example, when Ms. Jones with Alzheimer's disease wants to take a walk in the snow without putting on shoes and socks, we do not let her do so because we recognize that her reasoning is impaired. Most of us have no difficulty in making such a decision for Ms. Jones and, in fact, we feel that we have a responsibility to do so. However, when a person with schizophrenia wants to do something equally absurd, many mental health professionals have great difficulty in saying that the person cannot do so and in making a more reasoned decision for the person. We invoke principles such as patients' rights, personal autonomy, and the right to lead an alternate life-style for the person with schizophrenia. However, we almost never invoke these same principles for Ms. Jones with Alzheimer's disease because they would appear absurd. They are often equally absurd for individuals with schizophrenia.

---

[3] *See generally* E. F. TORREY. ET AL., SCHIZOPHRENIA & MANIC-DEPRESSIVE DISORDER (1994).

IMPAIRED LOGIC AND INSIGHT

The brain changes which accompany schizophrenia and manic-depressive illness produce two important deficits: impaired logic and impaired insight. Impaired logic is one of the hallmarks of schizophrenia and is the basis for much delusional thinking, e.g., an individual who glances at you on the street is therefore thought to be a KGB agent sent to kill you. Impaired insight is the inability to realize that something is wrong with you. Two recent studies have attempted to measure insight in individuals with psychosis. In one of these, carried out by Dr. Anthony David and colleagues in London, 47 percent of inpatients with schizophrenia and manic-depressive illness scored between 0 and 8 on an 18-point measure of insight.[4] In the other study, done by Drs. Amador and Strauss in New York, it was reported "that nearly 60 percent of the patients with schizophrenia had moderate to severe unawareness of having a mental disorder."[5] There is also some evidence suggesting that impaired insight in schizophrenia is due to the disease process affecting frontal lobe function.[6]

Although both logic and insight are impaired in a significant percentage of individuals who have schizophrenia and manic-depressive illness, there are three complicating aspects to this impairment. First, most individuals will have *some* logic and *some* insight so that it is not an all-or-none phenomenon. Second, although logic and insight may be severely impaired, other aspects of brain function such as memory may be intact, thereby giving an impression of normalcy. And third, impairment of logic and insight may fluctuate over time even without medication, and may fluctuate widely when on and off medication. These fluctuations produce much confusion among mental health professionals when trying to sort out issues of choice and responsibility.

SOME PROPOSED PRINCIPLES

Recognizing that schizophrenia and manic-depressive illness have a biological basis equally as much as do dementia and mental retardation leads to some logical principles. These principles can be used to

---

[4] *See* A. David et al., *The Assessment of Insight in Psychosis*, 161 BRITISH J. PSYCHOL. 599 (1992).

[5] X.F. Amador et al., *Poor Insight in Schizophrenia: Neurological and Defensive Aspects*, 20 PSYCHIATRIC QUARTERLY 123 (1996).

[6] *See* D.A. Young et al.,*Unawareness of Illness and Neuropsychological Performance in Chronic Schizophrenia*, 10 SCHIZOPHRENIA RESEARCH 117 (1993).

solve problems of choice and responsibility such as those posed in this conference. These principles include:

1. ASSESS THE PERSON'S LOGIC AND INSIGHT: There are many neuropsychological tests for logic which can be done as part of am ental status exam. There are now also tests for insight which are easy to administer.[7] These will establish a baseline against which the person's behavior can be judged. To use one example cited in the conference material, the person may well wish to go bungee jumping, but if they wish to try it without the cord, then you can be sure that their logic is impaired.
2. ASSESS THE PERSON'S UNDERLYING PERSONALITY: Brain diseases are equal opportunity diseases and affect all personality types. Our study of identical twins in which one was affected with schizophrenia or manic-depressive illness and the other was well, showed clearly that a person's underlying personality is minimally affected by the brain disease itself.[8] Thus when a person who is mentally disabled continues to smoke despite lung disease, or shoplifts, or is promiscuous, you should ask yourself whether or not the person would be doing the same thing if he/she had never gotten sick. For example, my sister, who has schizophrenia, has great difficulty managing her finances. She also had great difficulty managing her finances before she developed schizophrenia. And my mother and my other sister, neither of whom had schizophrenia, also had difficulty managing finances.

   There are two possible means of assessing a person's underlying personality to determine its relative role in causing troublesome behavior. One means is the use of formal personality tests such as the Minnesota Multiphasic Personality Inventory (MMPI) which can tell you, for example, whether the person is inherently a risk-taker (and thus would be likely to have gone bungee jumping) or inherently has sociopathic traits (and thus would be likely to have shoplifted). Using such personality tests may shed considerable light on whether the person's behavior is predominantly a product of his/her mental disability or of his/her underlying personality. The other means of assessing underlying personality is by knowing

---

[7] *See* X.F. Amador et al., *Assessment of Insight in Psychosis*, 159 AM. J. PSYCHIATRY 873 (1993).

[8] *See generally* TORREY, *supra* note 3.

the person over a long period of time. This is feasible in treatment programs in which one professional or a team of mental illness professionals has responsibility for the same patients continuously for many years.

The most highly praised and effective example of this is the PACT model of continuous treatment teams originated in Madison, Wisconsin, and now found in many other states. In such situations where the team professionals have known the patients on their team for many years, the assessment of underlying personality versus effects of mental disability are much less problematic.

In summary, do not blame all behavior on the mental disability. Some of it may just be the person's underlying personality. This principle is especially helpful in assessing problems of sexual behavior.

3. ASSESS YOUR OWN PHILOSOPHY: Mental health professionals are notoriously liberal in their political beliefs and feelings about human rights. For that reason it is important to ask yourself whether the decision you are urging on a mentally disabled person is the person's wish or merely *your* wish. We are skilled at rationalizing one for the other. For example, when we defend a person's right to refuse medication which he/she needs to function in the community, are we really acting in the *person's* best interest or merely our own?
4. APPLY THE ALZHEIMER'S TEST: When confronted with an ethical dilemma for a person with a mental disability, use Ms. Jones' Alzheimer's disease as a test case. For example, problems of confidentiality for individuals with schizophrenia should be assessed by comparing the options with what you would recommend for Ms. Jones. This will solve a surprising number of problems very quickly.
5. APPLY THE ASK-YOUR-GRANDMOTHER TEST: Grandmothers represent common sense, a commodity which is in surprisingly short supply among many mental health professionals and lawyers. For example, when confronted with the problem of whether to tell one mentally disabled person that another mentally disabled person who is trying to seduce him/her is HIV positive and boasts of having unprotected sex, 99.9 percent of all grandmothers will say that you should of course tell him/her. Only mental health professionals and lawyers have difficulty with such problems.

[Many state laws do not incorporate this "grandmother test" and specifically prohibit disclosure of a patient's HIV status. It is advisable to check the law in your state. Ed.]

6. REMEMBER THAT WE HAVE AN OBLIGATION TO NOT ONLY PROTECT A PERSON'S RIGHTS, BUT ALSO TO PROTECT THE PERSON AND THE PUBLIC AS WELL: "Rights" should not be reified as the *summum bonum*; they are simply an abstraction when removed from a human context. If the person or the public is at danger because of the person's mental disability, then we are obligated to utilize involuntary hospitalization, involuntary medication (including Norplant implants), conditional release, guardianship, outpatient commitment, assigned payeeship, and whatever other mechanism is legally available and appropriate to protect the person and the public. Our failure to do so has resulted in an extraordinary number of self-mutilations, injuries to others, suicides, and homicides. For example, in a New York City study of individuals who push random people onto subway tracks in front of trains, it was reported that 19 out of 31 of the individuals doing the pushing were actively psychotic at the time.[9] It has been estimated that "the rate of children born to psychotic women has tripled since deinstitutionalization first began."[10] And a study of women with chronic psychosis found that only one-third of the 75 children they had borne were being reared by the mothers.[11] A 1992 study in a New York psychiatric hospital reported that 3.4 percent of all admissions diagnosed with schizophrenia were HIV positive.[12] *We* are responsible for these failures, many of which have come from our propensity to reify the person's rights without considering the personal consequences for either himself/herself or others.
7. RECOGNIZE THE NEED FOR ASYLUMS: Most individuals with mental disabilities *can* live in the community *if* adequate outpatient services are provided. *However a small number cannot.* We must learn to accept the fact that some of our community place-

---

[9] *See* D.A. Martell & P.E. Dietz, *Mentally Disordered Offenders who Push or Attempt to Push Victims onto Subway Tracks in New York City*, 49 ARCHIVES OF GEN. PSYCHIATRY 472 (1992).

[10] M.V. Seeman et al., *Chronic Schizophrenia: A Risk Factor for HIV?*, 35 CAN. J. PSYCHIATRY 765 (1990).

[11] *See* J. Coverdale et al., *Developing Family Planning Services for Female Chronic Mentally Ill Outpatients*, 43 HOSP. & COMMUNITY PSYCHIATRY 375 (1992).

[12] *See* M. Sacks et al., *Seroprevalence of HIV and Risk Factors for AIDS and Psychiatric Inpatients*, 43 HOSP. & COMMUNITY PSYCHIATRY 736 (1992).

ments are failures because of some combination of mental disability and underlying personality. Such individuals should be returned to long-term inpatient facilities, asylums which protect both the individual and the public. Until we completely understand the causes and have definitive treatments for all mental disabilities, there will continue to be the need for a few asylums. Wishing it was otherwise will not change that reality.