

“Rotting With Their Rights On”: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients

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The recently formulated right of hospitalized psychiatric patients to refuse medication¹ has drawn increasing attention in the medical and legal literature and in the courts. Unfortunately, almost all that has been written approaches the subject theoretically, from the viewpoint of the development of constitutional law, without paying sufficient attention to the clinical realities or to the actual situation of the patient.

The states themselves vary in their attention to the subject. As of November 1977, most states had not addressed the question of medication refusal. Several states defined a right to be free from unnecessary, excessive or punitive medications and/or specified that all medications administered must be medically indicated. Alaska requires the consent of voluntary patients; Connecticut and Louisiana specifically do not require consent of voluntary or involuntary patients, while Oregon notes that all treatment is the sole responsibility of the physician. Four states grant a modified right to refuse: Iowa subject to override by next-of-kin or guardian, Michigan before preliminary court hearing, North Dakota after discharge is requested, and Wisconsin prior to final commitment.²

Empirically derived data, here as elsewhere, can provide the opportunity for the testing of theoretical constructs. In this paper, after reviewing common misconceptions about medication, we will apply the data derived from a small pilot study³ of patients who refuse medication to the constitutional arguments for patients' rights to refuse, in an attempt to determine if the abstract legal concept of "patients exercising their rights" can be more fully and realistically understood by investigation of the actual circumstances of refusal.

Common Misconceptions about Medication as Treatment†

Our experience in working with lawyers and with officers of the court and

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in reading the legal literature indicates that many members of the legal professions hold glaring misconceptions about psychotropic medication.

(1) One popular misconception is that there is no scientific evidence for the effectiveness of psychotropic drugs for particular psychiatric conditions; one such author (a lawyer) claims: "Any efficacy of drug therapy is fortuitous in light of current practices."⁴ In fact, there are scientifically rigorous studies which have demonstrated the effectiveness of neuroleptics, anti-depressants, and lithium used in the treatment of those very mental illnesses which afflict the majority of psychiatric patients that make up the population of state hospitals.⁵

(2) Another common misconception is that psychiatry is such an inexact science that we have little ability to predict what will happen to a patient if we do *not* give the patient medication in a particular situation. Such a belief runs contrary to the considerable amount of research data available on the natural history of severe untreated mental disorders prior to the introduction of psychotropic drugs, as well as the wealth of data available from actual clinical experience.^{6,7}

We are, in fact, well able to predict what will happen to the unmedicated patient whose excitement and hyperactivity have been steadily escalating despite environmental efforts to decrease his mania; we are rather well able to predict what will happen to the severely depressed patient with detailed and concrete suicidal plans who has not responded to interpersonal and environmental measures if he does not receive specific anti-depressant treatment rapidly.⁸

(3) A third misconception, especially prominent in the work of some legal writers,⁴ is that psychotropic medications are unusually dangerous and toxic; and that the risks are egregiously out of proportion to the benefits. For example:

These effects, of course, significantly affect those individuals drugged in many ways. Such individuals are so sedated by the drugs that they are often unable to read, to understand their rights in the institution, or to interact in any meaningful way with other patients or staff.⁹

Though opponents of medication dramatize the side effects, including dystonias (muscle spasm) and tardive dyskinesia (a lasting involuntary movement disorder) – "They turn you into zombies" – the overwhelming preponderance of data supports a high benefit/risk ratio for these medications and a safety record commensurate with other powerful pharmacologic agents.¹⁰

The reader of some forensic articles in this area may derive the impression that drugs used in psychiatry are the only ones with side effects. The reality of this issue, of course, is that there is no drug in the medical pharmacopeia that is without some side effects or potential toxicity; in fact the same could be said for water.

(4) Next, there is a common belief that "second rank" or alternative choices of treatment are usually consistent with ethical standards of medical practice. Often they are not.¹¹ For example, a lawyer writes:

A strong argument may be raised that the state may not seek to forcibly administer medication where less restrictive means are available. 'Less drastic means' could range from therapeutic techniques such as individual therapy, group therapy, occupational therapy and education to sufficient staffing of hospitals to ensure adequate supervision of patients.¹

In reality the patient whose manic hyperactivity is endangering his life may willingly accept only psychotherapy as treatment; but such an approach would not be humanely or ethically acceptable to medical standards.

(5) Some authors (*e.g.*¹) are peculiarly prone to misunderstand the specificity of medications in the biochemistry of mental illness; that is, the way in which the medications directly interact with those elements of brain chemistries that have been suggested^{12,13} to play central roles in the causation of illness.

Instead of sharing such a pharmacologic perception of medication, these authors inappropriately focus on two "uses" of medication – behavior control and punishment – that more nearly represent (respectively) a very secondary use and a gross *misuse* of medication. For example:*

treatment modalities whose *primary aims* [our emphasis] appear to be control and discipline, such as . . . electroshock therapy . . . and the widespread use of psychotropic drugs, are extremely prevalent in our state institutions.¹⁴

An analogy might perhaps clarify things: it is as though the management of diabetes with insulin injections were described as "sticking a needle in someone's leg every day"; though not untrue, this conceptualization misses the point.

(6) Another misconception about medication is that it brainwashes the patient into alien states of mind or conforming behavior, as in this quote:

With respect to intrusiveness upon a patient's mind, few things could be said to be more intrusive. The patient cannot resist the massive change that overcomes his mood, affect, temperament and thinking.¹⁵

In fact, properly used, psychotropic medications are chemically normative in their mechanism of action; that is, they restore existing imbalance toward the balanced norm.¹⁶ They are generally incapable of creating thoughts, views, ideas or opinions *de novo*, or of permanently inhibiting the process of thought generation. Thus, the psychotic conformist, cured of his psychosis with medications, remains the conformist; the depressed rebel, cured of his depression, remains the rebel still.

As to control of behavior, it is true that a large enough dose of any drug

*This widely quoted law review article, often cited to "prove" such points as that noted here, is grossly inaccurate when dealing with aspects of psychiatric practice. Like many such works on which much of the argumentation in the legal literature rests, it was written by law students, who, though versed in legal writing, clearly demonstrate no particular *psychiatric* expertise to reach such sweeping and unsupported conclusions.

that possesses sedating effects (including alcohol) will sedate a person; medications can be and have been used this way. It should be noted that most psychotropic drugs are relatively poor sedatives, however, and — in keeping with their normative effect — work predominantly on that excitement, agitation and assaultiveness that originates from the psychotic process itself.

In this regard it is particularly regrettable that the Massachusetts Department of Mental Health has sanctioned the use of forced medications “for behavior control” if designated as a “chemical restraint,” two infelicitous terms that appear to misrepresent the very point here at issue. The choice of terminology appears to us to reflect largely the legalistic atmosphere surrounding the injunctions against forced treatment related to the Boston State suit (*Rogers v. Okin*); the pejorative effect of this choice of words is easily shown by comparing the effect of “chemical restraint” to a more fitting description, “emergency treatment.”

(7) But perhaps the most serious misconception of all transcends matters of biochemistry. Rather than ascribing generally benevolent intentions to most members of the mental health system, while at the same time acknowledging the possibility of abuse, many lawyers tend to view psychiatrists as motivated solely by interests of greed, power or sadism: “If psychiatry learns nothing else from the burgeoning ‘patient’s rights’ movement, the lesson must be that the party is over.”⁴ A viewpoint that could picture contemporary psychiatry as a “party” reveals an appalling degree of anti-psychiatric prejudice. In fact, most psychiatrists administer medications because they believe, on the basis of the existing evidence, that they are thereby helping their patients. To structure a system with the assumption that sadism is the norm may smother benevolent intent in legalistic controls and thereby create a self-fulfilling prophecy.

The language of rights, with its litigious and paranoid assumption that good can only be received from others by pursuit and protection of law, must also recognize that the good that can be received from others in that way is often quite limited.¹⁷

And Solzhenitsyn reminds us:

Whenever the tissue of life is woven of legalistic relations, there is an atmosphere of moral mediocrity, paralyzing man’s noblest impulses.¹⁸

We will now consider the factual data on this subject by turning to our study, which we believe to be the only study extant that examines the clinical context of drug refusal by psychiatric in-patients.

The Study

The study, described elsewhere in detail,³ examined prospective data generated on all patients who overtly refused medication during a three-month period on an inpatient ward of a state-run community mental health center. 23 patients were found to have accounted for 72 discrete episodes of refusal; details of these episodes, as well as any additional factors

which the therapist thought were of importance, were recorded. The patients fell into three groups, based on the frequency of refusal and associated clinical data: *situational refusers* – patients with a variety of diagnoses, mostly newly admitted, refused one to three times, invariably for less than 24 hours; *stereotypic refusers* – all chronic patients, they seemed to respond to a variety of stresses with a stereotypic response – drug refusal for short periods (less than 24 hours); *symptomatic refusers* – these patients, for the most part young and intelligent with few previous admissions, refused consistently over extended periods (weeks to months) during their acute severe illnesses, making pharmacologic treatment impossible.

Results

The reasons offered by those patients who refused medication, with supplementary information from their doctors, fell into six categories. (Patients may have offered more than one reason for each episode or may have refused several times for differing reasons.)

(1) *No reason offered* – Nine patients at various times gave no reason for refusal.

(2) *Angry or seemingly irrelevant responses* – Seven patients gave such responses. Examples include: “I don’t want to look at your ugly face.” “I don’t want them, you Nazi.” “I don’t like the taste.” “I haven’t got any reason.” One patient refused because he was angry at his doctor for placing him in seclusion after assaultive behavior and another because he was upset over an upcoming pass from the hospital. In one case a patient refused a proprietary brand of medication which was different from his usual brand.

(3) *Side-effects* – Ten of 23 refusers at some time complained of side-effects from the medication. In four instances their doctors judged these complaints to be related to the medication and took remedial action. In the other instances the complaints were felt to be without physiologic basis.

(4) *Overt delusions* – Nine patients were overtly delusional about their medications. It is likely that a number of those patients who refused to offer a reason for refusal and those who complained of side-effects fell into this category as well. Patients’ delusions included: the belief that the medication was actually poison, that it “makes me crazy” or “makes me do funny things,” that the doctor would obtain sexual control of the patient if she took the medication, and that the staff was unwittingly giving the wrong medication thus making the patient worse. One patient regularly refused to take medication from the evening staff because of dependency longings and fears of submission which they evoked, but accepted them from the day staff. Three patients were catatonic and/or assaultive when medications were offered.

(5) *Privacy* – Eight patients offered justifications which could be classified roughly as attempts to maintain bodily privacy. Their reasons included: “I know what my body needs.” “I’m not having side-effects so I don’t need side-effects medication.” “I don’t want them; they don’t help.” “My body has been purified; I can’t take medications.” “Natural foods are better for me.” “I prefer to receive intra-muscular medication.” It was often difficult to decide if a patient’s reasoning in this category was or was not delusionally based (the last three reasons cited, for example), but if even

debatably relevant, the reasons were included here.

(6) *Legal rights* – Three patients maintained that it was their legal right to refuse medication, and that this was their “reason” and explanation for the refusal.

As noted above, regardless of the reason put forward, all patients in the first two categories – situational and stereotypic refusers (18 of 23 patients) – voluntarily accepted the medications again within 24 hours. The only exceptions were those cases in which the doctors agreed that the medication was causing side-effects and made some adjustment in the orders.

The symptomatic refusers (five patients), who refused for prolonged periods of time, deserve special scrutiny. All offered multiple reasons for refusal: no reason – four; angry or irrelevant responses – three; side effects – three (none thought to be physiologically-based by their doctors); overt delusions – four; privacy – five; and all three instances of patients noting their right to refuse medication as a reason. In the judgment of their physicians all five patients in this category were refusing for delusional reasons, four fearing that the medications would harm them in delusional ways and one believing that because of guilt he did not deserve to recover from his depression. These patients appeared to grasp at any argument which would offer a justification for their delusionally-based refusals. Had all of these cases come to a judicial determination of competency, as two of them did, it is likely that all five would have been found incompetent to judge questions of medication acceptance and refusal.

Discussion

Seven distinct arguments have been offered in the legal literature as grounds for a right to refuse⁹: (1) first amendment *rights to freedom of speech* are infringed upon by medication which interferes with thought and speech processes; (2) medication administration violates the eighth amendment’s prohibition of *cruel and unusual punishment*; (3) denial of a right to refuse violates fifth and fourteenth amendment *due process* guarantees; (4) mental patients are denied *equal protection* under the fourteenth amendment by being denied a right to refuse; (5) medication administration may be an abrogation of the *right to less restrictive alternatives*; (6) the right to refuse is inherent in the nascent *right to privacy*; (7) improper use of medication constitutes a denial of the newly formulated *right to treatment* for involuntarily committed patients.

As is clear from the clinical discussion that follows, many of these arguments played only a limited role (from the patient’s own point of view) in our patients’ refusal of medication; we are here identifying the patient’s perceptions, and not addressing whether the rights apply in legal terms.

(1) No patient specifically claimed that his right to freedom of thought and speech was being encroached upon by the medication, though one patient felt “it makes me crazy.” One could argue that the preference of a grandiose or depressed patient to remain psychotic and thus to “think crazy,” a conceptualization which fits two of our patients and may be more widely applicable,¹⁹ is an expression of freedom of thought. However, “intrusion” into those thought processes by administration of psychotropic medications (which tend to *normalize* psychotic thought disorder) is a far

cry from the “intrusion” represented by the brain-washing of unwilling, non-psychotic subjects. Far from interfering with first amendment rights to freedom of speech, in fact, psychotropics often provide the patient’s only hope of communicating in a way that is intelligible to others. The distress of a psychotic patient, desperately trying to force communication through the incoherence of his/her racing thoughts, is readily apparent and familiar to all clinicians; this common clinical picture reveals the inappropriateness of the “intrusion” concept to this issue.

(2-4) In no case was the issue of medication as punishment raised (eighth amendment) by any of the parties concerned. The one patient who felt that medication was being improperly administered, a view that might conceivably be interpreted as implying a denial of a right to treatment, was a voluntary patient who was clearly delusional at the time; she ultimately recovered on her drug regimen and acknowledged the delusional nature of her beliefs. The issues of due process and equal protection, though they may be inherent in the statements of those patients who claimed they had a legal right to refuse, were not explicitly formulated.

Two of the legal justifications for a right to refuse were used frequently:

(5) Several patients, in stating that they did not need the medication (n=3) or that they felt that a health food diet would be more useful (n=2), seemed to be implying that there was an alternative to medication that might, in some sense, be “less restrictive.” In all five cases the doctors felt strongly that medication was essential and irreplaceable as treatment, and four of the five patients fell into the symptomatic delusional category. Legal authorities have apparently failed in general to recognize the manner in which involuntary medications may themselves represent the “less restrictive alternative”; that is, a patient untreated might require extended inpatient hospitalization, while if treated (even involuntarily), rapid recovery and discharge may result¹¹ – a less restrictive alternative than the former. The isolation of the mentally ill from community life is a serious side-effect of untreated psychosis.

(6) The right of privacy, newly formulated and waxing in domain, might be said to lie at the heart of a large number of refusals. The patients who complained of side-effects (n=10) or of not having side-effects (n=1), those who simply said they did not want the medication or that it did not help (n=5), and those who offered angry or seemingly irrelevant responses to the proffered medication (n=7) may be seen as basing their position on a right to control what they consume – arguably a derivative of the right to privacy. Of these 23 instances, eleven involved symptomatic refusers and appeared to have a delusional core; five represented justified responses to medication side-effects (as judged by the doctor); and seven could not be said clearly to be either justified or delusional.

Arguments that the individual has a right to mental privacy, that is, a freedom from unwarranted interference with the generation of his thoughts, are difficult to apply in the case of those suffering from psychosis. The thought processes that one seeks to protect are frequently so disordered as to be causing not only major impairment in social and intellectual functioning but often severe psychic distress. Are we to be as zealous in guarding these psychotic thoughts from intrusion as we are with

non-psychotic individuals? And, if so, to what end? The grandiose, paranoid or self-deprecatory thinking which is the manifestation of many psychotic illnesses often inherently seeks its own perpetuation, declining any intervention. Thus to ask uncritically that the mentally ill patient consent to treatment is often to permit his psychotic illness to maintain itself, locking the patient into a self-reinforcing cycle, secluded in his "private" world and extruded by society from participation in everyday life.

Of note are the large number of reasons for refusal that defy classification in constitutional or legal terms: nine overtly delusional, seven angry or irrelevant, nine offering no reason. The medical literature, which recognizes other than legal motivations, may be more useful here. Among the reasons for drug refusal which have been noted are: a reluctance to leave a psychotic existence,¹⁹ strains in the doctor-patient relationship,²⁰⁻²¹ familial difficulties,²² and paranoia,²³ to which we might add tensions in the milieu on an in-patient ward.^{3,24}

The most striking information derived from the pattern of refusal in this study is that every patient in the situational and stereotypic groups (18 of 23 patients in the study) voluntarily reaccepted medication within 24 hours; the five remaining persistent refusers were all judged to be delusional about the medication. This suggests that in most cases patients are motivated to refuse by anger, whim, or psychotic reasoning and not by either a principled stand for individual autonomy or even a rationally based "informed refusal." In addition, the notion of ambivalence, which is foreign to the law, is of critical import here.²⁵ Psychotic patients may often have no unitary "will" as the law conceives it, but rather fluctuate back and forth between mutually exclusive desires, unable to resolve conflicting wishes. Many of our stereotypic refusers fit this model, refusing medication as often as they accepted it, impairing their treatment, trapped in their psychotic thought disorder. Most refusal (on the basis of our data) seems more a medical or psychotherapeutic problem than a legal one. One implication of this point is that the most important distinction among patients who refuse medication may be whether or not they are doing so in a non-psychotic and therefore competent manner, and not, as some have suggested, whether they hold voluntary or involuntary in-patient status, since both psychosis and incompetence cut across the lines of voluntariness.

In this regard, we must underscore a statistical anomaly often overlooked by legal authorities: the *clinical* significance of involuntary commitment is that the patient, quite simply, has said "No" to hospitalization and/or treatment — *i.e.*, the patient is a refuser. Though hospitalization and medication are legally quite distinct, they are often fused in the patient's mind as "forces acting on him" and may be indiscriminately refused, along with food, showers, toilet, etc., as noted earlier. Thus we would readily expect that by a predictable selection process we would expect to find more "nay-sayers" in the involuntary population.

(7) Regarding right to treatment, the tendency for each discipline — psychiatry and law — to examine the complex issues at the forensic interface from its point of view *in vacuo* can lead to conceptual chaos and a form of "doublethink."²⁶ This "doublethink" evolves in this manner: the involuntary patient is committed on the basis of dangerousness because of

mental illness; once committed he must be treated on the basis of right to treatment statutes; yet, if he refuses medication, such refusal is treated as the competent act of an "average prudent person," despite the fact that the patient's mental status is so extreme as to merit overriding his right to freedom, as defined by the commitment itself. One legal citation expressed it:

[I]nherent in an adjudication that an individual should be committed under the state's *parens patriae* power is the decision that he can be forced to accept treatments found to be in his best interest; it would be incongruous if an individual who lacks capacity to make a treatment decision could frustrate the very justification for the state's action by refusing such treatment.²⁷

Four objections are commonly raised to the above reasoning. The first is that dangerousness does not, in and of itself, imply incompetence; though true in general, the above citation can be read as arguing that the specific treatment issue at stake lies within the impaired capacity implicit in the involuntary commitment; that is, the patient is already being adjudged and treated under *parens patriae* as incompetent to refuse hospitalization as treatment; the question might then be raised: is he necessarily competent to refuse medication?

The second common objection raised is that other treatment modalities of comparable efficacy may be used if medication is refused. There are two problems with this objection: (a) the weight of evidence now suggests that for certain illnesses and conditions medications may be essential and irreplaceable as the treatment of choice; (b) in clinical reality (though not necessarily in theory) the negativism directed toward voluntary hospitalization itself is directed against *all* aspects of the hospital situation, *including* non-medical treatment aspects and even, occasionally, showers, hygiene matters, food, and in at least one instance²⁸ guardianship itself! In this regard, the third objection is that guardianship should be invoked in these contested cases; this question is too extensive to take up here and has been addressed elsewhere.²⁸ The crux of the matter is that the theory of guardianship is severely compromised by the exigencies of the actual practice, so that good, ethical medical care may be subverted.

The fourth objection offered is that the rights of the individual patient preclude administering treatment against his will. As noted above, there is considerable doubt whether, from the *patient's* point of view, patients' rights are at stake in most instances of refusal. In addition, however, the interests of the state, that is to say the citizenry at large, need to be considered. There may very well be a compelling state interest in returning psychotic individuals to society as quickly as possible in a recompensated condition, in guaranteeing to each citizen the right to the best possible treatment for his psychiatric disorder (even if, as a result of that disorder, the citizen is inclined to refuse), and in maintaining a psychiatric care system that is able to accomplish both those tasks effectively and efficiently. A demoralized, harassed psychiatric care system, or one whose providers spend inordinate amounts of time in legal proceedings, will not meet these standards.

Conclusion

In our small study the majority of legal arguments in support of the right to refuse medication were found not to fit the clinical reality. Similar, larger-scale studies may help clarify the issues with which both the legal and mental health systems must deal when considering the question of medication refusal; such studies might make a major contribution by weeding out those theoretical arguments which are rendered moot by clinical reality. Though law and psychiatry see the world through different models, they may appropriately inform each other of the facts pertinent to their areas of interface.

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