# Involuntary Commitment and the Treatment Process: A Clinical Perspective

GAIL C. EISENBERG, M.D.,*
BONNIE MUELLER BARNES, B.A.** and
THOMAS G. GUTHEIL, M.D.***

## Abstract

The serious question of involuntary hospitalization at this point in history is properly referred to due process in court. While numerous studies have addressed the decisions, statistics and outcomes in this area, insufficient attention has been paid to how the clinician may productively incorporate the clinical experience mobilized by the procedure into the therapeutic work. The authors suggest that the issues raised include maintenance of the alliance, responsibility, dependence, limit-setting, the subjective experience of the process, and the problem of counter-transference. They indicate how the various aspects of commitment may be explored so as to yield maximal therapeutic benefit, and maintain the alliance during the conflicts of an adversary procedure.

## Introduction

> The intense interest in providing due process for all citizens — particularly the mentally ill — is a relatively recent phenomenon. Even more recent is the accelerating concern for properly balancing these legal rights with *clinical* realities on some reasonable middle ground.[1]

The literature on involuntary commitment of the mentally ill is almost totally dominated by discussion of the forensic aspects: dangerousness and its predictability; legislation, judicial rulings and challenges; and matters of malpractice, negligence and related litigation. In Massachusetts, for example, the fact that G.L. 123 clearly permits involuntary commitment for mental illness when there is danger to self or others or inability to care for self does not prevent all three criteria from being subject to variable forensic interpretations and discussion in the literature.

*Dr. Eisenberg is Chief Resident in Psychiatry at the Massachusetts Mental Health Center and Clinical Fellow in Psychiatry, Harvard Medical School.
**Ms. Barnes is Research Assistant, In-Patient Services, Massachusetts Mental Health Center.
***Dr. Gutheil is Assistant Director, Adult In-Patient Services, and Assistant Professor of Psychiatry at the Massachusetts Mental Health Center, Harvard Medical School.
Reprint requests and galleys to Dr. Gutheil at 74 Fenwood Road, Boston, Massachusetts 02115. (617) 734-1300.

The clinical aspects of the commitment process, however, have been markedly scanted especially from two perspectives: (1) the subjective experience by doctor and patient of the actual events of commitment procedures and (2) the manner in which the ongoing treatment is affected thereby. From the latter perspective, the problem of maintaining the ongoing therapeutic alliance in the face of adversary proceedings is especially challenging.

These latter areas are our subject. After a brief review of pertinent literature, we address the ways in which the elements of the commitment process interdigitate with clinical issues in the treatment of psychiatric inpatients; with case vignettes[1] we illustrate the respective problems in the ongoing treatment, and suggest ways of maintaining a therapeutic position throughout the legal proceedings. Rather than considering the value of involuntary commitment itself, we are providing treatment recommendations for the clinician going through the process with the patient.

## Review of Pertinent Literature

As early as 1952 lawyers were stressing "the importance of a fair trial, with adequate notice and a chance to be heard before being deprived of one's liberty"[2]; as noted earlier, the focus in the literature has been on substantive, statistical, procedural, and social issues as well as on outcome study[3-8] with little attention drawn to the clinical aspects of formal civil commitment.[9-11] Since, as Hoffman[12] has pointed out, "there is virtually no case law on point for a variety of clinical situations," it is not surprising that most "of the existing state mental health statutes incompletely reflect (and sometimes do not reflect at all) contemporary legal *and* psychiatric understanding." (emphasis added)

Only a few authors have attempted to evaluate civil commitment from a clinical perspective.[2,12-15] In approaching the review of the literature on this topic we will look at the impact of civil commitment proceedings on the patient and on the alliance in terms of confrontative and traumatic aspects of commitment and the implications of the patient's often ambivalent communication for others involved in the process, *e.g.*, the patient's attorney.

## The Impact of Civil Commitment Proceedings: Confrontation and Trauma

Since the 1950's the literature on civil commitment has reflected a concern for "the traumatic effect of public trial on a patient . . . and the emotional stress to the recovered patient of a return to a community where he has been publicly stigmatized."[16] Guttmacher[2] suggested that "informal procedures be designed to minimize the psychic traumatization which a judicial trial frequently entails." That concern with trauma has varied at different times: whereas formerly the civil commitment *proceedings* were seen as particularly traumatic, today the pendulum has

swung so that the fact of commitment itself is considered to represent the greater trauma.[17]

Let us now examine (1) the impact on the patient of two procedural details — being served notice of the hearing and appearing in person[2] — and (2) the confrontative nature of the procedure in general.

The "right of an allegedly mentally ill person to personal notice and personal appearance at the hearing" are two procedural events in point which have been objected to as "excessively legalistic and detrimental to a person's best medical interest."[5] Little is known, however, as to what extent serving notice may have an adverse effect on the person; those few observations noted suggest that the impact may range from creating confusion and increasing resistance and suspicion to reducing the individual's anxiety.[5]

As noted above, the mere act of serving the technical and confusing legal papers "might defeat the state's beneficent motives by traumatizing the individual and reducng the likelihood of successful treatment;"[5] and "service of personal notice of pending commitment proceedings may [even] provoke violent acts or escape." This has led some authors to go so far as to suggest that "where the person is mentally incapable of understanding the nature of the proceeding or preparing therefor, or is so deranged that notice would do him harm, the purpose of protecting his interest can be more effectively accomplished in some other way than by serving him with legal papers."[2]

In a similar manner, requesting the presence of the person at the hearing simultaneously has been regarded as a legal strength[5] and a major defect[18] in laws governing commitment. Although it is claimed that recent developments have changed the punitive atmosphere of commitment procedures, the "mandatory appearance of the patient in court, his exposure as a public spectacle, and making a public record of the hearing" are thought to represent retention of procedures drawn "from the criminal trial which make the mentally ill feel like criminals."[18] Moreover,

> Requiring [the already paranoid patient] to sit in a courtroom and listen to his trusted physician and his nearest and dearest relatives testify to the facts regarding his mental condition is likely to confirm his worst suspicions. The result may be dangerous to them as well as injurious to him. If not restrained, either because the court fails to appreciate the seriousness of his disorder or for any other reason, he may (even) attempt to kill those who have "betrayed" him.[2]

Therefore, unless the individual is completely unaware of what is going on around him/her, each step and aspect of the process has at least a confrontative impact which varies from patient to patient[19] and can range from fear and panic[15,19] to confusion[20] to disbelief and denial.[19]

With due process procedures (in particular civil commitment)

confrontation of the patient occurs of necessity without any consideration for its timeliness, in terms of either the condition of the patient or the state of the alliance between doctor and patient. Stone[15] notes the difference between "confronting a patient in a therapeutic context *after* a therapeutic alliance has been established and confronting an alleged patient at an evidentiary hearing" (emphasis added), and others have pointed out that "the experience of being confronted with forensic argument invariably tends to aggravate" the person's illness through creating an accusatory climate; in addition, the proceedings may promote significant delay in obtaining treatment.[18]

## The Problem of Ambivalent Communication

Another aspect of the confrontation which often is ignored is the ambivalent nature of the communication of many patients and the problems such communications pose for the attorney. Lacking the training necessary to evaluate effectively the mental or emotional states of their clients,[21] laywers are not in a position to assess how much of their client's communication they can take at face value; indeed, contrary to clinical reality, it is usually "assumed that the legally competent patient knows what he wants and communicates his wishes unequivocally."[12] Chodoff[22] points out that patients' overt statement "that they will not accept treatment may at the same time be conveying other more covert messages — that they are desperate and want help, even though they cannot ask for it" (also see Katz[14] and Slovenko[23]); thus, a legally-expected release may disappoint or depress the patient hoping to be "involuntarily" detained.

For these reasons, a person's counsel often may be "bewildered by a noncommunicative or ambivalent client" for whom he/she is directed to act as advocate.[24]

Given the complexity of the clinical issues raised by due process proceedings in civil commitment, we would do well to keep in mind the caveat of Sehdev,[13] who observes:

> In the abstract, "rights" are always desirable and positive; "patient's rights" too, carry this connotation. Some of these "rights" create no conflict, since they would be actively pursued in the interest of clinically sound, personally respectful, and compassionate treatment of the individual. Others, however, may be contrary to the treatment objectives and detrimental to the welfare of the individual, his or her family, and society at large.

## Commitment and the Treatment Process

### 1) *Commitment and Alliance*

As indicated earlier, the maintenance of the therapeutic alliance is especially difficult in the context of an adversary proceeding; in this section we consider the negative effects and the unexpected positive

effects of commitment on the alliance, and offer technical suggestions on management of this difficult area.

Though dangerousness is the substantive question, commitment becomes an issue, in effect, when physician and patient *disagree* over the need for future hospitalization; the oppositional stance created by the disagreement may strain the alliance precisely because durable therapeutic rapport may not yet have formed by the time the petition is filed. A common alternative situation is that the pre-existing alliance has broken down in the face of regression or other stresses in the treatment.

> Ms. D. is a young woman involuntarily admitted after behaving in a psychotic and disruptive manner for several weeks. In the eight months prior to admission to our institution, Ms. D. was hospitalized briefly on three occasions, but commitment had not been sought. On admission to our institution, Ms. D. was floridly psychotic with many grandiose and paranoid delusions. Commitment was applied for and obtained.
>
> Initially, Ms. D.'s commitment had the limited effect of containing her for the purpose of receiving treatment, but the commitment predictably produced further intense strain on the alliance. For many months, Ms. D. viewed her physician as her jailer who was illegally incarcerating her; she dismissed the significance of her hearing before the judge. She tenaciously maintained the belief that her only problem was the commitment. Her primary goal was to get discharged from the hospital in whatever way possible; she expressed intense hatred for the doctor who had filed for commitment. These attitudes allowed her to avoid dealing with or working on any other important issues; only after much work and time was her doctor able to regain the faith of this distrustful, paranoid patient.

The experience of Ms. D. is consistent with what has been described in earlier literature by Guttmacher[2] and others: confronting the paranoid patient "with facts regarding his mental condition" may cause him to experience irreparable distrust of those individuals who have testified "against" him.

In addition, the case illustrates how the attempt to form an alliance based on self-observation may be defeated by the patient's resistive focus on the facts of the committed state; at a later time, however, this resistance may profitably be interpreted and explored. We must note that the patient's hatred of her doctor (in a paradox familiar to all clinicians) may well have signalled the beginning of the intense involvement with the therapist on which later work could build.

In attempting to manage this treatment dilemma of "ally vs. adversary," we recommend that the therapist attend to the alliance-building potential inherent in the fact that both parties — doctor and

patient — share the state of ignorance and uncertainty as to the outcome of the hearing. This may be presented validly to the patient as a disagreement being referred to the judge as referee; the doctor may then invite the patient to join in speculating about the decision. This joint speculation represents an alliance posture paradoxically extracted from an adversary issue.[3]

Of course, commitment does not inevitably introduce a strain on the alliance and may even improve the physician-patient relationship, as in this example.

> Mr. J. is a young man with two previous psychotic episodes, admitted voluntarily after a suicide attempt; soon after admission, he became very paranoid and distrustful of his doctor and the hospital staff, believing he was a guinea pig in their heartless experiments. He signed a release request, and commitment was filed for (on the basis of suicidality) and was obtained.
>
> Mr. J. accepted the commitment emotionally only when he received the formal announcement from the court. Because he had been formally committed by a judge, Mr. J. indicated he no longer believed that he was the victim of a cruel experiment. The legal aspect of the procedure reversed Mr. J.'s paranoid view of his doctor and the hospital.

In this case, the commitment hearing provided Mr. J. with the opportunity to have a neutral third party, the judge, make the decision about hospitalization. In this setting both parties stand in equity before the law — a position distinct from the usual relationship between physician and patient where the physician has authority over the patient, both real (medical) and transferential. For this particular patient the equality in the alliance posture actually countered the paranoid view (which may itself have expressed the patient's perception of the power structure in the dyad).

After the commitment hearing, whatever the outcome, the doctor and patient may look together at the experience, and this viewing together can re-cement the strained alliance; ultimately, the commitment process has been an experience which doctor and patient have shared. The next example highlights this "sharing" component.

> Several months after his second commitment Mr. K. felt that he should be discharged and filed a writ of *habeas corpus* which the hospital contested. Despite the opposition inherent in the issue, the intensity and drama of the courtroom hearing overshadowed the oppositional stance. The experience was important for both doctor and patient: the patient saw himself as cared for and taken seriously; the doctor was able to deal successfully with the potential threat to his medical authority. An increased mutual respect developed

between patient and doctor after together having been through an experience novel and unprecedented for both.

2) *Commitment, Responsibility and Dependence*

When a patient is committed to a mental institution, he/she temporarily loses not only freedom but also full ownership of personal responsibility; the physician and the legal system take over responsibility for hospitalization. Deferring responsibility to others may serve as a reconstructive experience for patients overwhelmed by life events. This situation, however, necessarily induces dependence on the hospital staff who serve as caretakers. As might be expected, this dependence is ambivalently regarded; moreover, the manner in which the patient reacts to the forced dependency of commitment is often based on past life experiences, as in this example.

> Ms. O., a young schizophrenic woman, was hospitalized and committed on several occasions in a repeating pattern: while living with her parents, she would become progressively more withdrawn and assaultive toward her mother. Prior to hospitalizations Ms. O. would be withdrawn to her room, leaving only to pick up the food mother left for her on the kitchen table. Thus, Ms. O.'s regressive behavior left her totally dependent on her parents, to whom she surrendered all responsibility.
>
> On her most recent admission for assault, she was committed for six months without a struggle and assumed that she would be staying in the hospital until her six month commitment had ended, as with all previous hospitalizations, where she would use the hospital primarily as a place which provided food and shelter in an unintrusive way. In effect, previous commitments had enabled her to remain entrenched in the same entitled, dependent position she had maintained throughout her life.
>
> In a therapeutic attempt to offer her a new approach which challenged this dependent stance, it was decided to discharge Ms. O. before the expiration of her commitment. This approach mobilized more responsible and independent behavior in Ms. O.

Although the substantive issue here was dangerousness (*i.e.*, the assault), it is clear from this example that commitment may serve as the focus for passive and dependent postures, predictably related to the patient's extra-hospital experiences. The patient conveys: "this hospitalization is *your* idea, *you* take care of me." The issue of dependence and responsibility may be mobilized for examination by the commitment process; in addition, as shown, the leeway around discharge provided by commitment can be put to therapeutic use.

3) *Commitment and Limit-Setting*

Commitment may serve the function of limit-setting[25] by countering

suicidal or homicidal behavior, as well as directly taking the patient away from action (flight from hospitalization) in the direction of verbalization.

> Mr. K.'s case illustrates how commitment set a limit on self-destructive behavior. Mr. K. is a young man with a years-long history of seriously self-destructive behavior; twenty-four hours after the subject admission he secretly obtained matches and set himself on fire. After medical treatment of burns he was committed for six months.
>
> Since he remained severely suicidal and self-destructive despite ECT treatment, Mr. K. was re-committed, an event to which he reacted with apparent anger. After improving, Mr. K. stated, in retrospect, that he had actively planned to jump off a building had he *not* been committed; he was grateful to his caretakers for thus saving his life. Although Mr. K. was consciously contemplating suicide, he had verbally denied any such intention to caretakers or attorney (this aspect of Mr. K.'s case exemplifies the ambivalent message communicated by the patient to the attorney, mentioned previously in the literature review).

In this case, as in many situations where a patient is committed, a limit was set on a form of dangerous behavior (though the terminology is different, this is the veritable intention of the law). Because Mr. K.'s prior life experience had provided insufficient unambivalent limit-setting, the limit set through commitment had been a new and constructive experience for Mr. K. as well as being a life-saving intervention.

As with limit-setting in general,[25] the opportunity is here provided for the therapist and patient to explore the experience of the judge's saying "no," either to the patient's wish to leave or the doctor's wish that the patient stay involuntarily; in either case a pressure is exerted away from action toward verbalization.

4) *Subjective Aspects of the Commitment Procedures*

As noted earlier, the commitment hearing clearly delineates the oppositional stance between the two parties: doctor and patient are each represented by an attorney in an adversary position, and each party may be cross-examined in a stressful manner. We will now examine the subjective effects of these procedures on the patient and the physician.

The patient is often asked questions which produce an increased likelihood of decompensation. The self-esteem of the patient may be at stake as in Ms. D.'s case.

> At the commitment hearing, Ms. D.'s physician was asked to read the admission note. In this note, Ms. D.'s past and present difficulties were described. Later, Ms. D. stated that her doctor had "made her life sound like a failure" at the commitment hearing.

A patient may be unable to testify appropriately due to psychosis; the "public" demonstration of this impairment may have a further detrimental effect on the already-compromised self-esteem of the mental patient.

Another aspect of the patient's experience of commitment is the punitive atmosphere of the hearing; *i.e.,* it may be misperceived as a criminal trial.[18] There may be a reality basis for this perception: many patients are originally brought to the hospital by police for behavior that would, in fact, occasion minor or major legal charges, were the actions not obviously attributable to mental illness and so treated by courts and police. Thus, the hearing or the commitment may "confirm" the guilt experienced by these patients from their punitive superegos.

As with the patient, the physician's self-esteem may be threatened by these proceedings. When the physician is interrogated, his/her competence, motives, and treatment methods are often challenged; moreover, the physician's credentials are routinely questioned and may even be disparaged by the patient's counsel as a legitimate forensic tactic. At a commitment hearing in a training setting, the beginning psychiatric resident may be among those testifying; since he/she may not yet have established a professional identity as a psychiatrist, he/she may be doubly threatened by the challenge to his/her competence.

The physician may be asked to reveal specific opinions in the presence of the patient as might never occur during ongoing therapy. Such relations can strain the tenuous alliance.

> For example, at Mr. K.'s commitment hearing his doctor was asked if he had an opinion regarding the patient's prognosis. The doctor stated that the prognosis was grave. It may conceivably have been beneficial for Mr. K. to be thus confronted with the fact that his doctor felt he had a serious illness; nevertheless, it did produce a strain on the alliance.

The effects of such enforced candor are not inevitably negative, and on occasion may even improve the alliance:

> In the process of cross-examining the petitioning resident, the attorney elicited the fact that, in addition to medical training, the resident had had prior experience in psychiatric social work. After the hearing the patient confessed himself impressed with these professional credentials, knowledge of which would not have come up in the usual treatment interactions.

5) *Commitment and Countertransference*

Like all modes of therapeutic intervention, petitioning for commitment is subject to inappropriate reactions on the part of the physician and treatment team;[26] we will now examine how such countertransferences

can affect the physician's decision to apply for commitment.

First, under what circumstances does the physician apply for commitment? The patient has refused to accept the physician's decision to continue hospitalization; thus, the patient has challenged the physician's authority. The clinician may be consciously or unconsciously angered at the narcissistic injury involved. Applying for commitment may also arise from the physician's wish to control or punish the difficult patient. Similarly, the physician may seek commitment when he feels overly protective towards a particular patient, one who may, in fact, be a person who habitually elicits a care-taking response from others.

*Failure* to apply for commitment may also derive from the counter-transference, as when the physician is tempted to dismiss the difficult or devaluing patient:

> Ms. P. was hospitalized after an incident of fire-setting — a clearly dangerous behavior making civil commitment appropriate when the patient's initial ten-day evaluation commitment elapsed. The patient, however, legalistically and energetically attacked the resident for depriving her of her rights and heaped personal abuse on him as well. Under this barrage, the resident found himself eager to discharge this troublesome patient, minimizing the substantial fire risk.

In similar cases, failure to apply for commitment may result from the extreme helplessness, anger and lowered self-esteem evoked in the treaters by the patients.

In general, physicians may have difficulty with commitment when certain unresolved conflicts are present. These may include tendencies toward excessive dependence or counterdependence and conflicts around the issue of control. All these considerations may distract from objective assessment of the substantive issue of dangerousness.

## Summary and Recommendations

We have examined the issue of commitment from a clinical perspective by reviewing the literature and presenting case vignettes. Through clinical examples, we conclude that commitment improves or strains the alliance, brings dependency issues to the forefront in the patient and the physician, sets a limit on self-destructive behavior, and is subject to counter-transference distortions.

Thus, we recommend first that commitment be viewed as a therapeutic issue as well as a forensic one. It is essential that the clinician remain aware of the effects of both involuntary hospitalization and the commitment procedures on the ongoing treatment process and keep in the foreground of discussion the issues we have noted.

Second, we suggest that the clinician seek out possibilities for the alliance even in areas that do not seem to provide such opportunity and

even in the face of the oppositionality inherent in the issue. One example is the model we have described in which the clinician actively shares with the patient the uncertainty of the judicial outcome; in addition, both members of the dyad can "worry in unison" about the effects of either commitment or release.

Third, we suggest that the clinician keep clearly in mind the fact that — as with other administrative interventions — the decision to apply for commitment must be based on objective criteria of dangerousness (or, in some jurisdictions, inability to care for oneself); this objectivity is best attained through careful attention to possible distorting contaminants originating from the countertransference. Supervision and consultation may be employed in the customary manner to this end.

Finally, we indicate that the clinician's agency — for whom she/he works — is inherently clouded by the issue of involuntary commitment. The clinician is petitioning in *opposition* to the patient's stated intention, but theoretically in *accord* with what the patient would wish were she/he not mentally ill; in addition, it could be argued that the clinician is serving a social purpose as well in protecting society from the dangerous patient. After the petition is filed, however, it is the clinician's proper role to help the patient deal with the matter in the context of therapy.

## Acknowledgement

The authors acknowledge their indebtedness to Drs. D. Ingram, J. Gudeman, M. Shore, R. Shapiro and P. Appelbaum for their critical review and suggestions, and to Mrs. T. Giarratani and Ms. D. Vilinsky for assistance in the preparation of this manuscript.

## Footnotes

1. Identifying data are altered to preclude recognition in all examples.
2. In Massachusetts the right to notice is mandatory and the question of presence at the hearing is currently unresolved.[17]
3. It might perhaps be objected that the shared uncertainty of the outcome is a sham posture where the circumstances clearly point to one decision: we submit that the utter unpredictability of judicial response — an unpredictability extremely familiar to clinicians in this field — easily refutes this objection.

## References

1. Treffert D, Krajeck R: In search of a sane commitment statute. Psychiatric Annals 6:56-81, 1976
2. Guttmacher M, Weihofen H: Psychiatry and the Law. New York,Norton, 1952
3. Szasz T: Law, Liberty and Psychiatry. New York, Macmillan Co., Inc., 1963
4. Ennis B: Prisoners of Psychiatry. New York, Avon, 1974
5. Developments in the law — civil commitment of the mentally ill. Harvard Law Review 87:1190-1406, 1974
6. Peszke M: Is dangerousness an issue for physicians in emergency commitment? Amer J Psychiatry 132:825-831, 1975
7. Dershowitz A: Two models of commitment: The medical and the legal. The Humanist July/August 19-23, 1971
8. Dershowitz A: Dangerousness as a criterion for confinement. Bulletin of the American Academy of Psychiatry and the Law 2:172-179, 1974
9. Sata L, Goldenberg E: A study of involuntary patients in Seattle. Hospital & Community Psychiatry 28:834-837, 1977

10. Penn N, Sundberg R, Roberts A: The dilemma of involuntary commitment: Suggestions for a measurable alternative. Mental Hygiene 53:4-9, 1969
11. Gove W: A comparison of voluntary and committed psychiatric patients. Arch Gen Psychiatry 34:669-676, 1977
12. Hoffman P: The right to refuse psychiatric treatment: A clinical perspective. Bulletin of the American Academy of Psychiatry and the Law 4:269-274, 1976
13. Sehdev H: Patients' rights or patients' neglect: The impact of the patients' rights movement on delivery systems. Amer J Orthopsychiatry 46:660-668, 1976
14. Katz J: The right to treatment — an enchanting legal fiction? University of Chicago Law Review 36:755-783, 1969
15. Stone A: Recent mental health litigation: A critical perspective. Amer J Psychiatry 134:273-279, 1977
16. World Health Organization: Hospitalization of Mental Patients. Geneva, 1955
17. Schwartz S, Stern D: Trial Manual for Civil Commitment. Newton, Mass., MHL Advisors Committee, 1976
18. Laws Governing Hospitalization of the Mentally Ill. Group for the Advancement of Psychiatry. Report No. 61, 6, 1966
19. Linn L: The mental hospital from the patient perspective. Psychiatry 31:213-223, 1968
20. Analysis of legal and medical considerations in commitment of the mentally ill. Yale Law Journal 56:1178-1209, 1947
21. Jacisin J: A psychiatrist's view. In Striar S, Goldman E, Jacisin J (Eds.) He's your client, but he's my patient: A symposium on attitudes toward the commitment of mental patients. The Michigan Nurse 48:4-6, 1975
22. Chodoff P: The case for involuntary hospitalization of the mentally ill. Amer J Psychiatry 133:496-501, 1976
23. Slovenko R: Civil commitment in perspective. J Public Law 20:1-32, 1971
24. Slovenko R: Criminal justice procedures in civil commitment. Hospital & Community Psychiatry 28:817-826, 1977
25. Gutheil TG: Limit-setting as therapy in clinical administration: Review & discussion. Transnat'l Ment Health Res Newsl 19(4):1,3-5, 1977
26. Gutheil TG: Legal defense as ego defense: A special form of resistance to the therapeutic process. Psychiatric Quart 51:251-256, 1979