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Problem Behavior: Pathology, Lawyers, and Referrals

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> The proper preparation and representation [of clients] may require the association by the lawyer of professionals in other disciplines.[1]

People frequently do or say things which seem "irrational" as judged by an "objective" observer. They do things or have ideas or feelings which seem not to make sense or are inconsistent with each other. They sometimes have difficulty in understanding matters which ought to be within their grasp. How are attorneys to evaluate such problem behavior when confronted with it in their practices? What is "normal" and what pathological, and what, if anything, depends on such distinctions? When does a client need professional help from those trained in dealing with "mental disorder," and what professions are appropriate to what phenomena? When may "disturbed" clients be dealt with as their own persons, and when should a client's "competence" be in question? When should a communication be accepted at "face value," and when is it necessary to probe to find what is "really" intended? These questions do not have ready answers in spite of their importance. In search of answers, lawyers sometimes consider turning to "mental health" experts.

The following notes are intended to acquaint lawyers with some vocabulary and concepts utilized in mental health professions. These materials are relevant to:

- —Legal issues relating to states of mind.
- —Appropriate case dispositions (for example, in sentencing and child custody).
- —Appropriate circumstances (regardless of legal needs) for referral of clients for mental health care.
- —The *lawyer's* needs: to understand the client as well as to understand and account for the lawyer's emotional and behavioral responses.

When lawyers have concerns with problem behavior which calls for help from professionals trained to deal with "mental disorders," they are con-

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* Professor of Law, Indiana University School of Law, Bloomington. The original text of this Article was prepared by Phyllida Parsloe, now Professor of Social Work, University of Bristol, when she and I first created materials for our course, "Roles and Relations in Legal Practice." *See infra* note 48 and accompanying text. While some of her work has survived revision, she has not worked directly with these material since 1978 and cannot be responsible for any errors which may appear. I am grateful to Erin Leff and Maureen Straub Kordesh for their help in revising this material.

1. MODEL CODE OF PROFESSIONAL RESPONSIBILITY EC 6-3 (1980).

fronted with a variety of professionals, including psychologists, psychiatrists, psychoanalysts, psychiatric nurses, social workers, and counselors. These professionals train in schools of medicine, social work, nursing, and education, in psychoanalytic institutes, and in departments of psychology, social relations, and home economics. They work in hospitals, in mental health clinics, in industry, and in schools, colleges, and universities, and they study and practice in different theoretical orientations using different therapies.

Developments in the mental health care environment have created a necessity for mental health professionals to communicate better among themselves and with outsiders. Significant developments have included the flourishing of community mental health clinics with interdisciplinary staffs and the increased funding of mental health care by grants and by group health insurance. These developments have required mental health professionals to be more effective in describing what they treat and in measuring their productivity.

One result of this need was the publication by the American Psychiatric Association of the *Diagnostic and Statistical Manual of Mental Disorders*[2] (hereinafter *DSM-III*) which attempts to categorize, independently of theoretical orientation, the conditions which mental health professionals treat. *DSM-III,* which conceptualizes a mental disorder "as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more areas of functioning (disability),"[3] uses descriptive language more accessible to laypersons and has gained wide acceptance.

Nevertheless, *DSM-III* is written against a background of practitioners' theoretical orientations and historical categories, to which we turn prior to discussing *DSM-III*'s specific classifications.

I. THEORETICAL ORIENTATIONS

There are many theories of what mental disorder is. Each theory fits some of the states considered to be mental disorders better than it does others. There is no reason why there should be a single explanation for all mental disorder, but there is a tendency in theoretical literature and among some therapists to take one theory and try to fit into it all kinds of mental disturbance. Other therapists, however, view different models as complementary and combine approaches from multiple theoretical orientations. The best known theories or models of explanation are identified below.

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2. AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1980) [hereinafter DSM-III].

3. *Id.* at 6.

A. The Medical Model

The medical model views mental disorder as a disease. This is still the most commonly used model among both laypersons and professionals, and the frequent use of the phrases "mental health" and "mental illness" comes from this model. (*DSM-III* does not use the term "mental illness.") The explanations take two forms.

One explanation is that the cause of a mental disorder is in the physical system of the body. The disorder may be inherited or acquired. While the causes of some disorders are yet to be determined,[4] the causes of others are known.[5] Clinicians who operate predominantly from this model believe greater understanding of mental disorder comes from physiological research. They are inclined to rely on "medical" treatment, for example, with drugs. The other explanation is that the intolerable stress on the mental systems of the person has caused a response which is seen as an illness, popularly known as a "nervous breakdown."

B. The Developmental Model

The developmental model theorizes that mental disorder is the result of faulty development. There are two different schools of thought on this model.

1. Psychoanalytic Schools

Psychoanalytic schools consider that the genesis of mental disorder lies in failure to negotiate the developmental stages of childhood satisfactorily. People who have not put behind them the problems of childhood can develop a mental disorder in later life when faced with stressful situations, particularly in close relationships with other people. Melanie Klein, for example, suggested that schizophrenia occurs in people who have failed to develop a sense of their own wholeness, a process which starts in the first year of life. She also considered that some depressive disorders develop in people who have failed to emerge from what she called the depressive position. This is a stage of life when babies (aged usually about 6 months) come to realize that the mothers who gratify them and meet their needs and the mothers who seem to deny them what they want are the same persons. The baby, coming to terms with this reality, acquires the capacity for ambivalence and concern. Those who fail to come through this depressive position may react to setbacks in adult life by experiencing depression.[6]

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4. *E.g.*, schizophrenia, which some research suggests is caused by chemical or metabolical disturbances.

5. *E.g.*, delirium tremens, which is caused by alcohol poisoning.

6. *See, e.g.*, Klein, *Our Adult World and Its Roots in Infancy*, 12 HUM. REL. 291 (1959).

Many theorists, like Klein, have elaborated, rationalized, developed, or diverged from the original psychoanalytic work of Sigmund Freud. While there are several psychoanalytic viewpoints (Freud's own theories developed significantly during his long career), the idea of the *unconscious* is basic to psychoanalytic theory of all schools. The unconscious is the concept that a person's emotions and behavior can be affected by memories and ideas, even fantasies, without the person being aware of them. Clinicians whose faith is in a psychoanalytic model treat with psychotherapy ("talking cure") and feel that drugs do not solve problems.

2. Learning Theory

Learning theory contends that behavior which is called mental disorder is learned behavior. It is not the symptom of underlying feelings or developmental failures, but maladaptive behavior which has been reinforced. This approach is used, for example, in treatment of irrational fears known as phobias. Patients are retrained not to fear the cats, elevators, or open spaces which they have learned to regard with such terror. Therapeutic communities designed according to this orientation establish systems of rewards for acceptable social behavior.

C. The Role Model

This theory sees mental disorder as a role which society imposes upon certain people and which they collude in accepting. This process provides society a way of controlling behavior which is defined as "mad" and "sick." For the people who act in problematic ways, this behavior is the only way to survive untenable social situations. Treatment in this model considers not just individuals, but the social group of which the individual is a member. In this model treatment which focuses exclusively on an individual, whether by psychotherapy, by drugs, or by behavior modification, is an attempt to locate problems in individuals which in reality exist in the social group.[7]

II. Classifications of Mental Illness

Classification of mental disorder is made difficult by attempts to reflect multiple factors of symptoms, severity, causes, treatment, and prognosis. Prior to *DSM-III,* mental disorders were traditionally classified in three groups: (1) personality disorder (also called character disorder, character neurosis, and, in extreme forms, psychopathy and sociopathy); (2) neurosis; and (3) psychosis. The distinctions among these categories are summarized in the following paragraphs.

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7. *See* R. Laing, Intervention in Social Situations (1971).

Personality disorder, which runs on a continuum from the normal person to the psychopath, is characterized by an inability to wait, a need for immediate gratification, an apparent inability to control one's behavior to please others, and an apparent lack of guilt. It can take the form of a violent temper and extremely aggressive behavior or of very passive, apathetic behavior. People with personality disorders seldom see themselves as ill or as having anything wrong with them. It is society who complains about them. Individuals with personality disorders do frequently complain of disturbances of mood, such as anxiety and depression.[8] A good deal of petty crime and some serious violent crime is committed by people with personality disorders. Demographic crime statistics suggest that individuals with personality disorders cause society the greatest trouble during adolescence and early adulthood. Personality disorders, however, cause lifelong problems for the afflicted individuals and those with whom they interact.

Addictive states and sexual perversions were traditionally classified as personality disorders (although not in *DSM-III*). Both are obviously defined largely by societal values and illustrate the problems with what can be called a "disorder." Homosexuality, for example, is seen by some as a sin, and in some places homosexual practices have been a crime. Therapists who see those homosexuals who come to them for help with their distress may see homosexuality as a disorder to be explained according to their models of mental disorder. To others, including other therapists, however, homosexuality is a healthy alternative sexual orientation. Mental health discourse, the law, and politics all exhibit ambivalence on such matters.

People suffering from neuroses are likely to see themselves as ill, although they may appear normal to others. Neuroses do not interfere substantially with the reality sense, and the sufferer is more likely to seek and cooperate in treatment. Neuroses involve, in severe form, feelings which most people have sometimes or have mildly all the time. All individuals have defensive styles which are to degrees better adapted to some situations than others; drawing boundaries between "normal" difficulties or unhappiness and neurosis is also affected by value judgments.

Psychoses are distinguished from neuroses by the fact that psychoses often involve a loss of reality sense. Persons suffering from schizophrenia, for example, may not know that they are different from other people. Hallucinations (sensory perceptions of nonexistent stimuli) and delusions (false beliefs) can occur in the psychoses. The psychoses are what the layman thinks of as madness.

Historically, psychosis was the province predominantly of psychiatrists in mental hospitals which cared for individuals who were considered a danger to themselves or others; neurosis was the concern of psychoanalysts and

8. DSM-III, *supra* note 2, at 306.

other psychotherapists; and personality disorder was the concern of more coercive therapies such as confrontation groups and penal institutions.

More recent developments have blurred distinctions between categories, however, and new categories have become current which do not easily fall within the traditional distinctions. Whether the differences between neuroses or personality disorders, on the one hand, and psychoses, on the other, are differences of degree or kind is unclear. In some instances, the psychotic state seems an aggravated version of a neurotic one. This is true in depression, for example. In other respects, however, psychotic persons were not necessarily neurotic first; neurotic persons are not especially likely to become psychotic. In instances where neurotic individuals do become psychotic, the psychoses they develop are not necessarily the ones most like their preceding neurosis; and psychotics in remission are not considered to have improved to a condition of neurosis. Further, adherence to one or another of the models of mental disorder described above tends to lead to the use of therapies according to one's model rather than to classification.

III. DSM-III CLASSIFICATIONS[9]

While *DSM-III* classifies mental disorders independently of theoretical orientation and treatment preferences, the concepts underlying traditional classifications are utilized.

In *DSM-III, psychotic* is:

> [a] term indicating gross impairment in reality testing. . . . When there is gross impairment in reality testing, the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence. The term psychotic does not apply to minor distortions of reality that involve matters of relative judgment. For example, a depressed person who underestimated his achievements would not be described as psychotic, whereas one who believed he had caused a natural catastrophe would be so described.
>
> Direct evidence of psychotic behavior is the presence of either delusions or hallucinations without insight into their pathological nature. The term psychotic is sometimes appropriate when an individual's behavior is so grossly disorganized that a reasonable inference can be made that reality testing is disturbed. Examples include markedly incoherent speech without apparent awareness by the person that the speech is not understandable, and the agitated, inattentive, and disoriented behavior seen in Alcohol Withdrawal Delirium.[10]

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9. While this section of this Article relies heavily on *DSM-III,* the presentation is, of course, mine and not the responsibility of the American Psychiatric Association (APA). Quotations used with permission of the APA.

10. DSM-III, *supra* note 2, at 367-68.

In some instances psychotic features are definitional aspects of entire classes of mental disorders, for example in Schizophrenic Disorders and Paranoid Disorders. In other instances, for example, Organic Disorders and Affective Disorders, there may or may not be psychotic features, depending on severity or on the definition of a specific disorder within the class.

Personality Disorder remains a distinct class of disorders in *DSM-III,* but the concept is broader than the traditional conception described above. "Personality" refers to:

> [d]eeply ingrained patterns of behavior, which include the way one relates to, perceives, and thinks about the environment and oneself. Personality *traits* are prominent aspects of personality, and do not imply pathology. Personality *disorder* implies inflexible and maladaptive patterns of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.[11]

A *neurotic disorder* is recognized in *DSM-III* as one in which:

> the predominant disturbance is a symptom or group of symptoms that is distressing to the individual and is recognized by him or her as unacceptable and alien (ego-dystonic); reality testing is grossly intact. Behavior does not actively violate gross social norms (though it may be quite disabling). The disturbance is relatively enduring or recurrent without treatment, and is not limited to a transitory reaction to stressors. There is no demonstrable organic etiology or factor.[12]

DSM-III does not include "Neuroses" as a class of disorders to avoid confusion between "neurosis" in a descriptive sense (as in "neurotic disorder" above) and "neurosis" as incorporating a psychoanalytic theory of an illness' origin. For the latter *DSM-III* urges use of "neurotic process," that is, "unconscious conflict arousing anxiety and leading to the maladaptive use of defense mechanisms that result in symptom formation."[13] A note in the *DSM-III* classification scheme states that neurotic disorders "are included in Affective, Anxiety, Somatoform, Dissociative, and Psychosexual Disorders."[14]

One respect in which *DSM-III* does not avoid theoretical orientations is in including in its conceptualization of mental disorder the aspect that a mental disorder is something "that occurs *in an individual.*"[15] This may not satisfy those adhering to the "role" model of mental disorder, described above. *DSM-III* does include in its classification scheme *Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment.* As these conditions include such categories as *anti-social problem,*

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11. *Id.* at 366. *See infra* text at note 47 for details.
12. DSM-III, *supra* note 2, at 364.
13. *Id.* at 9.
14. *Id.* at 17.
15. *Id.* at 6 (emphasis added).

academic problem, marital problem, and *parent-child problem,*[16] it seems probable that a substantial portion of mental health resources are directed to "conditions not attributable to a mental disorder."

The following discussion illustrates, but does not exhaust, the *DSM-III* classification scheme.[17] The comments on the disorders which follow are attributable to *DSM-III* only where such reliance is indicated. *DSM-III* classifications are mutually exclusive only where the particular definition makes them so; that is, an individual may suffer from more than one mental disorder.

A. Disorders Usually Evident in Infancy, Childhood or Adolescence[18]

The common factor in this first classification is that the onset *usually* occurs and becomes evident in earlier phases of life. Infants, children, and adolescents can suffer from other disorders, but in diagnosing such individuals, "clinician[s] should first consider the diagnoses included in this section."[19] These disorders may be organic (including birth defect) or psychological, and if organic, may result from heredity, disease, or injury. Disorders in this class may give rise to special education needs (for example, *Mental retardation, Attention deficit disorder,* and *Developmental reading, arithmetic,* and *language disorders*).[20] Some disorders in this class are distressing, but usually passing conditions, such as *Functional enuresis* and *Sleep terror disorder,*[21] but others are severe, difficult to treat disorders, such as *Infantile autism.*[22] *Eating disorders* include two disorders which commence in adolescence, *Anorexia nervosa* and *Bulimia,*[23] the former of which can lead to death.

B. Organic Mental Disorders

DSM-III's next major class can be summarized in *DSM-III*'s own words.

> The essential feature of all these disorders is a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain. Organic Mental Disorders are diagnosed (a) by recognizing the presence of one of the Organic Brain Syndromes, as described below, and (b) by demonstrating, by means of the history, physical examination,

16. *Id.* at 331-34.
17. The material in this Article is introductory only and is no substitute for consulting DSM-III itself, which would be a very useful volume for lawyers to have in their office libraries.
18. DSM-III, supra note 2, at 35-99.
19. *Id.* at 35.
20. *Id.* at 36-44.
21. *Id.* at 79-80, 85-86.
22. *Id.* at 87-90.
23. *Id.* at 67-71.

or laboratory tests, the presence of a specific organic factor judged to be etiologically related to the abnormal mental state. Under certain circumstances, however, a reasonable inference of an organic factor can be made from the clinical features alone, in which case only step (a) may be necessary for diagnosis . . . .

Differentiation of Organic Mental Disorders as a separate class does not imply that nonorganic ("functional") mental disorders are somehow independent of brain processes. On the contrary, it is assumed that all psychological processes, normal and abnormal, depend on brain function. Limitations in our knowledge, however, sometimes make it impossible to determine whether a given mental disorder in a given individual should be considered an organic mental disorder (because it is due to brain dysfunction of *known* organic etiology) or whether it should be diagnosed as other than an Organic Mental Disorder (because it is more adequately accounted for as a response to psychological or social factors [as in Adjustment Disorder] or because the presence of a specific organic factor has not been established [as in Schizophrenia]).

The organic factor responsible for an Organic Mental Disorder may be a primary disease of the brain or a systemic illness that secondarily affects the brain. It may also be a substance or toxic agent that is either currently disturbing brain function or has left some long-lasting effect. Withdrawal of a substance on which an individual has become physiologically dependent is another cause of Organic Mental Disorder.

The most common Organic Brain Syndromes are Delirium, Dementia, Intoxication, and Withdrawal. These syndromes display great variability among individuals and in the same individual over time . . . .

A wide variety of different emotional, motivational, and behavioral abnormalities are associated with Organic Mental Disorders. It is often impossible to decide whether the symptoms are the direct result of damage to the brain or are a reaction to the cognitive deficits and other psychological changes that constitute the essential features of these disorders.

Severe emotional disturbances may accompany cognitive impairment in a person who views it as a loss, a serious threat to self-esteem, or both. Anxiety, depression, irritability, and shame of varying degrees of intensity may be present . . . .

Emotional and behavioral disturbances may result in social isolation, by withdrawal or ostracism; and this, in turn, tends to aggravate the cognitive disability.[24]

C. Substance Use Disorders

DSM-III follows Organic Mental Disorders with Substance Use Disorders.

In our society, use of certain substances to modify mood or behavior under certain circumstances is generally regarded as normal and appropriate. Such use includes recreational drinking of alcohol, in which a majority of adult Americans participate, and the use of caffeine as a stimulant in the form of coffee. On the other hand, there are wide

24. *Id.* at 101-103.

> subcultural variations. In some groups even the recreational use of alcohol is frowned upon, while in other groups the use of various illegal substances for recreational purposes is widely accepted. In addition, certain substances are used medically for the alleviation of pain, relief of tension, or to suppress appetite.
>
> This diagnostic class deals with behavioral changes associated with more or less regular use of substances that affect the central nervous system. These behavioral changes in almost all subcultures would be viewed as extremely undesirable. Examples of such behavioral changes include impairment in social or occupational functioning as a consequence of substance use, inability to control use of or to stop taking the substance, and the development of serious withdrawal symptoms after cessation of or reduction in substance use. These conditions are here conceptualized as mental disorders and are therefore to be distinguished from nonpathological substance use for recreational or medical purposes.
>
> The disorders classified in this section are to be distinguished from the corresponding portions of the Organic Mental Disorders section. Whereas the Substance Use Disorders refer to the maladaptive behavior associated with more or less regular use of the substances, the Substance-induced Organic Mental Disorders describe the direct acute or chronic effects of these substances on the central nervous system. Almost invariably, individuals who have a Substance Use Disorder will also at various times have a Substance-induced Organic Mental Disorder, such as an Intoxication or Withdrawal.[25]

While *DSM-III* distinguishes substance use from organic disorders, both are distinguished from other mental disorders which may be associated with substance use. With depression, for example, substance use may be the sufferer's self-medication. Substance use may also aggravate such conditions. While substance use disorders are not included within personality disorders, as was done traditionally, personality disorder is indicated as a predisposing factor.[26]

D. Schizophrenic Disorders and Paranoid Disorders

Schizophrenic Disorders[27] and Paranoid Disorders[28] are major psychotic disorders. The essential features of Schizophrenic Disorders include:

> the presence of certain psychotic features during the active phase of the illness, characteristic symptoms involving multiple psychological processes, deterioration from a previous level of functioning, onset before age 45, and a duration of at least six months . . . . At some phase of the illness Schizophrenia always involves delusions, hallucinations, or certain disturbances in the form of thought."[29]

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25. *Id.* at 163.
26. *Id.* at 168.
27. *Id.* at 181-93.
28. *Id.* at 195-98.
29. *Id.* at 181.

In Paranoid Disorders:

> [t]he essential features are persistent persecutory delusions or delusional jealousy, not due to any other mental disorder, such as a Schizophrenic, Schizophreniform, Affective, or Organic Mental Disorder. . . .
>
> The boundaries of this group of disorders and their differentiation from such other disorders as severe Paranoid Personality Disorder and Schizophrenia, Paranoid Type, are unclear.
>
> The persecutory delusions may be simple or elaborate and usually involve a single theme or series of connected themes, such as being conspired against, cheated, spied upon, followed, poisoned or drugged, maliciously maligned, harassed or obstructed in the pursuit of long-term goals. Small slights may be exaggerated and become the focus of a delusional system.[30]

Schizophrenic and Paranoid Disorders are difficult to treat and have tended to fill mental hospitals with long stay patients. The control of the symptoms of schizophrenia with drugs has played a major role in the drastic reduction in the population of mental hospitals, as patients are returned to local communities where they *are supposed* to receive continuing treatment and support (but too frequently do not).

Schizophrenia is distinguished in categories which will have different onsets and prognoses, but schizophrenia is likely to show some of the following symptoms:

1. Detachment and lack of interest in other people or in what goes on in the world.
2. Hallucinations and delusions, or communication may be incomprehensible. Schizophrenic speech has been described as the knight's move in chess. It may be a series of babbling sounds or single words repeated, or words used as if in a dream.
3. Lack of congruity between the expression of feelings and verbal description of them. A schizophrenic may tell you how sad he feels at his mother's death while roaring with laughter. (This is where the name "split mind" comes from—it does not mean dual personality).
4. Grimacing and twisting of the body and face, weeping or violent temper outbursts for no reason apparent to an observer.

E. Affective Disorders

The next major *DSM-III* class is that of Affective Disorders.[31]

> The essential feature of this group of disorders is a disturbance of mood, accompanied by a full or partial manic or depressive syndrome, that is not due to any other physical or mental disorder. Mood refers to a

30. *Id.* at 195.
31. *Id.* at 205-24.

> prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.[32]

Depression, as a mental disorder, is characterized by feelings of depression, by physical slowing down or intense agitation, by loss of feeling for other people or of purpose or hope in the future, by disturbed sleep and by inability to eat. Traditionally, depression has been included within neurotic disorders, but when a depressed person begins to lose touch with reality, to talk of having committed an unpardonable sin, or of his inside turning bad, then the depression is said to have psychotic features. "Studies in Europe and in the United States indicate that in the adult population, approximately 18% to 23% of the females and 8% to 11% of the males have at some time had a major depressive episode."[33] "The most serious complication of a major depressive episode is suicide."[34] A number of drugs have been found helpful in treatment, and depression, therefore, is in the front line in debate between physical and mental orientations to causation and treatment of mental disorder.

In *Bipolar Disorders,* (traditionally manic depression) the person swings between states of depression and states of great elation and excitement. In the manic phase he will be continuously active, sleeping little and beginning new schemes and activities all the time. In manic states people may buy things they neither want, nor have money to pay for, and write checks which will not be honored although at other times they are careful, honest people. They are often the life and soul of the party and amusing, but exhausting to be with. The depressive stage is like that described above.

F. Anxiety Disorders

Anxiety Disorders include three conditions traditionally categorized as neuroses: anxiety states, phobias, and obsessive compulsive neurosis. As conceived in *DSM-III:*

> In this group of disorders anxiety is either the predominant disturbance, as in Panic Disorder and Generalized Anxiety Disorder, or anxiety is experienced if the individual attempts to master the symptoms, as in confronting the dreaded object or situation in a Phobic Disorder or resisting the obsessions or compulsions in Obsessive Compulsive Disorder. Diagnosis of an Anxiety Disorder is not made if the anxiety is due to another disorder, such as Schizophrenia, an Affective Disorder, or an Organic Mental Disorder.
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> It has been estimated that from 2% to 4% of the general population has at some time had a disorder that this manual would classify as an Anxiety Disorder.[35]

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32. *Id.* at 205.
33. *Id.* at 117.
34. *Id.* at 216.
35. *Id.* at 225.

Phobic disorders[36] involve an acute fear of some apparently harmless object or situation like a cat, an open space, a spider, or a closed space. Many people have mildly phobic reactions to, for example, insects, and such reactions are only considered disorders when they seriously interfere with everyday living over a period of time. Acute short-lived phobias are common in four to six year-olds and usually die away. In serious form a phobia may make an individual "housebound," unable to leave home.

Anxiety states[37] include disorders in which there is a strong feeling of anxiety which is "free floating"; that is, it is not attached to any particular topic or event, or if it is, it seems out of all proportion to the event. The feeling can be accompanied by the physical reactions which go with fear, such as nausea, diarrhea, breathlessness, and dizziness. The state can come on gradually or very suddenly in a panic attack.

DSM-III includes within Anxiety states, *obsessive compulsive disorder,*[38] which traditionally was viewed as a distinct neurosis. In this disorder the sufferers are worried by recurring thoughts which go round and round in their minds and by the need continually to check their actions. Such people establish elaborate routines to control their ruminations. For example, they may be pestered by the thought that they are carrying germs. To ensure that they are clean, they may wash every time their hands touch any part of their house—and use up a bar of soap a day. They know this is crazy, and yet they feel doom will befall them if they do not carry out the ritual.

Also included in Anxiety states is *Post-traumatic stress disorder,* of which:

> [t]he essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience.
>
> The characteristic symptoms involve reexperiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic, dysphoric, or cognitive symptoms.[39]

Events mentioned as giving rise to Post-traumatic stress disorder include: rape and assault, military combat, accidents, natural disasters, and man-made disasters such as bombing, torture, and death camps.

G. *Somatoform and Dissociative Disorders*

Conditions traditionally known as *Hysterical neurosis* are included in two *DSM-III* classes, Somatoform Disorders and Dissociative Disorders.

> The essential features of [Somatoform Disorders] are physical symptoms suggesting physical disorder . . . for which there are no demonstrable

36. *Id.* at 225-30.
37. *Id.* at 230-39.
38. *Id.* at 234-35.
39. *Id.* at 236.

> organic findings or known physiological mechanisms and for which there is positive evidence, or a strong presumption, that the symptoms are linked to psychological factors or conflicts. . . . [T]he symptom production . . . is not under voluntary control . . . .[40]

This phenomenon is now less commonly found in a "pure form," which involves bodily symptoms with no physical basis and a freedom from any emotional discomfort—"la belle indifference." Freud saw many people with pure conversion neurosis (that is, the emotion is converted into a bodily symptom)—for example, people with apparently paralyzed limbs, but without the neurological symptoms of paralysis. We do occasionally see hysterical blindness, deafness, or paralysis now, but more frequently one gets a mixture of an anxiety state and conversion neurosis where people have acute internal pains for which no physical base can be found, but which worry them greatly because they fear, for example, they have cancer.

"The essential feature [of *Dissociative Disorders*] is a sudden, temporary alteration in the normally integrative functions of consciousness, identity, or motor behavior."[41] *Psychogenic amnesia* and *Multiple personality* are included in this class.

H. Psychosexual Disorders

Psychosexual Disorders[42] include the subclasses of *Gender identity disorders, Paraphilias* (in which "unusual or bizarre imagery or acts are necessary for sexual excitement"[43]), and *Psychosexual dysfunction.* Other psychosexual disorders include *Ego-dystonic homosexuality:*

> This category is reserved for those homosexuals for whom changing sexual orientations is a persistent concern, and should be avoided in cases where the desire to change sexual orientations may be a brief, temporary manifestation of an individual's difficulty in adjusting to a new awareness of his or her homosexual impulses.[44]

I. Disorders of Impulse Control Not Elsewhere Classified[45]

This is a residual classification of disorders very likely to bring clients to lawyers, including *Pathological gambling, Kleptomania, Pyromania,* and *Intermittent explosive disorder.*

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40. *Id.* at 241.
41. *Id.* at 253.
42. *Id.* at 261-83.
43. *Id.* at 266.
44. *Id.* at 281.
45. *Id.* at 291-98.

J. *Personality Disorders*[46]

This classification, which *DSM-III* defines as conditions in which "*personality traits* are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress," has been previously discussed.[47] Of the disorders which *DSM-III* includes in this class, *Antisocial personality disorder* is the one which most conforms to the traditional idea of personality disorder. Some personality disorders seem less acute versions of psychotic disorders, for example, *Paranoid* and *Schizoid personality disorders. Narcissistic* and *Borderline personality disorders* have received much attention in theoretical and therapeutic literature in recent years.

IV. Referral to Mental Health Professionals

In working with clients who present examples of problem behavior, lawyers may wonder what would be the implications of getting to know such clients as they are and working with them at less distance. We respond to these issues in accordance with our defensive styles, which raises questions regarding our own problem behavior.

Law students in "Roles and Relations in Legal Practice" confront these materials following their work with a client who violates criminal laws following the consumption of alcohol.[48] On the present occasion he has held up a bar at which he is known. Lawyers need to maintain their integrity in working with such clients and to avoid being overwhelmed by the distress of clients' situations. When the students learn before meeting their new client that he has had several public intoxication convictions and that his prior felony convictions have all involved activities influenced by alcohol consumption, the strategies they develop to handle the case are influenced by their needs for comfort and safety. Students' propensities are to view the client as a "loser" who is sufficiently "sick" to engage their sympathies, in order to make defending him morally acceptable, and to fit the case into familiar legal categories of defense and mitigation. Having thus perceived the problem, they refer the client to mental health professionals for treatment (or send him to prison if the defense and plea for treatment do not prevail).

Students discover, upon reflection and discussion, that there were alternative views of this client which they avoided exploring, and that the par-

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46. *Id.* at 305-30.

47. *See supra* notes 10-11 and accompanying text.

48. The work described in these paragraphs is from a role enactment in Roles and Relations in Legal Practice, in which each student enacts a role of client, defense attorney, or prosecutor. For further detail, see Greenebaum & Parsloe, *Roles and Relations in Legal Practice,* 28 J. Legal Educ. 228 (1976).

ticular client could have been seen as a "success story." In spite of having had an alcoholic father and having dropped out of high school, the client developed a craft skill, held jobs, and supported his family. The client's public intoxication convictions, spread out over the twenty-eight years of his adult life, were relatively few. No serious effort had been made to provide the client with help for his problem behavior on the occasion of his prior convictions, perhaps due to officials having stereotyped the client on the basis of his family background. This vision of the client is more complex, and finding it may have required engaging the client at less distance than would have been comfortable. The student attorneys are sometimes disappointed if the client does not seem fully grateful for an advantageous plea bargain negotiated with the prosecutor, but if the client has never been really "known" by the client's attorney, his reserved feelings are understandable. Students properly assert that they are not qualified to be therapists, and that being therapists is not a part of their obligations as lawyers, but they discover, nevertheless, that how they work with clients inevitably has an impact, for better or for worse, on those clients.

When clients fail to follow through on the legal or personal help which lawyers provide them, the lawyer may feel angry or betrayed. Lawyers may feel unhappy working with clients who show their insincerity that way. There are structural parallels, however, between clients failing to follow through with agreed courses of action and law students responding to course assignments with incomplete preparation or cutting classes. In each instance clients want something which can be obtained only with the intervention of helping professions; in order to obtain that goal the professions, through their representatives, counsel (insist on) a course of action. In order to obtain the desired goal, the clients "agree" to the programs, but the clients are, of course, at best ambivalent about the changes in their lives which they must endure and may not understand the programs or their necessity. In exploring the meaning of confusing human circumstances, there is no "objective" way of knowing, as between professional and client, who is confused about what.[49]

Professional definitions and doctrines have "territorial" and heuristic functions. They stake out the profession's areas of expertise and indicate the questions which members of the profession ask about the material with which they work. A layman inevitably has difficulty communicating in a foreign territory where a different language is spoken. The problem is aggravated, where the foreign discipline is mental health, by judgmental feelings about incompetence (we are not supposed to need help) and discomfort regarding the intimacy which communication about sensitive, personal matters involves.

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49. *See* R. BURT, TAKING CARE OF STRANGERS (1979).

Lawyers should consider "mental health" professionals in respects other than as specialists who treat "mental disorder"; particularly, many mental health professionals are experts in facilitating constructive interpersonal relationships. In addition to considering whether to refer clients for mental health treatment, lawyers should, therefore, consider consulting with mental health professionals regarding the lawyer's strategy for working with the client, the management of legal and mental health "treatments" to support rather than detract from each other, and assistance to the lawyers in accounting for their biases and in coping with the distress of clients' problems in ways which will not lead to "burn out."

Lawyers will feel the distrust toward mental health professionals which laypersons have toward professionals in all fields. Mental health professionals, of course, have varied competencies, as do lawyers and members of other professions. Establishing constructive working relationships in all instances involves searching for the most appropriate practitioner and working with that practitioner to build mutual trust and confidence. In doing so, lawyers need not be concerned that helping relationships between lawyers and mental health professionals will be one-sided, as lawyers have aptitudes, experience, and expertise upon which mental health workers will need to draw.