

**New York Law School
Public Law and Legal Theory
Research Paper Series 05/06 # 7**

Limited in Sex, They Dare:
Attitudes Toward Issues of Patient Sexuality
By Michael L. Perlin
Professor, New York Law School
(<http://www.nyls.edu/mperlin>)

This paper can be downloaded free of charge from the
Social Science Research Network at:
[http://ssrn.com/abstract= 809405](http://ssrn.com/abstract=809405)

**"LIMITED IN SEX, THEY DARE":
ATTITUDES TOWARD ISSUES OF PATIENT SEXUALITY**

Michael L. Perlin

I began practicing mental disability law part-time in 1971 as a public defender in Trenton, New Jersey, and full-time in 1974, when I became director of the Division of Mental Health Advocacy of the New Jersey Department of the Public Advocate. I represented criminal defendants in insanity defense trials, in incompetency-to-stand-trial proceedings, at insanity acquittal retention hearings, and at post-incompetency-adjudication placement hearings (1). Also, I represented civil patients at commitment hearings, in class actions involving the right to treatment, the right to refuse treatment, and a variety of other civil rights issues (2). It was not until 1979, however, that I gave any serious thought to the question of patient sexuality: to what extent do persons institutionalized because of mental disability retain the same rights to sexual autonomy that the rest of us enjoy, and, in most cases, take for granted?

Why would it take eight years to understand such a simple human need? Perhaps it was because the other problems my clients faced appeared to be so overwhelming (in many cases, literally, of life or death). Perhaps it was because no client—of the hundreds and hundreds I had represented on an individual basis—had ever raised the issue with me, perhaps because at that time I had not come to appreciate how the issue of *sanism* (the virulent prejudice faced by persons with mental disabilities, both in institutions and in the community) (3) influenced my own and others' thinking about this matter or, perhaps, the matter simply never entered my mind.

I acknowledge that this may have been the residue, at least in part, of my own unconscious or passive prejudices or unwarranted assumptions about persons with mental illness. Another reason may be that discussing sexual practices is not something that clients and lawyers—or any people who have a formal relationship with each other but do not know each other well—do.

MY FIRST AWARENESS

My ignorance, though, came to a screeching halt in 1979, and I can identify the precise moment when it happened. One of the first major class actions that I litigated was a civil rights action to vindicate the rights of institutionalized patients to participate in voluntary, compensated, therapeutic work programs, consonant with the mandates of the federal Fair Labor Standards Act (1, § 14-4, p. 66-74, 4, 5). After extensively consulting with both our named plaintiffs and other non-named plaintiff class members, John Ensminger, my co-counsel (6) and I came to a tentative settlement with lawyers representing state and county hospitals, but decided that, before we would sign the settlement, we needed to determine if this disposition of the case met with our clients' approval (7), a determination that places unique responsibility on counsel to ascertain that the settlement is "fair, adequate, and reasonable" (8). It was not logistically feasible to question each of the 8,000+ members of the class as to whether they approved of the settlement (nor was it required by court rules in cases of so-called "civil rights" class actions (9)). We thought, however, that it made sense to poll a sample (albeit, perhaps, not a random sample) which we did by meeting with "patient governing councils" at each of the hospitals in which our clients were housed.

Comment: Debbie: Is this confusing? Should we put the pinpoint material in the cite (14-4, p 66-74) in brackets to set it off???

We did this, and immediately realized that, in terms of the ultimate settlement, this had been a fortuitous decision. Class members, by way of example, discussed a range of issues, e.g., payment for incidental work, and the relationship between institutional and community work programs, that had not received much consideration during the pretrial negotiation process (and that were eventually part of the final order). [I am consciously leaving for another article any sort of extensive discussion of the specific ethical issues that are involved when lawyers representing large classes of persons institutionalized because of mental disability move forward in class action litigation (on the questions of the role of named plaintiffs, obligations on the lawyers of seeking out representative samplings of class member attitudes, etc.).] But, something else happened that forever changed the way that I thought about psychiatric hospitalization.

My colleague and I went to Marlboro Psychiatric Hospital (at which many of our clients resided) one balmy spring night to meet with the governing council members. My recollection is that there were about 25-35 in the group; the hospital's population at this time was well over 1,000 patients. We met on the porch of a sprawling, Victorian building that the hospital used for patient activities, and went into our pitch. We explained who we were, why we had brought the case, why we were settling rather than going to trial, what the settlement entailed, and why we were there for input. As we talked, I kept

scanning the porch, making eye contact, wondering if there would be patients (as there had been at every other facility we had visited) who would come up to us at the end of our visit to tell us about other issues, potential lawsuits, whatever.

But, as I was doing this, my attention was arrested by the sight of a young couple kissing passionately and fondling each other. The couple was most likely in their mid twenties, and both were relatively well-dressed. I mention this, because at that time, our clients' wardrobes ranged from state-issued overalls (in the forensic facility), to horribly mismatched out-of-style clothes (that had obviously been dropped off by a local Goodwill-type agency, and distributed to patients without thought of size or fashion compatibility), to their own brought-from-home clothes. This couple's attire clearly fell into this last category. They were seated in the middle of a middle row and were surrounded on all sides by other patients, who ranged in age from 18 to 65 plus. Also, and significantly, neither was beset by the ravages of tardive dyskinesia (from which so many patients suffered at that time). I mention this because the couple looked "different" than the vast majority of our clients, and I still wonder to this day whether my reaction to this scene would have been different if this couple had not presented in a physically attractive way.

I tried very hard not to stare, but it was difficult. First, their behavior was totally unexpected. Also, as I observed what was going on, I was thunderstruck by what I instantly realized was something that I had not witnessed, and failed to realize that I had not witnessed, in all of the work that I had done representing patients in psychiatric hospitals for the past eight years. This was the first time that I saw patients express physical affection for each other. I realized that this was a clue to understanding the hidden world of the state psychiatric institution.

At the end of our presentation, I spoke to a patient who, although not a named plaintiff, was one of our key client-witnesses, and asked him whether he knew the couple. He said that he did, and that their story was well-known to many hospital residents: they were from the same home town, knew each other in high school, but became a couple only after they were institutionalized. He explained that what I saw was "pretty tame," compared to what happened occasionally on field trips or during "free time" (the Marlboro campus covered many acres with many relatively-out-of-eye-range nooks and crannies), but, that he surmised that the couple was on "good behavior," because "you guys were lawyers and all."

I drove home in a half-daze, reflecting on what I had seen that night, and everything that I had not seen over the **prior** eight years. At that time, New

Jersey's psychiatric hospitals ranged from total maximum security to medium security to open ward. Now so much became clear to me. I recalled having clients come to see me in an unused day room or cafeteria or library (wherever we could have some privacy for our lawyer-client discussion), furtively tucking in shirt tails, arranging blouses, blushing. Now it all made sense. I was mortified and chagrined that I had never "gotten it" before, that I had never even thought about, let alone realized, what had been going on. And certainly, there was no hospital policy addressing the issue of "patient sexuality." Indeed, the few policies that existed at that time at other hospitals did little more than forbid any sort of interaction (10). It had even been suggested elsewhere that "sexual activity between psychiatric inpatients should be strictly prohibited, and when it occurs patients should be isolated...and tranquilized if necessary" (11). One hospital's guidelines counseled patients as follows: "If you develop a relationship with another patient, staff will get together with you to help decide whether this relationship is beneficial or detrimental to you..." (12).

The next day, when I went to my office, I told some of my colleagues what had happened, and I found the responses to be interesting. Some said, "Sure, that makes sense," but others said, "Leave it alone!" (reasoning that, if we were to raise this issue in public, we might have to weather a firestorm of criticism, especially from conservative legislators, that might threaten our agency's existence (The Division of Mental Health Advocacy was a state-funded office)). Still others said, "Back burner it; we've got too many other cases on our docket now." So we decided that we would approach the issue quietly; we would ask our "field representatives" (psychologists, social workers and psychiatric nurses) to be especially alert for client complaints, or even stories that dealt with questions of sexuality on hospital wards.

After a few weeks, it became clear that inquiry was going to be difficult and challenging. Most of our staff reported that there were no complaints; the few who had learned of complaints were quickly told that the patient did not want to "rock the boat," or "make waves." But all agreed that this was an important issue; there was simply no way to raise it.

After a while, our attention was refocused. Our office was immersed in complex right-to-refuse-litigation in *Rennie v. Klein*. Also, on March 30, 1981, John Hinckley shot Ronald Reagan, leading me to focus most of my attention on averting attempts to abolish the insanity defense in New Jersey and in Congress. In 1982, I left the Division of Mental Health Advocacy to become Special Counsel to the New Jersey Public Advocate. At that point, my docket became broader-based, and I spent a substantial amount of time on the preparation of *amicus* briefs in the U.S. Supreme Court on a wide variety of legal issues. Questions of sexual autonomy faded into the background.

MY TEACHING

Two years later, in 1984, I became a professor at New York Law School, and assumed directorship of the law school's Federal Litigation Clinic, supervising a caseload of social security/federal benefits cases on behalf of persons with physical and mental disabilities. I also began to teach mental health law, and regularly assigned to students to read (for the first day of class) Susan Sheehan's magnificent book, *Is There No Place on Earth For Me?*, the story of "Sylvia Frumkin," a brilliant but seriously mentally disabled young woman who was a chronic (albeit atypical) patient at Creedmoor State Hospital in New York City (13). Sheehan did not flinch from looking at the issue of patient sexuality, noting that hospital staff aides often refused to fill out "incident reports" on patient sexual activity because they found the subject matter "so unsavory," and further noting that one of the many "sexual escapades...[involved] two staff members [who] were injured when they went into the men's bathroom to separate [a patient] and his willing partner" (13, p. 92).

When we discussed the book in class, I would ask students which issues they thought were the most important that Sheehan had raised. Invariably, the blackboard would fill with 20-30 legal issues, but never did a student spontaneously and voluntarily raise the issue of patient sexuality. When I mentioned it, I usually got blank stares. Occasionally, a student would add a few words about the significance of sexuality to all persons, but all too often, the only comment would be something on the level of "Eww, gross!"

MY WRITING

During my first six years as a professor, my scholarship mostly proceeded on two tracks: I completed the first edition of a multi-volume treatise on mental disability law (1), and I wrote several law review articles that both excoriated the Supreme Court's criminal procedure decisions in cases involving defendants with mental disabilities (14-16), and attempted to create a unified theory by which we could better understand what I saw as the irrationality of our insanity defense and incompetency-to-stand-trial policies (17-19).

But, in 1990, that changed. After nearly two decades as a practitioner, advocate, author and teacher, I had come to realize that there was a deeper understructure to mental disability law that could not be understood or confronted simply by reading, analyzing and deconstructing cases and statutes. Dr. Morton Birnbaum's perfect term, "sanism," was the key to explaining that corrosive and malignant understructure (20, 21, p. 764 n.12). Sanism, I came to realize,

Comment: Again, should the page # part of the cite be in brackets?

is an irrational prejudice of the same quality and character as other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia and ethnic bigotry. It permeates all aspects of mental disability law and affects all participants in the mental disability law system: litigants, fact finders, counsel, expert and lay witnesses. Its corrosive effects have warped mental disability law jurisprudence in involuntary civil commitment law, institutional law, tort law, and all aspects of the criminal process (pretrial, trial and sentencing)....Sanist myths exert especially great power over lawyers who represent persons with mental disabilities. The use of stereotypes, typification, and deindividualization inevitably means that sanist lawyers will trivialize both their client's problems and the importance of any eventual solution to these problems. Sanist lawyers implicitly and explicitly question their clients' competence and credibility, a move that significantly impairs the lawyers' advocacy efforts (3, p. 684 [footnotes omitted]).

Elsewhere, I have identified these sanist myths:

- 1) Mentally ill individuals are "different" and, perhaps, less than human. They are erratic, deviant, morally weak, sexually uncontrollable, emotionally unstable, superstitious, lazy, ignorant, and demonstrate a primitive morality. They lack the capacity to show love or affection. They smell different from "normal" individuals, and are somehow worth less.
- 2) Most mentally ill individuals are dangerous and frightening. They are invariably more dangerous than non-mentally ill persons, and such dangerousness is easily and accurately identified by experts. At best, people with mental disabilities are simple and content, like children. Either *parens patriae* or police power supply a rationale for the institutionalization of all such individuals.
- 3) Mentally ill individuals are presumptively incompetent to participate in "normal" activities, to make autonomous decisions about their lives (especially in areas involving medical care), and to participate in the political arena.

- 4) If a person in treatment for mental illness declines to take prescribed antipsychotic medication, that decision is an excellent predictor of future dangerousness and the need for involuntary institutionalization.
- 5) Mental illness can easily be identified by lay persons and matches up closely to popular media depictions. It comports with our common sense notion of crazy behavior.
- 6) It is, and should be, socially acceptable to use pejorative labels to describe and single out people who are mentally ill; this singling out is not problematic in the way that the use of pejorative labels to describe women, blacks, Jews or gays and lesbians might be.
- 7) Mentally ill individuals should be segregated in large, distant institutions because their presence threatens the economic and social stability of residential communities.
- 8) The mentally disabled person charged with crime is presumptively the most dangerous potential offender, as well as the most morally repugnant one. The insanity defense is used frequently and improperly as a way for such individuals to beat the rap; insanity tests are so lenient that virtually any mentally ill offender gets a free ticket through which to evade criminal and personal responsibility. The insanity defense should be considered only when the mentally ill person demonstrates objective evidence of mental illness.
- 9) Mentally disabled individuals simply don't try hard enough. They give in too easily to their basest instincts, and do not exercise appropriate self restraint.
- 10) If "do-gooder," activist attorneys had not meddled in the lives of people with mental disabilities, such individuals would be where they belong (in institutions), and all of us would be better off. In fact, there's no reason for courts to involve themselves in all mental disability cases (3, pp. 724-25 n. 220).

Once I understood the meaning which Birnbaum had ascribed to sanism, much of what I had realized a decade earlier at Marlboro State Hospital came, for the first time, into crisp focus. If, as I saw it, sanist myths, based on stereotypes, are the result of rigid categorization and overgeneralization, then they function psychologically to "localize our anxiety, to prove to ourselves that what we fear does not lie within" (22, p. 240). We thus labeled all individuals with mental illness as being "deviant, morally weak, sexually uncontrollable [and] emotionally unstable (3, pp. 393-394). And often, we (especially professionals) regard them as being fundamentally different from us, and

lacking human qualities, including needs for affection and dignified ways of expressing affection. Our attitudes toward the sexuality of persons with mental disabilities reflect this labeling in this way:

Society tends to infantilize the sexual urges, desires, and needs of the mentally disabled. Alternatively, they are regarded as possessing an animalistic hypersexuality, which warrants the imposition of special protections and limitations on their sexual behavior to stop them from acting on these “primitive” urges. By focusing on alleged “differentness,” we deny their basic humanity and their shared physical, emotional, and spiritual needs. By asserting that theirs is a primitive morality, we allow ourselves to censor their feelings and their actions. By denying their ability to show love and affection, we justify this disparate treatment (10, p. 537 [footnotes omitted]).

Now, it was all starting to make sense.

MY FIRST (AD)VENTURE

At about the same time, I began to talk about patient sexuality issues with my friend Joel Dvoskin, who was then Associate Commissioner in charge of forensic services of the New York State Office of Mental Health. We had been discussing the issue of patients’ access to condoms at a time when it was generally assumed that condoms would not be made available to patients in many forensic hospitals, and that they should actually be treated as contraband. Politically, providing or allowing condoms in a state-run forensic psychiatric facility **was** likely to be viewed as “condoning” sex among patients. This was, Joel said, “a very complicated issue”:

On one hand, many of our patients were quite vulnerable, and some had been sexually victimized many times in their lives, as children and as adults. Others had long records of predatory sexual behavior, within and without correctional environments. I believed that I had a duty to protect my vulnerable patients from harm. On the other hand, I was well aware of the fact that in any large facility, it would be virtually impossible to successfully prevent all forms of sexual contact among the patients. If I were to agree that condoms were contraband, it seemed to me that I might be contributing to the spread of HIV, which was then presumed to be a fatal disease (23).

Further, Joel pointed out to me that there was virtually no legal or psychiatric literature to which he could turn for guidance on such an important question, and then suggested I think about the broader issues of patient sexuality

more fully (commenting, drily, "Hey Michael, you have tenure now. What can they do to you?"), inviting me to give a Grand Rounds presentation at Kirby Forensic Psychiatric Center on the topic.

I agreed. I began my research (my research assistant immediately told me that some of her classmates offered a variety of snide comments when she told them of the assignment...), and I began to write the Grand Rounds paper. But, before I did, something remarkable happened at my office, which I have since recounted in an article I wrote about how sanism permeates law teaching:

I was sitting at my faculty lunch table, and conversation turned to upcoming presentations that we would soon be doing. My colleagues mostly take left-liberal positions on a wide variety of issues, and are generically the exact mix of retro '60s generationists and early baby boomers that you'd expect. They (appropriately) are quick to criticize any behavior that is racist, sexist, ethnically bigoted or homophobic. Rush Limbaugh would probably view them as one of his worst 'politically correct' horror fantasies. I'm not terribly out of place in this group.

When it got to be my turn, I said that I was going to be speaking about the right of institutionalized mentally disabled persons to sexual interaction. All conversation came to a screeching halt. 'Michael, are you serious?' 'Are you crazy (sic)?' 'Michael, even for you, you've gone too far!' 'What are you going to say next: that they can get married?!?' Et cetera.

At this stage of my life and career, few things surprise me. Yet, I must admit that I was stunned—not by the response (I spend lots of time in places where few people agree with me about anything...so I don't expect, or want, agreement with whatever it is I'm talking about), but by the identity and background of the people who were uttering these sentiments. As I've said, these were classic New York liberals, many of whom had spent much of their distinguished professional, academic and personal lives rooting out and exposing prejudiced and stereotypical behavior toward virtually every minority group one could imagine. The buck, though, stopped there (7, p. 714).

With this in mind, I went to Kirby, did the presentation (which lasted 45 minutes), and then asked, innocently, "Are there any questions?" After 75 minutes of questioning, the program host pointed out that another meeting was scheduled for the room, and we thus had to stop (though there were still at least a dozen hands waving). I had clearly tapped a hidden issue that screamed out for debate. The audience was composed of forensic mental health professionals who

worked at Kirby (psychiatrists, psychologists, nurses, allied therapists, therapy aides), hospital administrative staff, and a few lawyers who frequently represented Kirby patients.

I returned to my office, and immediately began converting the presentation into a law review article, one that was subsequently published by the *NYU Review of Law and Social Change*. (10), With the publication of that article—and subsequent ones on the same general topic (1, § 3C-5.1, pp. 416-421, 24-27)—came one of the most remarkable sets of experiences of my professional life. I was asked regularly, and without letup, to make basically the same presentation before audiences at hospitals, state agencies, professional associations, advocacy groups, and law schools across the nation. My experiences giving this presentation have been so informative and so illuminating, I decided to write this article to share the range of responses and attitudes with which I was confronted over the years.

Comment: Same question abt need for brackets

MY TITLE

My article title comes from Bob Dylan's masterpiece, *It's Alright Ma (I'm Only Bleeding)*, and is found in this remarkable verse:

Old lady judges watch people in pairs
Limited in sex, they dare
To push fake morals, insult and stare
While money doesn't talk, it swears
Obscenity, who really cares
Propaganda, all is phony (28).

I don't think Dylan was thinking about the subject of this article when he wrote this song—it is perhaps best known for the lines “But even the president of the United States/Sometimes must have/To stand naked”—but nothing could possibly better describe what I am talking about.

THEIR ATTITUDES

Had I sought to create a projective test that would reveal my audiences' view of sexuality (with all its permutations), I could not have done better than to do what I did by taking this talk on the road. Audience members' responses can be broadly broken down into these categories:

- 1) Anger
- 2) Denial

- 3) Projection
- 4) Transference/countertransference
- 5) Fear
- 6) Religiosity
- 7) Connection

I will address each of these in turn.

Anger

When I gave this talk at the Florida Institute of Mental Health (part of the University of South Florida in Tampa), an audience member (from the general public) leapt to his feet, and denounced me: "Professor Perlin, you are an agent of the devil!" At a New York City hospital presentation, a nurse folded her arms across her chest, and announced, "Professor, you are the very embodiment of evil!" Perhaps these comments were based on religious beliefs. I cannot be sure. I experienced similar responses at other hospitals and at least one national forensic psychiatry conference.

I am accustomed to hearing members of my audience disagree with me, given the range of topics I choose to speak and write about, but never have I experienced the level of vituperation and anger that I have heard time after time when I have spoken about this topic. [Well, almost never. A young psychiatrist (perhaps a resident, perhaps an intern) at a private hospital in New Jersey once threw a plate of food at me during a luncheon talk I was giving about the right to refuse treatment. This was at some point between 1975-1979.]

Denial

At a Grand Rounds talk at Rochester Psychiatric Hospital, a young psychologist got up and said, "I don't get it. Sex isn't very important anyway. What's the big deal?" I questioned her comment, which she delivered very matter-of-factly, and she made it clear that she was referring globally to sex (and not simply to sexual interaction between patients). I resisted—with great difficulty—the urge to respond, "Doctor, get a life." When you lecture about sex to mental health professional audiences, you need to focus on self-control.

At other presentations, audience members have, time after time, expressed the view that "These people (sic) have no sense of sexuality; you're making a big deal out of nothing." I would estimate that, in 90% of these instances, the

persons espousing these views have been either psychiatrists (almost always older men) or nurses (almost always women) The psychiatrists either self-identified or were dressed in white coats; the nurses all self-identified.

In 2003, I did a site visit at a psychiatric institution in Montevideo, Uruguay, and was visiting a ward that, we were told, housed “high-functioning” teenage males. Some, in fact, were not mentally ill at all, but were individuals with physical disabilities who had been “dumped” at the institution within a week of being born, and had been there ever since.

I asked a staff member about patient sexuality, and was told, “Please! There’s not one of them interested in sex!” We then walked into the day room, where a music video was on the TV (a far more R-rated video that one might see on MTV or VH-1), including a scene of two teenage girls kissing passionately and deeply. Judging by the expressions on the boys’ faces, their agitation, and their comments to their ward mates, the staff member could not have been more wrong.

Also, there have been times, when speaking to audiences of American psychiatrists, there has not been a single member of the audience who offered a question or comment. As this has never happened to me in the 30 plus years that I have been doing public speaking about the entire range of *other* mental health law topics, I conclude this must be more than chance.

Projection

My best story here is one that was shared with me by Debbie Dorfman, a frequent co-author, both on questions of patient sexuality (25) and other mental disability law topics (29-31). When Debbie practiced law in Santa Clara, California, she began a lengthy series of negotiations with the managers-owners of board and care homes (facilities to which ex-hospital patients were deinstitutionalized, but in which they lived involuntarily for months or years, much longer than they spent in hospitals, thus suggesting that, if anything, the issue of sexual expression and autonomy would self-evidently be even more important in these sites) to establish patient sexuality policies in each. She accomplished this at almost all the homes, save for one where the owner was adamantly against letting patients have sex. Debbie argued and negotiated, and finally, the owner told her, “OK, Ms. Dorfman, you win. Patients at my facility can have sex on Saturday evenings from 7-8 p.m.” Debbie asked, “Why then?” Because, the owner responded, “That’s when my wife and I do it. If it’s good enough for us, it’s good enough for them.”

Other examples are important (albeit less memorable). When I spoke about this topic at an American Psychiatric Association annual meeting, the only comment from the audience was from an APA member who criticized the paper for not directly addressing the special issues raised in the cases of gay patients. At a talk to a major nationally-based patient advocacy organization, I was challenged by an audience member who saw "nothing wrong" with staff members having sex with patients, accusing me of being sanist in arguing for a total ban on such activity. When I questioned him, he answered, "Well, I can see myself wanting to have sex with a patient. Who are you to tell me I can't?" I had no response to his desire, but did as to his proposed plan of action. (I make it clear in my presentation that I believe that any hospital sexuality policy should absolutely forbid such relationships.).

Transference/Countertransference

I spoke about this topic at a major New York hospital, and thought it worthy to note that, at the time, only two law professors showed any interest in this topic: myself and Professor Susan Stefan (32, 33). An audience member jumped up, and said, "No, Professor. What's much more interesting is why you and Professor Stefan are so obsessed with this topic." (I responded to him by reaching my hand into my jacket pocket, pulling out an envelope, and saying, "Here's my honorarium. Would you like to do a session now?" When I got home and told the story to my wife [a psychotherapist], she said, "No, what you should have said is, 'Actually, doctor, the more interesting question is why you are so obsessed with what you perceive as my obsession.'" She has always thought better on her feet than I do...).

Fear

Two interrelated fears are expressed almost every time: that sexual freedom will lead to an epidemic of pregnancies (and perhaps outbreaks of AIDS), and that allowing sexual freedom will lead to a flurry of anti-institutional litigation. The short answers are 1) there is absolutely no empirical evidence that this has happened at any facility that has established more liberalized sexual activity policies over the past decade, and 2) that this is but one more example of what Stanley Brodsky has brilliantly neologized as "litigaphobia": the excessive and irrational fear of litigation" (34-37).

The reality is that there has been virtually no litigation over this issue at all, and that the only important case was litigated more than twenty years ago (38). Here, there may be legitimate counterarguments: certainly the fear of nonconsensual sex is a rational one; there are no legal guidelines, either statutory or caselaw-based, as to determining who is and who is not competent to consent. But these are both issues that can be addressed by the drafting and implementation of thoughtful policies, *not* by simply banning all sexual interaction. Over a decade ago, by way of example, Clarence Sundram and Paul Stavits wrote a carefully balanced article suggesting guidelines in cases involving persons with mental retardation (39), but that article has never been cited in any reported litigation.

Also, the fears of pregnancy and HIV are obviously legitimate ones. Ironically, policies that purport to ban all sexual contact (along with a concomitant ban on condoms) may well increase the risk of both. But, the fears of unfounded and improper litigation on this question have no basis in fact.

Religiosity

I was told by a nurse at a New Jersey state hospital that “God explicitly forbids what you are talking about,” the nurse adding that he would “pray for [my] soul.” Many other audience members have invoked religious arguments in rejecting my plea that these issues be at least considered thoughtfully. This implies that, even if policies *are* promulgated to protect and promote the sexual autonomy of institutionalized individuals, individual line staff at a hospital—the people on whom the implementation of any such policy inevitably falls—may simply refuse to cooperate with the policy because their own sense of religious “morality” forbids it. Writing about this question earlier, I considered, by way of example, the likelihood that individual staff members’ religion “may teach that unmarried persons—of any mental capacity—should not have sex, or that married persons—of any mental capacity—should not have extramarital sex” (10, p. 526-527). I have not yet figured out the extent to which this attitude triggers the responses I have received on this topic.

Connection

This response has been very different, and, to my mind, very positive. A significant number of audience members often express enthusiasm about my presentation, and it is not unusual at all for listeners to come forward and say to me, *sotto voce*, "I definitely agree with you, but it is impossible to convince anyone at my hospital to change!" As opposed to those whom I described earlier, generally, those who respond favorably are psychologists, social workers and patient advocates (and, probably, 90% have been female).

I have also been overwhelmed by the response of audience members who identified themselves as persons with disabilities and, speaking from the audience for all in attendance to hear, have told moving stories of their attempts to maintain relationships (despite opposition from family members, staff, and others), which, in some cases have resulted in marriage and the birth of children. Again, as I have previously stressed: "Simply put, the sexuality of persons with mental disabilities is one of the most threatening issues confronting clinicians, line workers, administrators, advocates, and attorneys who are involved in mental health care related work, as well as the families of individuals with mental disabilities" (10, p. 520).

I have maintained e-mail relationships with some of these audience members and have developed friendships with others. What has been consistent was their relief and gratitude that *someone* took the issue seriously.

CONCLUSION

We all talk about sex every day in every possible way. The sex lives of politicians, celebrities, and athletes are a staple of speculation, websites, and TV talk shows. But we remain in total denial when confronted with questions about the sexuality of persons with mental disabilities, especially those who have been institutionalized. As I indicated above, in the twelve years since I added this to my research agenda, I have given at least two dozen presentations to audiences of lawyers, mental health professionals, former patients, governmental officials, patient advocates and others. While it is certainly true that, during that period of time, state civil hospital censuses have continued to fall (although that decrease has not been replicated at forensic hospitals), in many states, there are still large numbers of long-term civil patients for whom the hospital has become, in effect, their permanent residence. This issue, thus, continues to resonate.

When I make these presentations, the responses often perfectly mimic the behavior that Dylan castigates in the line that follows the line that gave rise to my title: "To push fake morals, insult and stare" (28). Perhaps if we begin to think about these issues in a non-self-referential way (thus avoiding the false "ordinary common sense" (40) that has contaminated the social discourse), persons residing in psychiatric hospitals finally, again, in Dylan's words, will no longer be limited to "thinking of forbidden love" (41).

ACKNOWLEDGEMENTS

The author wishes to thank Pamela Cohen, Joel Dvoskin and Douglas Mossman for their rigorous reading of earlier drafts of this manuscript and their many helpful thoughts and suggestions, Jackie Halpern for her excellent research and editing assistance, Christopher Porter for his flawless administrative help, and Roy Basit of the New York Law School library for his beyond-the-call-of-duty work.

REFERENCES

1. E.g., *Dixon v. Cahill*, Docket No. L30977/y-71 P.W., reprinted in Perlin ML: *Mental Disability Law: Civil and Criminal* § 14-7. Newark, NJ. Lexis-Nexis. 2nd Ed., 2002
2. *Rennie v. Klein*, 462 F. Supp. 113, D.N.J. 1978, suppl., 476 F. Supp. 1294, D.N.J. 1979, modified, 653 F.2d 836, 3d Cir. 1981, vacated, 458 U.S. 1119, 1982, on remand, 720 F.2d 266, 3d Cir. 1983 (right to refuse treatment)
3. Perlin ML: On "sanism": *SMU Law Review* 1992; 46:373-407
4. *Schindenwolf v. Klein*, No. L4129375 P.W., N.J. Super. Ct. Law Div. 1979
5. Perlin ML: The right to participate in voluntary, therapeutic, compensated work programs as part of the right to treatment: a new theory in the aftermath of *Souder*. *Seton Hall Law Review* 1976; 7:298-339
6. Ensminger J, Liguori T: The therapeutic significance of the civil commitment hearing: an unexplored potential. *Journal Psychiatry and Law* 1978; 6:5-44
7. See Perlin ML: You have discussed lepers and crooks: sanism in clinical teaching. *Clinical Law Review* 2003; 9:683-729
8. *Parks v. Portnoff Law Assoc.*, 243 F.Supp.2d 244, 250, D. Pa. 2003
9. N.J. Court Rules 4:32-2(b) (tracking Federal Rules of Civil Procedure 23)

10. Perlin ML: Hospitalized patients and the right to sexual interaction: beyond the last frontier? *NYU Review of Law and Social Change* 1993-1994; 20:517-546
11. Binder R: Sex between psychiatric inpatients. *Psychiatric Quarterly* 1985; 57:121-126
12. Keitner G, Grof P: Sexual and emotional intimacy between psychiatric inpatients: formulating a policy. *Hospital and Community Psychiatry* 1981; 32:188-193
13. Sheehan S: *Is There No Place on Earth For Me?* New York, Random House, 1982
14. Perlin ML: The supreme court, the mentally disabled criminal defendant, and symbolic values: random decisions, hidden rationales, or "doctrinal abyss"? *Arizona Law Review* 1987; 29:1-98
15. Perlin ML: The supreme court and the mentally disabled criminal defendant: recent developments. *Bulletin American Academy Psychiatry and Law* 1987; 15:391-409
16. Perlin ML: The supreme court, the mentally disabled criminal defendant, psychiatric testimony in death penalty cases, and the power of symbolism: dulling the Ake in Barefoot's Achilles heel. *New York Law School Human Rights Annual* 1985; 3:91-169
17. Perlin ML: Psychodynamics and the insanity defense: "ordinary common sense" and heuristic reasoning. *Nebraska Law Review* 1990; 69:3-70
18. Perlin ML: Unpacking the myths: the symbolism mythology of insanity defense jurisprudence. *Case Western Reserve Law Review* 1989-1990; 40:599-731
19. Perlin ML: Are courts competent to decide questions of competency? Stripping the facade from *United States v. Charters*. *University Kansas Law Review* 1990; 38:957-1001
20. Birnbaum M: The right to treatment: some comments on its development, in *Medical, Moral and Legal Issues in Mental Health Care*. Edited by Ayd FJ. Baltimore, Williams and Wilkins, 1974; 97-141
21. *Koe v. Califano*, 573 F. 2d 761, 2d Cir. 1978
22. Gilman S: *Difference and Pathology: Stereotypes of Sexuality, Race, and Madness*. Ithaca, NY, Cornell University Press, 1985

23. Email to author from Joel Dvoskin, Ph.D., October 5, 2004. (on file with author)
24. Perlin ML: "Make promises by the hour": sex, drugs, the ADA and psychiatric hospitalization. *DePaul Law Review* 1997; 46:947-985
25. Mossman D, Perlin ML, Dorfman DA: Sex on the wards: conundra for clinicians. *Journal American Academy Psychiatry and Law* 1997; 25:441-460
26. Perlin ML: *The Hidden Prejudice: Mental Disability on Trial*. Washington, DC, American Psychological Association, 2000
27. Payne A, Perlin ML: Sexual activity among psychiatric inpatients: international perspectives. *Journal Forensic Psychiatry* 1993; 4:109-129
28. Bob Dylan: *It's Alright Ma (I'm Only Bleeding)* (1965)
29. Perlin ML, Dorfman DA: Is it more than "dodging lions and wastin' time"? Adequacy of counsel, questions of competence, and the judicial process in individual right to refuse treatment cases. *Psychology, Public Policy and Law* 1996; 2:114-126
30. Perlin ML, Gould K, Dorfman DA: Therapeutic jurisprudence and the civil rights of institutionalized mentally disabled persons: hopeless oxymoron or path to redemption? *Psychology, Public Policy and Law* 1995; 1:80-119
31. Perlin ML, Dorfman DA: Sanism, social science, and the development of mental disability law jurisprudence. *Behavioral Science and Law* 1993; 11:47-66
32. Stefan S: The protection racket: rape trauma syndrome, psychiatric labeling, and law. *Northwestern University Law Review* 1994; 88:1271-1345
33. Stefan S: Whose egg is it anyway? Reproductive rights of incarcerated, institutionalized and incompetent women. *Nova Law Review* 1989; 13:405-456
34. Brodsky SL: A case report of litigaphobic release from an involuntary commitment. *Public Service Psychology* 1983; 2:11
35. Brodsky SL: Fear of litigation in mental health professionals. *Criminal Justice and Behavior* 1988; 15:492-500
36. Breslin FA et al.: Developments of a litigaphobia scale: measurement of excessive fear of litigation. *Psychological Reports* 1986; 58:547-550
37. Brodsky SL: Litigaphobia: a professional disease. *Contemporary Psychology* 1983; 28:204-205
38. *Foy v. Greenblott*, 190 Cal. Rptr. 84, Ct. App. 1983

39. Sundram C, Stavis P: Sexual behavior and mental retardation. *Mental and Physical Disability Law Reporter* 1993; 17:448-455
40. Perlin ML: "She breaks just like a little girl": Neonaticide, the insanity defense, and the irrelevance of "ordinary common sense." *William and Mary Journal Women and Law* 2003; 10:1-31
41. Bob Dylan, *Black Diamond Bay* (1976)

ABOUT THE AUTHOR

Michael L. Perlin is professor of law at New York Law School, where he also directs the online mental disability law program, and serves as director of the International Mental Disability Law Reform project of the law school's Justice Action Center. Previously, he was director of the Division of the State of New Jersey's Division of Mental Health Advocacy, in the Department of the Public Advocate. He graduated from Rutgers University and from Columbia University School of Law where he was a Harlan Fiske Stone Scholar.