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"Everybody Is Making Love or Else Expecting Rain": Considering the Sexual Autonomy Rights of Persons Institutionalized Because of Mental Disability in Forensic Hospitals and in Asia

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"EVERYBODY IS MAKING LOVE/OR ELSE EXPECTING RAIN": CONSIDERING THE SEXUAL AUTONOMY RIGHTS OF PERSONS INSTITUTIONALIZED BECAUSE OF MENTAL DISABILITY IN FORENSIC HOSPITALS AND IN ASIA

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Abstract: One of the most controversial policy questions in all of institutional mental disability law is the extent to which patients in psychiatric hospitals have a right to voluntary sexual interaction. The resolution of this matter involves difficult and sensitive questions of law, social policy, clinical judgment, politics, religion, and family structures. As difficult as these questions are in cases involving civil hospitals, the difficulties are exacerbated when the topic is the application of the right in forensic hospitals. Such facilities typically house individuals involved in the criminal-justice system: who may be incompetent to stand trial; who have been found incompetent to stand trial; who have been found not guilty by reason of insanity; or in some cases, who have been convicted of crimes. The legal statuses of these populations raise public concerns such as the extent to which they are entitled to exercise civil rights while institutionalized, and the potential additional danger that might be associated with the granting of sexual freedom to these populations.

Additional difficulties are presented when we consider the application of this right in both civil and forensic hospitals in Asia, where the notion of "patients' rights" regrettably lags far behind the construction of such rights in Western nations. How different would my conclusions be if I were looking at these issues from an international perspective? And what impact, if any, would the new United Nations Convention on the Rights of Persons with Disabilities (U.N. Convention) have on my answer?

It is impossible to meaningfully come to grips with the multiple issues presented in this Article without also dealing with the social attitude of sanism, an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry. Sanism infects both our jurisprudence and our lawyering practices; it is largely invisible and largely socially acceptable, based predominantly upon stereotype, myth, superstition, and deindividualization. It is sustained and perpetuated by our use of alleged "ordinary common

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sense" and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.

This Article will (1) discuss the state of the law that applies to sexual autonomy in psychiatric institutions, (2) review the social policy issues as they relate to (a) forensic patients and (b) Asia, (3) explain the pernicious impact of sanism, and (4) seek to offer some tentative solutions to the underlying dilemmas.

INTRODUCTION

Over the past fifteen years, I have frequently spoken about issues related to psychiatric patient sexuality. I have grown accustomed to the "There he goes again!" eye-rolling I get from colleagues when I tell them that I write and think about the issues related to institutionalized patients having sex. When I first worked on this topic, I led with this observation in the introduction to my oral presentation,[1] and I assure you, nothing much has changed since then. But I have gotten older and wiser (well, older) so my response is much cooler than it used to be.[2]

But back then—and until very recently—I focused solely on what would probably be seen as the most benign population to consider: civil patients in psychiatric hospitals. How would people react if this inquiry were "jumpshifted" into a discourse about other populations? Back then, I also focused solely on the domestic aspects of this question. How different would my conclusions be if I were looking at these issues from an international perspective? Finally, what impact, if any, would the new

1. *See* Michael L. Perlin, *"Limited in Sex, They Dare": Attitudes Toward Issues of Patient Sexuality*, 26 AM. J. FOR. PSYCH. 25, 34 (2005) [hereinafter Perlin, *Limited*] (quoting Michael L. Perlin, *"You Have Discussed Lepers and Crooks": Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683, 714 (2003) [hereinafter Perlin, *Lepers*]).

2. For one pointed exchange, *see* Perlin, *Limited*, *supra* note 1, at 38–39:

> 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 . . . . 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 . . .).

United Nations Convention on the Rights of Persons with Disabilities[3] (U.N. Convention) have on my answer?

To begin with, sexual behavior is inextricably intertwined with "custom, tradition, and taboo."[4] A consultant to Disabled Women's Health Policy and Programs has written that "disabled people are sexual minority members, due to . . . the presence of the *threat* in our nurture and nature."[5] A recent experience reflects these attitudes. Last summer, I attended the International Academy of Law and Mental Health Congress in Padua, Italy. At that conference, a colleague (and former student of mine), New York Law School Adjunct Professor Heather Ellis Cucolo, gave a fascinating, thoughtful, and balanced talk, *Right to Sex in the Treatment and Civil Commitment of Sexual Violent Predators*, as part of a panel called *Disability Rights and the Law*.[6] The reactions were astounding. One of her co-panelists sat, rocked back and forth, becoming redder and redder in the face until I feared she was headed for aneurism territory. The man next to me in the audience began to draw concentric circles on a yellow pad, making the circles smaller and smaller, writing harder and harder until the nib of his pencil broke (I will omit any Freudian interpretation . . .). One woman walked out in what I would call in "high dudgeon." On the other hand, some of us in the audience were transfixed, delighted that Professor Cucolo had tackled this most taboo of taboos.

Baseball fans know the meaning of the phrase "swinging a weighted bat." When a player awaits his turn to bat, he often swings a weighted bat; that is, a bat injected with a metallic substance to make it much heavier than the regulation bat. The actual bat he swings in the game then gives the illusion of being much lighter than it is. To some extent, Professor Cucolo's talk was the "weighted bat" for me. If you keep *her* talk in mind, the topics I address in this Article—the sexual autonomy of

3. G.A. Res. A/61/106, U.N. Doc. A/RES/61/106 (Dec. 13, 2006).

4. Tomris Türmen, *Reproductive Rights: How to Move Forward?*, 4 HEALTH & HUM. RTS. 31, 32 (2000).

5. Barbara Waxman Fiduccia, *Current Issues in Sexuality and the Disability Movement*, 18 SEXUALITY & DISABILITY 167, 169 (2000) (emphasis added). *See* Michael L. Perlin, *On "Sanism,"* 46 SMU L. REV. 373, 389 (1992) ("From the beginning of recorded history, mental illness has been inextricably linked to sin, evil, God's punishment, crime, and demons.") [hereinafter Perlin, *On Sanism*].

6. *See* FINAL PROGRAM, XXXTH INTERNATIONAL CONGRESS ON LAW AND MENTAL HEALTH (June 25, 2007), at 28, *available at* http://www.ialmh.org/Padua2007/Final_Program.doc, *permanent copy available at* http://www.law.washington.edu/wlr/notes/83washlrev481n6.pdf.

forensic patients[7] and the sexual autonomy of patients in Asia[8]—should not seem quite so beyond the pale.

Of course, that might just be silly on my part. For if the sexuality of a *civil* patient population in the United States is still "a public policy question as controversial as they get,"[9] how then do we begin to approach the questions of whether *forensic* patients or patients in *Asian* nations have these rights? Additionally, if we begin to slide into the morass of "cultural relativism" in discussing whether there is, or should be, a uniquely Asian perspective,[10] the entire enterprise becomes even more challenging. But that is no reason to skirt the issue.

The resolution of these matters involves difficult and sensitive questions of law, social policy, clinical judgment, politics, religion, and family structures. Again, as difficult as these questions are in cases involving civil hospitals, the difficulties are exacerbated when discussing the application of these rights in forensic hospitals. Such facilities typically house individuals involved in the criminal-justice system: people who may be incompetent to stand trial; who have been found to be incompetent to stand trial; who have been found not guilty by reason of insanity; or in some cases, who have been convicted of crimes.[11] The statuses of the populations in question raise public concerns about the extent to which they are entitled to exercise civil rights while institutionalized,[12] and the potential additional danger that might be associated with granting them sexual freedom.[13] As I have already noted, the problems that we face in grappling with this issue in the West are further heightened in the context of Asian culture.

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7. A population that has always been afforded less autonomy and *fewer* liberty rights than the universe of *civil* patients.

8. Asia is the only region of the world where there is no regional human-rights court or commission in operation, and a region in which issues of sexual autonomy have often been off the table as a matter of political and social discourse.

9. Michael L. Perlin, *Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?*, 20 N.Y.U. REV. L. & SOC. CHANGE 517, 520 (1994) (quoting Rob Karwath, *Mental Center Sex Rule Studied*, CHI. TRIB., Apr. 9, 1989, at 1).

10. *See infra* Part II.B.

11. *See generally* Michael L. Perlin, *"For the Misdemeanor Outlaw": The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA. L. REV. 193 (2000). On the procedural-due-process rights of convicted persons in forensic facilities, see, for example, *Vitek v. Jones*, 445 U.S. 480 (1980).

12. *See generally* 2 MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL, §§ 3C-1 to 9.2a, at 386–493 (2d ed. 1999) (discussing, *inter alia*, procedural and substantive rights of persons in forensic facilities).

13. *See id.* §§ 3C-5 to 5.2, at 416–21.

It is impossible to meaningfully come to grips with the multiple issues that I am raising here without also coming to grips with the social attitude of sanism. Sanism 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.[14] It infects both our jurisprudence and our lawyering practices, is largely invisible and largely socially acceptable, and is based predominantly upon stereotype, myth, superstition, and deindividualization. It is sustained and perpetuated by our use of alleged "ordinary common sense" and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.[15] Only if we contextualize our attitudes toward patient sexuality within the fabric of our sanist society can we begin to come to grips with the problem at hand.[16]

In this Article, I will (1) discuss the state of the law that applies to sexual autonomy in psychiatric institutions; (2) review the social policy issues as they relate to (a) forensic patients, and (b) patients in Asia; (3) explain the pernicious impact of sanism; and (4) offer some tentative solutions to the underlying dilemmas. The issues before us are ones that we have been, as a society, all too willing to ignore; however, changes in social attitudes and changes in the law (as reflected in the U.N. Convention) require us to turn our attention—seriously—to this matter.

The title for this Article comes from Bob Dylan's towering masterpiece, *Desolation Row*.[17] The song has been characterized by critics as an "image of the world . . . far removed from marches toward social progress,"[18] and as an example of "unjust condemnation of the sensitive, isolated individual striving for transcendence by a society out of touch with reality or moral truth that forces conformity to its own arbitrary and absurd rules based on the selfish desires and fantasies of

14. *See generally* Perlin, *On Sanism*, *supra* note 5.

15. *See* MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL (2000); Michael L. Perlin, *"Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did*, 10 J. CONTEMP. LEGAL ISSUES 3 (1999).

16. *See infra* Part III.

17. BobDylan.com, Desolation Row, http://bobdylan.com/moderntimes/songs/desolation.html (last visited Oct. 26, 2008), *permanent copy available at* http://www.law.washington.edu/wlr/notes/83washlrev481n17.pdf.

18. ROBERT SHELTON, NO DIRECTION HOME: THE LIFE AND MUSIC OF BOB DYLAN 283 (Beech Tree Books 1997).

those in possession of power . . . ."[19] Perhaps, as Adam Lively has described it, the song is "a repository for all the world's accumulated hopes, fears, nightmares, and other dreams . . . . the ultimate testing-ground of human experience."[20]

Desolation Row is a "deliberate cultural jumble"[21] built on "general deviance."[22] So too has mental disability law become a jumbled law seeking to remediate "general deviance" in a way that is similarly "far removed from marches toward social progress." Dylan's lyric "Everybody is making love/Or else expecting rain" serves as a perfect metaphor for the topic that I am discussing here.[23]

I. THE STATE OF THE LAW

Remarkably (or perhaps not so remarkably), there is virtually no law on the books that deals with this precise topic. Some American jurisdictions have enacted "patients' bills of rights" providing a broad array of civil rights and liberties for persons institutionalized in psychiatric hospitals.[24] Most of these laws flow from the historic and monumental decision *Wyatt v. Stickney*.[25] *Wyatt* found a broad-based right to treatment for institutionalized mental patients.[26] Despite this

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19. Anonymous, Desolation Row, http://www.geocities.com/Athens/Forum/2667/desolati.html (last visited Oct. 26, 2008), *permanent copy available at* http://www.law.washington.edu/wlr/notes/83washlrev481n19.pdf.

20. Adam Lively, *Adolescence Now*, *in* THE DYLAN COMPANION: A COLLECTION OF ESSENTIAL WRITING ABOUT BOB DYLAN 198, 208 (Elizabeth Thomson & David Gutman eds. 1990).

21. Frank Kermode & Stephen Spender, *The Metaphor at the End of the Funnel*, *in* THE DYLAN COMPANION, *supra* note 20, at 155, 158.

22. *Id.* at 159.

23. A full-scale analysis of Dylan's metaphors is beyond the scope of this Article. My sense—honed by having listened to this song hundreds and hundreds of times, and having seen Dylan perform it on at least a dozen occasions—is that the alternative "or else expecting rain" suggests the barrenness of a world without sex and love, but always within a context of political change and revolution. On the other hand, at least one author has argued that at the heart of *Desolation Row* is an exploration of "the erotic relationship [that] must be governed by a keeping of promises." Adam Gearey, *Outlaw Blues: Law in the Songs of Bob Dylan*, 20 CARDOZO L. REV. 1401, 1406–07 (1999). I disagree with Gearey, and believe that *Desolation Row* is, at heart, a profoundly political song.

24. See 2 PERLIN, *supra* note 12, §§ 3A-14 to 3A-14.5a, at 125–48 (discussing state-level patients' bills of rights).

25. 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); *see generally* 2 PERLIN, *supra* note 12, §§ 3A–3.1 to 3A–3.2d, at 24–57.

26. *Wyatt*, 344 F. Supp. at 381. I discuss this aspect of *Wyatt* in Perlin, *supra* note 9, at 529, and in Michael L. Perlin, *"Make Promises by the Hour": Sex, Drugs, the ADA, and Psychiatric Hospitalization*, 46 DEPAUL L. REV. 947, 965–66 (1997) [hereinafter Perlin, *Promises*]. *See*

ruling, only a few jurisdictions follow the lead of *Wyatt* and mandate a limited right to sexual interaction,[27] and in at least one of these laws, there are limitations for forensic patients.[28] Of the important post-*Wyatt* cases, forensic patients were part of the plaintiff class only in the Ohio case of *Davis v. Watkins*.[29] Much of the case law ignores forensic patients entirely. The leading U.S. case, *Foy v. Greenblott*,[30] deals with a civil patient in a locked ward.[31]

All of this leads, logically, to the next question: since we are, by all accounts, a fairly litigious group of people, why has this area—one that deals with the most personal of rights[32]—not been the subject of greater

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generally Michael L. Perlin et al., *Therapeutic Jurisprudence and the Civil Rights of Institutionalized Mentally Disabled Persons: Hopeless Oxymoron or Path to Redemption?*, 1 PSYCHOL. PUB. POL'Y & L. 80, 82 (1995) ("[P]atients' bills of rights in almost all states have established baseline civil rights governing the substantive and procedural limitations on the involuntary civil commitment process, the right to treatment, and the right to refuse treatment.") (footnotes omitted).

27. *See, e.g.*, MONT. CODE. ANN. § 53-21-142(10) (2005) ("Patients have the right to be provided, with adequate supervision, suitable opportunities for interaction with members of the opposite sex except to the extent that a professional person in charge of the patient's treatment plan writes an order stating that such interaction is inappropriate to the treatment regimen."); N.J. STAT. ANN. § 30:4-24.2(e)(10) (West 1975) ("[Patients have the right] [t]o suitable opportunities for interaction with members of the opposite sex, with adequate supervision."); OHIO REV. CODE ANN. § 5122.29(I) (West 2000) (guaranteeing a patient's "right to social interaction with members of either sex, subject to adequate supervision, unless such social interaction is specifically withheld under a patient's written treatment plan for clear treatment reasons").

28. *See* OHIO REV. CODE ANN. § 5122.01(C)(1) & (2). Typically, forensic patients are afforded fewer civil rights than are civil patients, and they are housed in facilities that provide less personal autonomy. *See also* Michael L. Perlin, *International Human Rights Law and Comparative Mental Disability Law: The Universal Factors*, 34 SYRACUSE J. INT'L L. & COM. 333, 354–55 (2007).

> Virtually all studies and reports referred to in this article have focused on the status (and plight) of civil patients: those whose commitments to the mental health system were not occasioned by arrest or other involvement in the criminal court process. Depressingly, persons in the forensic system generally receive—if this even seems possible—*less* humane services than do civil patients.

See id. at 354 (footnote omitted).

29. 384 F. Supp. 1196, 1201–02 (N.D. Ohio 1974). *Davis*, like most of *Wyatt*'s early progeny, was brought in the early 1970s, at a time when the *idea* that patients at psychiatric hospitals had a broad array of civil rights was an entirely new (and controversial) development. *See, e.g.*, 2 PERLIN, *supra* note 12, § 3A–3.1, at 24–32. At this time, the expansion of any of these rights to individuals in forensic facilities was simply not "on the table" in most jurisdictions, the *Davis* litigation being a rare exception. *See id.* § 3A–3.3, at 57–59.

30. 190 Cal. Rptr. 84, 87 (Ct. App. 1983).

31. I discuss the significance of *Foy* in Perlin, *supra* note 9, at 532–33, in Perlin, *Promises*, *supra* note 26, at 967, and in 2 PERLIN, *supra* note 12, § 3C-5.1, at 416–21.

32. This is especially ironic in that we acknowledge the significance of sexual autonomy in related areas of law, but we ignore it here. *See* Perlin, *supra* note 9, at 531 ("The law acknowledges that sexual desire is a sufficiently important personal trait so that its diminution must be weighed

scrutiny, in court decrees, or even in substantial scholarly writings?[33] Although there *has* been attention paid to this issue in nursing and psychiatric literature,[34] there has been virtually no carryover to the question of the legal implications of our policies, or the lack of such policies.[35]

An examination of key documents in international human-rights law, on the other hand, provides us with some tantalizing possibilities. Consider variously: (1) the "right to freedom of association with others" from the International Covenant on Civil and Political Rights;[36] (2) the express application of these rights to persons with mental disabilities in the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care;[37] and (3) language in the new

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into the formulation of a medication refusal policy. Yet the law simultaneously denies the power and importance of sexual desire with respect to hospital ward life.").

33. The only modern law review article on the global issue of mental patient sexuality published in the United States, other than those that I have written, is Winiviere Sy, *The Right of Institutionalized Disabled Patients to Engage in Consensual Sexual Activity*, 23 WHITTIER L. REV. 541 (2001). For a transnational perspective, see Hella von Unger, The Meaning and Management of Women's Sexuality in Psychiatric vs. Community-Psychiatric Settings in Berlin, Germany (June 26, 2007) (unpublished paper). Dr. Unger's paper was presented at the Thirtieth International Congress on Law and Mental Health, in Padua, Italy. *See supra* note 6.

34. *See, e.g.*, May Dobal & Diana Torkelson, *Sexual Rights of Persons with Serious and Persistent Mental Illness: Gathering Evidence for Decision Making*, 5 J. AM. PSYCHIATRIC NURSES ASS'N 150 (1999); May Dobal & Diana Torkelson, *Making Decisions About Sexual Rights in Psychiatric Facilities*, 18 ARCHIVES PSYCHIATRIC NURSING 68 (2004) [hereinafter Dobal & Torkelson, *Decisions*]; Eddie McCann, *Exploring Sexual and Relationship Possibilities for People with Psychosis: A Review of the Literature*, 10 J. PSYCHIATRIC & MENTAL HEALTH NURSING 640 (2003); Ronald Stevenson, *Sexual Medicine: Why Psychiatrists Must Talk to Their Patients About Sex*, 49 CAN. J. PSYCH. 673 (2004). For an earlier sociological inquiry into the relationship between social attractiveness and staff attitudes toward patients, see Edmund G. Doherty, *Social Attractiveness and Choice Among Psychiatric Patients and Staff: A Review*, 12 J. HEALTH & SOC. BEHAV. 279 (1971).

35. *See* Perlin, *Last Frontier*, *supra* note 9, at 532 ("[M]any hospitals remain reluctant to promulgate such policies . . . ."). *But see* Dobal & Torkelson, *Decisions*, *supra* note 34, at 72 (explaining that fifty-six percent of hospitals polled reported having such policies).

36. *See* International Covenant on Civil and Political Rights art. 22, Mar. 23, 1966, 999 U.N.T.S. 171, *available at* http://www.unhchr.ch/html/menu3/b/a_ccpr.htm, *permanent copy available at* http://www.law.washington.edu/wlr/notes/83washlrev481n36.pdf.

37. *See* G.A. Res. 46/119, U.N. Doc. A/RES/46/119 (Dec. 17, 1991). Although these Principles are now superseded by the U.N. Convention, they retain both historical and symbolic significance. Also, they have been cited as persuasive authority in leading cases on institutional rights and mental disability law. *See, e.g.*, Victor Rosario Congo v. Ecuador, Case 11.427, Inter-Am. C.H.R., Report No. 63/99, OEA/Ser.L./V/II.102, doc. 6 rev. ¶ 54 n.8 (1999):

> The UN Principles for the Protection of Persons with Mental Illness are regarded as the most complete standards for protection of the rights of persons with mental disability at the international level. These Principles serve as a guide to States in the design and/or reform of

U.N. Convention that mandates nations to "[p]rovide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes."[38] All of these documents provide potential ammunition for those seeking to secure rights for this class of individuals.

But it is all, as should be clear, vividly speculative, since to the best of my knowledge, these issues have never been raised in litigation.[39] My research also fails to reveal any cases on point in any Asian nation, a topic to which I will return later. The answer to why there has been so little consideration of these issues lies in a consideration of the underlying social policy issues.

II. SOCIAL POLICY ISSUES

There are multiple issues of social policy embedded in this discussion that contribute to the paucity of attention paid to these issues. First, I will discuss the issues that relate more specifically to forensic patients. Second, I will discuss those that may have the greatest relevance to a consideration of these issues in an Asian context.

A. Issues Endemic to Forensic Patients

There are clusters of issues that are particularly pertinent in the cases of forensic patients: (1) those that flow from societal *fears* of persons whose connection to the mental health system originates from involvement in the criminal-justice system; (2) the ways in which those fears have led to societal *short-sightedness* in our approach to these problems; and (3) the *rights* that such patients have, in spite of these social attitudes.

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mental health systems and are of utmost utility in evaluating the practices of existing systems. Mental Health Principle 23 establishes that each State must adopt the legislative, judicial, administrative, educational, and other measures that may be necessary to implement them.

(English translation available in MICHAEL L. PERLIN ET AL., INTERNATIONAL HUMAN RIGHTS AND COMPARATIVE MENTAL DISABILITY LAW 809–22 (2006) [hereinafter PERLIN, HUMAN RIGHTS]). I discuss the significance of the *Congo* case in, *inter alia*, Michael L. Perlin, *An Internet-Based Mental Disability Law Program: Implications for Social Change in Nations with Developing Economies*, 40 FORDHAM INT'L L.J. 435, 448 (2007).

38. G.A. Res. A/61/106, *supra* note 3, art. 25.

39. On the relationship between international law and the rights of persons with mental disabilities, see generally PERLIN, HUMAN RIGHTS, *supra* note 37.

1. Fears

Fears about patient sexuality emanate from stereotype-driven misperceptions about patients' dangerousness, from worries about a public backlash, and from long-documented overreactions on the part of hospital administrative staff to the specter of litigation.

a. A Heightened Fear of Increased Danger Because of the Fact That the Patients Are Forensic Patients[40]

The assumption, of course, is that patients in forensic hospitals are more dangerous than those in civil hospitals and, perhaps directly as a result of this assumption, are less "worthy" of having "privileges,"[41] and/or require greater social control. But this attitude—which appears to be nearly universal—is based on an assumption that such patients are more dangerous than the norm. In many jurisdictions, if a patient is involved *in any way* with the criminal-justice system, he or she is automatically housed in the most secure forensic facility no matter the underlying charge or his individual risk assessment.[42] This administrative decision—one that is rarely noted and even more rarely challenged[43]—creates a systemic bias as to *all* forensic patients, improperly eliminating the need for individualized risk assessments.[44]

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40. I consider the implications of this false assumption in the context of the non-discrimination principles of the Americans with Disabilities Act in Perlin, *supra* note 11.

41. *See* Rex D. Glensy, *Quasi-Global Social Norms*, 38 CONN. L. REV. 79, 118 (2005) ("Perhaps because of its empowering nature, throughout the centuries, individuals and governments have persistently tried to deny liberty to others, either indiscriminately or by picking and choosing categories of people whom are deemed worthy or unworthy of enjoying its privileges.").

42. *See* Perlin, *supra* note 11, at 201–02.

43. *See, e.g.*, Hubbard v. State, 812 S.W.2d 107, 110–11 (Ark. 1991); Moten v. Commonwealth, 374 S.E.2d 704, 705 (Va. Ct. App. 1988); State v. LeFlore, 537 N.W.2d 148, No. 94-1825-CR, 1995 WL 366220, at *1 (Wis. Ct. App. May 9, 1995) (unpublished table opinion); State v. Phillips, 458 N.W.2d 388, No. 89-1010, 1990 WL 95989, at *1 (Wis. Ct. App. Apr. 24, 1990) (unpublished table opinion).

44. *Cf.* Clare Dwyer, *Risk, Politics and the "Scientification" of Political Judgement*, 47 BRIT. J. CRIMINOLOGY 779, 783 (2007) ("As a result of the changing population within the prisons, policy and risk assessment became concerned with political as opposed to individual risk factors.").

b. A Heightened Fear of Adverse Publicity on the Part of Institutional Administrators if They Were to Countenance Such Behavior[45]

I tell my Mental Disability Law students that the most important mental health policymaker in New York City is the front-page-headline writer for the *New York Post*, our most garish and outrageous tabloid (I am confident readers can fill in the appropriate parallel from their home towns). All of mental disability law is influenced by the pernicious power of the vividness heuristic: a cognitive simplifying device that teaches us that "when decisionmakers are in the thrall of a highly salient event, that event will so dominate their thinking that they will make aggregate decisions that are overdependent on the particular event and that overestimate the representativeness of that event within some larger array of events."[46] Writing about the high-publicity infanticide cases of Andrea Yates and Susan Smith, I said this about the power of the vividness effect: "[T]o the best of my knowledge, little has been written about the ways that the publicity given to one case involving a specific mental condition has led to a significant sea change in the ways that subsequent jurors decide cases involving defendants with a similar mental condition."[47] It should be no surprise that this has a particularly onerous impact on this area of law and policy.

c. The Fear of Tort Litigation That Concomitantly Ignores Potential Tort Exposure for Maintaining the Status Quo Ante

Fear of tort-based litigation has led to over-confinement[48] and overuse

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45. For a discussion of this in the contexts of sexually-violent-predator laws, see Michael L. Perlin, *"There's No Success like Failure/and Failure's No Success at All": Exposing the Pretextuality of* Kansas v. Hendricks, 92 NW. U.L. REV. 1247, 1258 n.62 (1998) [hereinafter Perlin, *No Success*], and of competency-to-stand-trial cases, see Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625, 638 n.56 (1993) [hereinafter Perlin, *Pretexts*].

46. Frederick Schauer, *Do Cases Make Bad Law?*, 73 U. CHI. L. REV. 883, 895 (2006). I discuss the vividness heuristic in the context of mental disability law in, *inter alia*, Michael L. Perlin, *"She Breaks Just Like a Little Girl": Neonaticide, the Insanity Defense, and the Irrelevance of "Ordinary Common Sense,"* 10 WM. & MARY J. WOMEN & L. 1, 4 (2003) [hereinafter Perlin, *She Breaks*]; Michael L. Perlin, *"The Executioner's Face Is Always Well-Hidden": The Role of Counsel and the Courts in Determining Who Dies*, 41 N.Y.L. SCH. L. REV. 201, 231 (1996); Michael L. Perlin, *The Sanist Lives of Jurors in Death Penalty Cases: The Puzzling Role of "Mitigating" Mental Disability Evidence*, 8 NOTRE DAME J.L. ETHICS & PUB. POL'Y. 239, 271 (1994). I discuss it specifically in the context of sexual autonomy in Perlin, *supra* note 9, at 536 n.118.

47. Perlin, *She Breaks*, *supra* note 46, at 2.

48. *See* Perlin, *supra* note 11, at 231.

of restraints,[49] notwithstanding a robust collection of cases that have found liability in cases involving improper commitment[50] or improper use of restraints.[51] Many times when I have talked about this general topic, audience members have expressed a fear of litigation. I posed the question this way in an earlier article:

> [H]ow will the well-documented fear of many mental health professionals of being sued—what some commentators term "litigaphobia"[52]—affect the adoption of, or compliance with, any policy that appears to increase the potential for patients' sexual activity (for fear that litigation might quickly follow unwanted births or the spread of sexually transmitted diseases)?[53]

This fear ignores the possibility that patients might sue for violations of their state statutory rights, federal Americans with Disabilities Act (ADA) rights, or international human rights, triggered by a deprivation of sexual autonomy.[54] This is a possibility never discussed in this policy debate.[55]

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49. *See* Michael L. Perlin, *The Regulation of the Use of Seclusion and Restraints in Mental Disability Law*, http://www.narpa.org/regulation.of.seclusion.htm (last visited Sept. 11, 2008), *permanent copy available* at http://www.law.washington.edu/wlr/notes/83washlrev481n49.pdf. *See generally* 2 PERLIN, *supra* note 12, § 3B-10.6 for a summary of cases dealing with restraint and seclusion issues.

50. *See, e.g.*, 3 PERLIN, *supra* note 12, § 7A-6.3, at 345–50 (citing and discussing cases).

51. *See id.*, § 7A-6.4f, at 363–64 (citing and discussing cases).

52. To my knowledge, the term "litigaphobia" was coined by Stanley Brodsky. *See* Stanley L. Brodsky, *Fear of Litigation in Mental Health Professionals*, 15 CRIM. JUST. & BEHAV. 492, 497 (1988) (discussing the overreaction of mental health professionals to the risk of malpractice litigation). I discuss litigaphobia in a tort-law "duty to protect" context in Michael L. Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 LAW & PSYCHOL. REV. 29, 61–62 (1992).

53. Perlin, *supra* note 9, at 525–26 (footnotes omitted).

54. Compare, for example, *Foy v. Greenblott*, 190 Cal. Rptr. 84 (Ct. App. 1983), where an institutionalized patient and her infant child sued the mother's treating doctor for failure to maintain proper supervision to either prohibit her from having sex or to provide her with contraceptive devices. On how this phenomenon dominates policy in the area of seclusion-and-restraint law, see Perlin, *supra* note 49.

55. If the U.N. Convention—rich with positive social rights—is eventually ratified by Congress and signed by the President, the resolution of this policy dilemma may eventually be altered, and the enhancement of individual rights and autonomy might eventually come to be seen as the preferred approach.

2. Short-Sightedness

Failure to take seriously issues of patient sexual autonomy is self-defeating. It ignores the reality that most patients will be reintegrated into a community in which sexuality is an important component, and it stems from our discomfort with even *defining* "sex."

a. A Failure to Consider That the Opportunity to Engage in an Intimate Relationship May Be Critical to a Patient's Adjustment to the Outside World Once Released[56]

When I first wrote about patient sexuality, I noted a significant issue: the opportunity to take part in intimate relationships may be critical to a patient's successful reintegration into the outside world.[57] Professor Cucolo has focused on this in her recent work on sex offenders. She asks why we fail to acknowledge that the concept of intimacy is "the key to preventing and minimizing re-offense."[58] This is a reality that must be considered as we further explore this issue.[59]

The literature is clear: we impose significant barriers that prevent institutionalized persons with mental disabilities from establishing intimacy.[60] Yet, one study showed that most patients in high-security hospitals "valu[ed] being in a caring relationship [while] in the hospital," and that there was likely "an ongoing desire for intimacy regardless of gender, diagnosis or offense group."[61]

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56. *See, e.g.*, W.L. Marshall et al., *The Enhancement of Intimacy and the Reduction of Loneliness Among Child Molesters*, 11 J. FAMILY VIOLENCE 219, 220 (1996) ("[I]ntimacy deficits and loneliness are linked to actual offending . . . .").

57. *See* Perlin, *supra* note 9, at 524 ("Is it clinically beneficial or antitherapeutic to allow institutionalized patients autonomy in sexual decision making? In answering this question, to what extent ought we consider research on the therapeutic value of touching and physical intimacy?") (citing, *inter alia*, ASHLEY MONTAGU, TOUCHING: THE HUMAN SIGNIFICANCE OF THE SKIN (1971); H.F. Harlow et al., *From Thought to Therapy: Lessons from a Primate Laboratory*, 59 AM. SCIENTIST 538 (1971)).

58. Heather Ellis Cucolo, Right to Sex in the Treatment and Civil Commitment of Sexual Violent Predators, (June 26, 2007) (unpublished paper), *available at* http://www.law.washington.edu/wlr/notes/83washlrev481n58.pdf. Professor Cucolo's findings were presented at the Thirtieth International Congress on Law and Mental Health in Padua, Italy. *See supra* note 6.

59. *See* Doherty, *supra* note 34, at 283, 287 (discussing how interpersonal relationships among patients can help further treatment goals).

60. *See* Judith A. Cook, *Sexuality and People with Psychiatric Disabilities*, 18 SEXUALITY & DISABILITY 195, 200 (2000).

61. Heidi Hales et al., *Sexual Attitudes, Experience and Relationships Amongst Patients in a High Security Hospital*, 16 CRIM. BEHAV. & MENTAL HEALTH 254, 260 (2006).

b. A Tension Between an Individual's Right to Free Expression of Sexuality, and Concern That a Patient Might Act Coercively Toward Another Patient, Especially in a Mixed-Sex Ward

This is the knottiest problem of all, and one that needs serious and sober thought. A forensic hospital, by definition, is a closed ward in most jurisdictions. Inside such a hospital, it may be more difficult to avoid contact with someone who is "sexually interested" than it often is in the "free world." At least one federal appellate court has ruled that "there must be a fundamental constitutional right to be free from forced exposure of one's person to strangers of the opposite sex when not reasonably necessary for some legitimate, overriding reason . . . ."[62] How may the right of institutionalized patients to be free from unwanted sexual attention be safeguarded in this context? Policymakers need to take this problem seriously in crafting any sort of protocol. When they do so, however, they should consider that the only recent study of sexuality in a high-security hospital concluded that there was "little evidence" of patients in that setting being coerced into sexual relationships.[63]

It is not enough for hospital administrators to presume coercion, using that assumption as a basis for denying patients their right to free expression. They must instead carefully craft policies that protect individuals from "unwanted sexual attention" while still safeguarding autonomy. There is no evidence that this is an issue being taken seriously.[64]

c. A Failure to Define What We Actually Mean by "Sex"

Without belaboring the obvious, what are we talking about when we say "sex"?[65] Our failure to define and discuss sex reflects our social

62. Kent v. Johnson, 821 F.2d 1220, 1226 (6th Cir. 1987).

63. Hales et al., *supra* note 61, at 260.

64. *See, e.g.*, Harlan Spector, *Should Psychiatric Hospital Patients Be Permitted to Have Sex?*, THE PLAIN-DEALER, June 25, 2008, *available at* http://blog.cleveland.com/metro/2008/06/should_psychiatric_hospital_pa.html, *permanent copy available at* http://www.law.washington.edu/wlr/notes/83washlrev481n64.pdf (quoting a patients' rights attorney questioning whether "women in psychiatric hospitals are even capable of consenting to sex").

65. *See* Sy, *supra* note 33, at 546 (discussing policies at Napa State Hospital in California that proscribe "open mouth kissing, oral stimulation of genitals (including breasts), anal stimulation or intercourse, sexual intercourse . . . promiscuous behavior . . . prolonged closed mouth kissing, intimate body to body contact, touching underneath clothing, touching of genitals (including breasts), exhibition of the body in any manner judged to be provocative and sexually

discomfort and squeamishness with this entire matter. Interestingly, in one of the few cases establishing any sort of right to sexual interaction, a federal court in Ohio held—gratuitously, apparently[66]—that Lima State Hospital patients have a right to be "provided counseling or other treatment for homosexuality."[67] Although this language does not appear to have been adopted by other courts (and the decision is well over thirty years old), I would not be so bold to predict that sexual-preference issues would pass entirely under the social radar if sexual autonomy rights were to be granted to forensic patients.

3. Rights

Notwithstanding the fears and examples of short-sightedness catalogued above, the reality is that institutionalized persons with mental disabilities—including forensic patients—*do* have at least some right to sexual expression and autonomy. By rejecting this legal reality, public opinion creates a social disconnect and allows for an irrational universe in which the extent to which a patient's rights may be vindicated may well rest on a triviality, such as which institution within the same geographic region of a state the patient is housed in.[68]

a. A Disconnect Between Potential Legal Sources That Might Support the Right[69] and Public Opinion That Utterly Rejects That Position[70]

It is not difficult for me to predict the level of public outrage if this idea were to be suggested by a politician. There was a movement to drum out of office the New York City Chancellor of Education when he

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solicitous . . . ." (internal quotation and footnote omitted)); *see also* Perlin, *supra* note 9, at 527 ("Does it make a difference if we are discussing monogamous heterosexual sex, polygamous heterosexual sex, monogamous homosexual sex, polygamous homosexual sex, or bisexual sex? Does sex mean intercourse? What about oral sex? Anal sex? Masturbation? Voyeurism? Exhibitionism?") (footnotes omitted).

66. There is no evidence that this issue was ever raised by either party in court pleadings or oral arguments.

67. Davis v. Watkins, 384 F. Supp. 1196, 1208 (N.D. Ohio 1974).

68. *See infra* text accompanying notes 72–74.

69. I argue in Perlin, *Promises*, *supra* note 26, at 965–70, that this right is protected by the Americans with Disabilities Act.

70. *Compare* Perlin, *Limited*, *supra* note 1, at 36 ("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!'") *with id.* at 36–41 (discussing reactions to presentations on this topic in audiences more receptive than the general public).

said that condoms should be made available to high-school students.[71] The reaction to what I am discussing here would be, I expect, more intense. But that should not end the discussion. At the least, the idea that institutionalized psychiatric patients have some sexual autonomy rights should be tested in a court of law—an arm of government presumably less susceptible to the vicissitudes of public pressure than administrative agencies.

b. The Intra-Jurisdictional Inconsistencies That Often Accompany the Development of Institutional Sex Policies

In her article about sexual activities in California institutions, Winiviere Sy points out the significant disparity between the restrictive policies at Napa State Hospital[72] and the less restrictive ones at Sonoma Developmental Center.[73] In at least one New York hospital, there have been different policies for male and female patients. Male patients leaving the facility on unsupervised community leave would be given condoms upon request. Female patients, on the other hand, had to have their competency (informally) assessed before birth-control pills could be prescribed.[74] This makes no conceptual sense, of course, and is most likely a reflection of the head-in-the-sand way we approach the underlying issues.[75]

B. Issues Endemic to Asia[76]

I found it very interesting that, when I told knowledgeable colleagues that I was writing this Article, they inevitably said, "Good luck with your research! You won't find a thing [about this specific sub-topic]."

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71. *See* Perlin, *supra* note 9, at 526 n.44.

72. *See supra* note 33.

73. Sy, *supra* note 33, at 547 (explaining that patients were allowed to engage "in activity directed to sexual arousal, because the expression of one's sexuality is the right of every person") (internal quotation and footnote omitted).

74. Perlin, *supra* note 9, at 541.

75. Much of the development of patients' rights litigation over the past thirty-five years has gone to ensure that there are "individualized treatment plans" for each institutionalized individual. *See generally* 2 PERLIN, *supra* note 12, § 3A–3.1c. We totally ignore this when it comes to issues of sexuality.

76. On the question of whether Asians are more likely to be civilly committed than are Caucasians, see S. Ali et al., *Are Asians at Greater Risk of Compulsory Psychiatric Admission than Caucasians in the Acute General Adult Setting?*, 47 MED. SCI. & L. 311 (2007) (discussing how Asian patients are significantly overrepresented as inpatients in some psychiatric hospitals).

Perhaps I have just been blessed to have a superb research assistant (it is always good to be lucky). But the reality is that my colleagues were wrong, and that there is some literature on this point, albeit to me, extraordinarily *depressing* literature.[77] Before looking at that literature, though, I will first address the issue of "cultural relativism."

1. Cultural Relativism

Advocates of cultural relativism "claim that rights and rules about morality . . . are encoded in and thus depend on cultural context."[78] I believe that cultural relativism is an inappropriate approach to this question. I unequivocally endorse the arguments of Patrick Hui, writing about birth-control policies in China in the context of the United Nation's Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW):[79] "Cultural relativism is not sufficient justification for the denial of the universal application of human rights standards."[80] As Arati Rao has stated: "[T]he notion of culture favored by international actors must be unmasked for what it is: a falsely rigid, ahistorical, selectively chosen set of self-justificatory texts and practices whose patent partiality raises the question of exactly whose interests are being served and who comes out on top."[81] I begin with this position to

77. Most, but not all, of the information available in the English language is from China and Japan. I am hoping that the publication of this Article will spur interest in this topic in other Asian nations.

78. Hirad Abtahi, *Reflections on the Ambiguous Universality of Human Rights: Cyrus the Great's Proclamation as a Challenge to the Athenian Democracy's Perceived Monopoly on Human Rights*, 36 DENV. J. INT'L L. & POL'Y 55, 56 (2007) (quoting HENRY J. STEINER & PHILIP ALSTON, INTERNATIONAL HUMAN RIGHTS IN CONTEXT: LAW, POLITICS, MORALS 192 (1996)).

79. Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. Doc. A/34/46 (Dec. 18, 1979).

80. Patrick T.C. Hui, *Birth Control in China: Cultural, Gender, Socio-economic and Legislative Perspectives in Light of CEDAW Standards*, 32 H.K.L.J. 187, 199 (2002); *see also* Joel Richard Paul, *Cultural Resistance to Global Governance*, 22 MICH. J. INT'L L. 1, 13 n.51 (2000) (citing, *inter alia*, Michael C. Davis, *Constitutionalism and Political Culture: The Debate over Human Rights and Asian Values*, 11 HARV. HUM. RTS. J. 109 (1998) (criticizing cultural relativism as deterministic and tautological)); Karen Engle, *Culture and Human Rights: The Asian Values Debate in Context*, 32 N.Y.U. J. INT'L L. & POL. 291 (2000) (same); Simon S.C. Tay, *Human Rights, Culture, and the Singapore Example*, 41 MCGILL L.J. 743 (1996) (examining the problematic character of the cultural argument in the context of Asian human rights)).

81. Arati Rao, *The Politics of Gender and Culture in International Human Rights Discourse*, *in* WOMEN'S RIGHTS, HUMAN RIGHTS: INTERNATIONAL FEMINIST PERSPECTIVES 167, 174 (Julie Peters & Andrea Wolper eds., 1995). For an anthropological perspective, see also Ann-Belinda S. Preis, *Human Rights as Cultural Practice: An Anthropological Critique*, 18 HUM. RTS. Q. 286 (1996) (rejecting cultural relativism). On deploying cross-cultural perspectives in this inquiry, see

preempt those who would reject the universality of human rights as they apply to all aspects of mental disability law.[82]

2. Rights in China

It is necessary to first look at China's history of mandatory sterilization of persons with mental retardation. In the 1980s, laws were passed in Gansu province: first, forbidding individuals with "hereditary retardation" from having children,[83] then, mandating sterilization for such individuals.[84] Similar laws were enacted in other provinces, and within a few years, there were parallel laws in five other sectors, some forbidding marriage, some forbidding childbearing, and some mandating sterilization.[85] These laws, which apply to one-third of China's population, flowed in significant part from the predominant Chinese notion that mental disabilities were "inherited" diseases.[86]

China's 1994 Law on Maternal and Infant Health Care requires

Man Yee Karen Lee, *Universal Human Dignity: Some Reflections in the Asian Context*, 3 ASIAN J. COMP. L., Issue 1, art. 10, at 1 (2008).

82. *Cf.* Michael L. Perlin, *International Human Rights and Comparative Mental Disability Law: The Role of Institutional Psychiatry in the Suppression of Political Dissent*, 39 ISR. L. REV. 69, 89–92 (2006) (discussing societal blindness to ongoing violations of the international human-rights law of persons with mental disabilities); Perlin, *supra* note 28, at 333 (examining universal factors to determining international human-rights violations involving persons with mental disabilities); Michael L. Perlin & Eva Szeli, *Mental Health Law and Human Rights: Evolution and Contemporary Challenges*, *in* MENTAL HEALTH AND HUMAN RIGHTS (Michael Dudley ed., forthcoming 2008) (discussing the history of the intersection—or lack thereof—of debates over human rights and disability rights), *available at* http://www.law.washington.edu/wlr/notes/83washlrev481n82.pdf; Michael L. Perlin, *"Through the Wild Cathedral Evening": Barriers, Attitudes, Participatory Democracy, Professor tenBroek, and the Rights of Persons with Mental Disabilities*, 13 TEX. J. ON C.L. & C.R. 413 (2008) [hereinafter Perlin, *Wild Cathedral*] (discussing literature on persons with mental disabilities and international human rights).

83. *See* Linda Johnson, *Expanding Eugenics or Improving Health Care in China: Commentary on the Provisions of the Standing Committee of the Gansu People's Congress Concerning the Prohibition of Reproduction by Intellectually Impaired Persons*, 24 J.L. & SOC'Y 199, 221–22 (1997) (reprinting Provisions of the Standing Committee of the Gansu People's Congress Concerning the Prohibition of Reproduction by Intellectually Impaired Persons, adopted Nov. 23, 1988).

84. Daniel S. Gewirtz, *Toward a Quality Population: China's Eugenic Sterilization of the Mentally Retarded*, 15 N.Y.L. SCH. J. INT'L & COMP. L. 139, 149 (1994).

85. *See* Gewirtz, *supra* note 84, at 149; Matthew D. Martin III, *The Dysfunctional Progeny of Eugenics: Autonomy Gone AWOL*, 15 CARDOZO J. INT'L & COMP. L. 371, 408 (2007).

86. *See* Gewirtz, *supra* note 84, at 149 (mental retardation perceived to be inherited); Johnson, *supra* note 83, at 226 n.38 (schizophrenia and manic depression presumed to be inheritable diseases).

premarital checkups to determine the presence of "relevant mental diseases,"[87] defined as mental diseases that "may have an adverse effect on marriage and child-bearing."[88] The Chinese Marriage Law forbids marriage if either individual "is suffering from any disease that is regarded by medical science as rend[er]ing [sic] a person unfit for marriage,"[89] a category regularly construed to include mental disabilities.[90] Beyond that, the law adds that a marriage is invalid "if any party has suffered from any disease that is held by medical science as rend[er]ing [sic] a person unfit for getting married and the disease has not been cured after marriage."[91]

3. Rights in Japan

Although the state of affairs in Japan is not quite as bleak, an article considering the role of the disability-rights advocacy movement in that nation notes that individuals with disabilities "have been taught from an early age to accept as well as cherish their dependence on the care they receive from parents and institutions."[92] Scholars have begun to consider the negative social repercussions of principles of hierarchy and dependence in Japanese society,[93] but they have paid little attention to the specific intersection between these principles and sexual autonomy.

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87. Law of the People's Republic of China on Maternal and Infant Health Care, art. 8(3), *available at* http://www.npc.gov.cn/englishnpc/Law/2007-12/12/content_1383796.htm, *permanent copy available at* http://www.law.washington.edu/wlr/notes/83washlrev481n87.pdf.

88. *Id.* art. 7(3).

89. Marriage Law of the People's Republic of China, art. 7(b), *available at* http://www.lawinfochina.com/law/display.asp?db=1&id=1793&keyword, *permanent copy available at* http://www.law.washington.edu/wlr/notes/83washlrev481n89.pdf.

90. *See* Xiaoqing Feng, *A Review of the Development of Marriage Law in the People's Republic of China*, 79 U. DET. MERCY L. REV. 331, 337 (2002).

91. Marriage Law of the People's Republic of China, art. 10(c), *available at* http://www.lawinfochina.com/law/display.asp?db=1&id=1793&keyword, *permanent copy available at* http://www.law.washington.edu/wlr/notes/83washlrev481n91.pdf.

92. Katharina Heyer, *From Special Needs to Equal Rights: Japanese Disability Law*, 1 ASIAN-PAC. L. & POL'Y J., Issue 1, at 1, 17 (1999).

93. *See, e.g.*, Taimie L.Bryant, *For the Sake of the Country, For the Sake of the Family: The Oppressive Impact of Family Registration on Women and Minorities in Japan*, 39 UCLA L. REV. 109, 109 n.2 (1991) (citing, *inter alia*, TAKEO DOI, THE ANATOMY OF DEPENDENCE (1973) (discussing the role of presumption on the benevolence of hierarchical superiors in Japanese personality and society); Hiroshi Wagatsuma & Arthur Rosett, *The Implications of Apology: Law and Culture in Japan and the United States*, 20 LAW & SOC'Y REV. 461 (1986) (discussing the intersection between various psychological features connected to hierarchical social organization and the legal system)).

These two portraits—a nation that seeks to suppress all sexuality in individuals with mental disabilities,[94] and a nation that privileges institutional dependence—do not lead to much optimism as we consider the matter currently before us. However, I do not want to paint an entirely pessimistic picture, as there is some recognition of the problem. In supporting the need for a U.N. Convention on the Rights of Persons with Disabilities, delegates to an Asia-Pacific regional conference held in Bangkok in 2003 declared that "international human rights standards require that people with disabilities should enjoy the same basic human rights as all other human beings."[95] Sadly, this statement appears at odds with prevailing social and cultural norms as well as legislation in much of this region.[96] The delegates noted that such persons are subjected to "widespread violations of their human rights," including specifically, "forced sterilisation."[97]

The U.N. Convention and the Bangkok recommendations[98] are encouraging. However, the backdrop of the Chinese and Japanese experiences remind us that realization of the rights set out in the Convention will not come easily.[99] Advocates and activists in this area face barriers when seeking to articulate and implement an array of sexual autonomy rights for persons with mental disabilities. In short, this is not an easy question.

III. SANISM

Sanism 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

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94. *Cf.* Vanessa Torres Hernandez, *Making Good on the Promise of International Law: The Convention on the Rights of Persons with Disabilities and Inclusive Education in China and India*, 17 PAC. RIM L. & POL'Y J. 497 (2008) (concluding that China fails to provide universal education for children with disabilities).

95. *Bangkok Recommendations on the Elaboration of a Comprehensive and Integral International Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities* (2003), *available at* http://www.worldenable.net/bangkok2003/recommendations.htm, *permanent copy available at* http://www.law.washington.edu/wlr/notes/83washlrev481n95.pdf [hereinafter *Bangkok Recommendations*].

96. *Cf.* Man-Chung Chiu, *Development of an Indigenous Legal Theory of Sexual Justice in Hong Kong*, 37 H.K.L.J. 775 (2007) (discussing the possibility of creating an indigenous legal theory of sexual justice in Hong Kong).

97. *See Bangkok Recommendations*, *supra* note 95.

98. *See id.*

99. *See supra* text accompanying notes 83–93.

permeates all aspects of mental disability law and affects all participants in the mental disability law system: litigants, fact-finders, counsel, and expert and lay witnesses.[100] Its corrosive effects have warped mental disability jurisprudence in the law of involuntary civil commitment, institutional law, tort law, and all aspects of the criminal process (pretrial, trial, and sentencing).[101] It reflects what civil-rights lawyer Florynce Kennedy has characterized the "pathology of oppression."[102] In earlier articles, I have explored the relationship between sanism and sexuality.[103] If 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."[104] We thus have labeled all individuals with mental illness as being "deviant, morally weak, sexually uncontrollable, [and] emotionally unstable."[105] And often, we (especially professionals)[106] regard those with mental disabilities as being fundamentally different from us, lacking human qualities such as the needs for affection and dignified ways of expressing affection.[107]

A. Sanist Myths

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.

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100. *See* Perlin, *On Sanism*, *supra* note 5, at 398–405.

101. *See id.* at 400–05.

102. *See* Morton Birnbaum, *The Right to Treatment: Some Comments on Its Development*, *in* MEDICAL, MORAL AND LEGAL ISSUES IN HEALTH CARE 97, 107 (Frank J. Ayd, Jr. ed., 1974) (discussing Kennedy's conception of sanism).

103. *See* PERLIN, *supra* note 15; Perlin, *Lepers*, *supra* note 1; Perlin, *On Sanism*, *supra* note 5.

104. SANDER L. GILMAN, DIFFERENCE AND PATHOLOGY: STEREOTYPES OF SEXUALITY, RACE, AND MADNESS 240 (1985).

105. Perlin, *On Sanism*, *supra* note 5, at 383.

106. Although I refer here primarily to mental health professionals, lawyers often mirror the same attitudes. *See, e.g.*, Spector, *supra* note 64 (describing the chief lawyer for the nonprofit Nebraska Advocacy Services as questioning "whether women in psychiatric hospitals are even capable of consenting to sex"). On sanist behavior by lawyers, see generally Perlin, *Lepers*, *supra* note 1.

107. *See generally* Perlin, *Limited*, *supra* note 1.

> 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.[108]

Think about the basic "sanist myths" that I have discussed previously in the specific context of this Article's topic:

> 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.
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> 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 (1) future dangerousness, and (2) 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.
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> 7. Mentally ill individuals should be segregated in large, distant

108. Perlin, *supra* note 9, at 537 (footnotes omitted).

> 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.
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> 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.
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> 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.[109]

These myths contaminate those social policies that deal with and control the lives of persons with mental disabilities, especially *institutionalized* persons with mental disabilities. And they are most pernicious when it comes to issues of sexuality.

B. Sanism in Asia

In China, these biases are more pronounced. A news report summarized what experts characterize as "the social view that is currently held by the general public in China": "[Mentally retarded] people make no contribution to the society, are invisible shackles to their parents, cause great misery to themselves, and are a heavy burden to the country."[110] It is hard to imagine a more sanist sentence.

These attitudes are exaggerated in other Asian cultures as well. A review of Malaysian law concludes that *current* Mayalsian mental-health legislation "reflects the stigmatizing approach toward the persons with mental illness that prevailed in the 1950s and 1960s," an approach in

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109. Perlin, *Lepers*, *supra* note 1, at 724–25 n.220.

110. Hongjun Su & Don C. Van Dyke, *Breaking the Silence and Overcoming the Invisibility: Down Syndrome in China, Part I*, 20 INT'L PEDIATRICS 25, 28 (2005) (internal citation omitted).

which mental illness is viewed as a "purely biological aberration."[111] A Hong Kong study stressed:

> In Chinese societies, there is more severe stigma against individuals and thus relatives of mental health consumers, as Chinese culture attaches more importance to the collective representation of families, and having a mentally ill relative is considered something one should feel ashamed of, for it can imply an inferior origin of the family, failure of the parents, or even sin committed by ancestors.[112]

The authors of the study concluded that this social stigma "has tremendous impacts on the recovery of individuals with mental illness in terms of employment, social resources, and availability of community-based facilities."[113] The relationship between the legacy of this stigma—feelings of shame and inferiority—and the repression of the sexuality of persons with mental disabilities in Asian cultures should be crystal clear.[114]

C. Influence of Sanism on Forensic Patients

If there has ever been a special-interest group with no lobby, support system, political-action committee, or fan club, it is that of forensic psychiatric patients. It is a sure bet that at this moment there is no organized group of advocates whose "action agenda" leads off with, "Let's make sure that forensic patients have a right to sex!" My research turns up nothing—not a single court case, article, or Internet mention—that addresses this issue.

Some of this state of affairs, this abject lack of interest, results in part from the policy dilemmas that I discussed earlier.[115] However, even

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111. A. Rahamuthulla Mubarak, *Malaysia's Social Policies on Mental Health: A Critical Theory*, 17 J. HEALTH & SOC. POL'Y 55, 59 (2003). Of course, there are many nations with no mental health law at all. *See* Perlin, *supra* note 28, at 337 (citing to recent report by the World Health Organization revealing that twenty-five percent of all nations in the world have no such law).

112. Hector W.H. Tsang et al., *Stigmatizing Attitudes Towards Individuals with Mental Illness in Hong Kong: Implications for Their Recovery*, 31 J. COMMUNITY PSYCHOL. 383, 385 (2003); *see generally* MICHAEL L. PERLIN, THE JURISPRUDENCE OF THE INSANITY DEFENSE 37 (1994) ("Ever since Prince Ptah-hotep attempted the first classification of mental illness almost five thousand years ago, conceptions of such illness have been inextricably linked to the notion of sin . . . .") (footnotes omitted).

113. Tsang et al., *supra* note 112, at 394.

114. On the *invisibility* of persons with mental disabilities in China, illustrated by the treatment of those with Down Syndrome, see generally Su & Van Dyke, *supra* note 110.

115. *See supra* Part II.A.

more of it results from the omnipresence of sanism. The peculiar interplay between sanism and sexuality—an interplay that I have discussed extensively in the past[116]—is particularly warped in considerations of the right of forensic patients to exercise sexual autonomy while institutionalized.

Because of sanism, we attribute to all forensic patients an immutable and pernicious level of dangerousness—one that is constant, universal, and not subject to remediation. Because of sanism, we employ the vividness heuristic so as to typify *all* behaviors of *all* forensic patients, based on what *some* patients might do *some* of the time.[117] Because of sanism, we blind ourselves to violations of constitutional and statutory rights (domestic and international) for fear of "bad publicity." A review of my book, *The Hidden Prejudice*, made this point better than I could:

> It is likely many readers will have trouble staying "on the bus" with Perlin when they read Chapter Seven in which he argues for the right of institutionalized persons to have sexual interaction. Perhaps that proves Perlin's point, however, about how extensive, pervasive, and culturally rooted prejudices against persons with mental illness are, serving "ultimately as a 'Rorschach test' for the degree to which we are willing to punish people via restrictions of the ability to exercise civil rights because they suffer from mental illness."[118]

If we ignore these realities, any attempt to have a constructive conversation about the issue of sanism will be doomed to fail.

D. Impact of the U.N. Convention

I indicated earlier that a "cultural relativism defense," which would endorse a perpetuation of the status quo, fails.[119] This rejection is not simply premised on personal preference or on philosophical position, but is also grounded in the law, specifically the new U.N. Convention.[120] As I noted earlier, the U.N. Convention mandates that nations "[p]rovide persons with disabilities with the same range, quality and standard of

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116. *See generally* Perlin, *supra* note 9; Perlin, *Limited*, *supra* note 1.

117. *See supra* notes 45–46 and accompanying text.

118. Bruce Spector, *Disabilities and the Law*, 12 BIMONTHLY REV. L. BOOKS, No. 3 (May–June 2001), at 15, 18, *available at* http://www.nesl.edu/library/bimonthly/brlb123.doc, *permanent copy available at* http://www.law.washington.edu/wlr/notes/83washlrev481n118.pdf.

119. *See supra* notes 78–82 and accompanying text.

120. Convention on the Rights of Persons with Disabilities, G.A. Res. A/61/106, *supra* note 3.

free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes."[121] Not insignificantly, the U.N. Convention also mandates that such individuals "retain their fertility on an equal basis with others."[122] Professors Michael Stein and Janet Lord have recently written eloquently about how *another* Article in the U.N. Convention—Article 30, which sets out social rights of participation in cultural life—"serves as a vital channel of engagement with such society when such participation is embraced by the community," and increases "self-reliance and empowerment."[123] Other commentators have concluded that the U.N. Convention "is regarded as having finally empowered the 'world's largest minority' to claim their rights, and to participate in international and national affairs on an equal basis with others who have achieved specific treaty recognition and protection."[124] If the U.N. Convention is taken seriously—if it is, in fact, more than a "paper victor[y]"[125]—then perhaps it can be used as a vehicle to uproot that aspect of sanism that continues to deny sexual rights to institutionalized persons with mental disabilities.[126]

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121. *Id.* art. 25 (a).

122. *Id.* art. 23 (1)(c).

123. Michael Ashley Stein & Janet Lord, *Jacobus tenBroek, Participatory Justice, and the UN Convention on the Rights of Persons with Disabilities*, 13 TEX. J. ON C.L. & C.R. 167, 182 (2008). I discuss this article extensively in Perlin, *Wild Cathedral*, *supra* note 82.

124. Rosemary Kayess & Phillip French, *Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities*, 8 HUM. RTS. L. REV. 1, 4 (2008) (footnotes omitted); *see also id.* at 4 n.17 (citing statements made by the High Commissioner for Human Rights, Louise Arbour, and the Permanent Representative of New Zealand and Chair of the Ad-Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Ambassador Don Mackay, at a Special Event on the Convention on Rights of Persons with Disabilities, convened by the U.N. Human Rights Council, 26 March 2007).

125. Michael L. Perlin, *"What's Good Is Bad, What's Bad Is Good, You'll Find out When You Reach the Top, You're on the Bottom": Are the Americans with Disabilities Act (and* Olmstead v. L.C.) *Anything More Than "Idiot Wind"?*, 35 U. MICH. J.L. REFORM 235, 246 (2002) (quoting Michael Lottman, *Paper Victories and Hard Realities*, *in* PAPER VICTORIES AND HARD REALITIES: THE IMPLEMENTATION OF THE LEGAL AND CONSTITUTIONAL RIGHTS OF THE MENTALLY DISABLED 93 (Valerie J. Bradley & Gary J. Clarke eds., 1976)). In the specific context of United Nations Conventions, see Sara Dillon, *What Human Rights Law Obscures: Global Sex Trafficking and the Demand for Children*, 17 UCLA WOMEN'S L.J. 121, 154 (2008) ("A specialized human rights convention does not in itself guarantee substantial change . . . .").

126. There is some evidence that in other jurisdictions, parallel rights are being taken seriously. *See, e.g.*, Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocol No. 11, Nov. 1, 1998, art. 8(1), *available at* http://conventions.coe.int/treaty/EN/Treaties/html/005.htm, *permanent copy available at* http://www.law.washington.edu/wlr/notes/

In summary, the climb uphill is steep. Those seeking fundamental and systemic changes in this area need to confront a powerful array of forces designed to blunt or subvert change: our tradition of palpable discomfort when it comes to even *thinking* about patient sexuality;[127] our fears about expanding autonomy rights for *any* patients in forensic institutions;[128] the tradition in some Asian nations of seeking to suppress *all* sexual behavior on the part of persons with mental disabilities;[129] and the omnipresence of sanism[130] (abetted by pretextuality,[131] the use of heuristics,[132] and the use of false "ordinary common sense").[133] It is my hope that this Article calls attention to this cluster of issues so as to begin the remediation process.

IV. SOME TENTATIVE SOLUTIONS

It seems futile to offer "solutions" to a problem that most do not even realize exists, particularly when most people vehemently reject the notion that there is any need for remediation. But I will try. Perhaps these thoughts will be of some interest or help.[134] I recognize that—in and of themselves—my solutions will not eliminate the entire array of problems discussed in this Article. But I do believe that if they are

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83washlrev481n126.pdf, *construed in* X. v. Iceland, App. No. 6825/74, 5 Eur. Comm'n H.R. Dec. & Rep. 86, 87 (1976) (finding that the Article prohibiting public authorities from interfering with a person's right to respect for his private and family life, his home, and his correspondence is broad enough to encompass an entitlement to "establish and to develop relationships with other human beings, especially in the emotional field for the development and fulfillment of one's own personality"). This issue is discussed in Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 MD. L. REV. 20, 94 (2004).

127. *See generally* Perlin, *Limited*, *supra* note 1.

128. *See generally* Perlin, *supra* note 11 (discussing the overuse of maximum-security facilities as sites for evaluations of defendants in incompetency and insanity cases).

129. *See, e.g.*, Gewirtz, *supra* note 84; Johnson, *supra* note 83.

130. *See, e.g.*, Perlin, *On Sanism*, *supra* note 5.

131. *See generally* Perlin, *supra* note 15; Perlin, *No Success*, *supra* note 45; Perlin, *Pretexts*, *supra* note 45.

132. *See, e.g.*, Perlin, *She Breaks*, *supra* note 46.

133. *See* Perlin, *supra* note 15, at 14; Michael L. Perlin, *Psychodynamics and the Insanity Defense: "Ordinary Common Sense" and Heuristic Reasoning*, 69 NEB. L. REV. 3 (1990).

134. One of these recommendations (the third) applies specifically to forensic issues; another (the fifth) applies specifically to issues involving Asian nations (though "cultural relativism" issues are certainly raised in human-rights contexts in other nations as well). The rest apply equally to both, as well as to the question of patient sexuality in other contexts such as civil hospitals and Western nations.

implemented, we will begin to make some modest progress, and we will, for the first time, treat patients "as human beings."[135]

First, we must take our heads out of the sand and confront the fact that institutionalized psychiatric patients—like the rest of us—think about sex. (I had originally typed in "all the time," and then deleted it . . . maybe . . .) It is a fatal error to think otherwise. In one of my earlier articles, I shared this vignette from a visit to a psychiatric hospital in Uruguay:

> [I] 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.[136]

Had the staff acknowledged the reality—that the teenage boys had sexual feelings and were expressing normal sexual urges—then the institution might have been able to begin to think about structuring meaningful sexual-autonomy policies that comport with international human-rights norms and standards.

Second, we must also acknowledge that the great majority of residents in such facilities will eventually leave and reenter free society. This should force us to think about how repressive sexual policies (or non-policies) will affect their behavior in the free world.

Third, we must come to grips with the extent to which our sanist behavior drives our attitudes in these cases. By treating *all* patients in this legal category as if they are likely to be randomly sexually violent—

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135. Falter v. Veterans' Admin., 502 F. Supp. 1178, 1185 (D.N.J. 1980). I discuss the implications of this opinion for all matters that involve the marginalization of persons with mental disabilities in Michael L. Perlin & John Douard, *"Equality, I Spoke that Word/As if a Wedding Vow": Mental Disability Law and How We Treat Marginalized Persons*, __ N.Y.L. SCH. L. REV. __ (forthcoming 2008), *available at* http://www.law.washington.edu/wlr/notes/83washlrev481n135.pdf.

136. Perlin, *Limited*, *supra* note 1, at 37.

ignoring the fact that many forensic patients are charged with minor offenses (in some jurisdictions, mere misdemeanors)[137]—we blind ourselves to social realities.

Fourth, this discourse must consider the therapeutic jurisprudence implications of how we treat such patients. I wrote the following fifteen years ago, and it still applies:

> We must also question the therapeutic or antitherapeutic implications of official hospital policies that control the place, manner, and frequency with which such individuals can have sexual interactions. We must consider the implications of these policies on ward life and their implications for patients' post-hospital lives. These questions are difficult ones, but we must ask them nonetheless if we wish to formulate a thoughtful, comprehensive response to the wide range of questions this subject raises.[138]

The development of therapeutic jurisprudence as an academic discipline[139] should force us to consider the therapeutic outcomes of different policies about sexual activity.

Fifth, we must recognize that for these purposes cultural relativism is a pretextual sham.[140] We must be willing to reject it as a barrier to the ability of persons with mental disabilities to exercise their human and legal rights.

Finally, changes in the law, such as the passage of the ADA in the United States and the publication of the U.N. Convention, have the potential to shift policies governing much of institutional and community-based mental disability law. For this to happen, lawyers need to start thinking about the underlying issues. So far, this has not

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137. *See* Perlin, *supra* note 11.

138. Perlin, *supra* note 9, at 547.

139. Therapeutic jurisprudence presents a new model by which we can assess the ultimate impact of case law and legislation on mentally disabled individuals. Therapeutic jurisprudence requires (1) studying the role of the law as a therapeutic agent; (2) recognizing that substantive rules, legal procedures, and lawyers' roles may have either therapeutic or anti-therapeutic consequences; and (3) questioning whether such rules, procedures, and roles can or should be reshaped so as to enhance their therapeutic potential, while not subordinating due-process principles. *See* Perlin, *She Breaks*, *supra* note 46, at 30–31 n.233. S*ee generally* ESSAYS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1991); LAW IN A THERAPEUTIC KEY: RECENT DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1996); THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW (Bruce J. Winick ed., 1997); THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (David B. Wexler ed., 1990).

140. I discuss pretextuality extensively in PERLIN, *supra* note 15, and Perlin, *supra* note 15.

happened. My recommendation to my fellow members of the bar is to get at it. I have written extensively about how sanism affects lawyers,[141] even lawyers who focus their practices on the representation of marginalized persons.[142] It is essential that this reality be taken seriously by members of the bar, especially those whose practices include representation of persons with mental disabilities.

This list is in no way comprehensive. I offer it here as a modest starting point. If we begin to think critically about these issues, it is far more likely that we will begin to take seriously the core questions about sexuality and autonomy that I pose in this Article.

CONCLUSION

I chose Bob Dylan's "Desolation Row" to use in the title of this Article because of its depiction of a "cultural jumble" built on "general deviance."[143] The sanism that is shown towards patients in forensic facilities and towards patients in Asia, as well as the pretextuality that defines the judicial process as it relates to these issues, similarly "jumble" mental disability law, confounding and conflating different types of social deviance. This creates another desolation row. In one of the starkest images in the song, Dylan sings:

> And the only sound that's left
> After the ambulances go
> Is Cinderella sweeping up
> On Desolation Row[.][144]

In the past four decades, a sexual revolution changed the way we think about gender, sex roles, personal relationships, and sexual expression. The last thirty years have seen a legal civil-rights revolution

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141. On how lawyers are sanist, see Michael L. Perlin, *"Baby, Look Inside Your Mirror": The Legal Profession's Willful and Sanist Blindness to Lawyers with Mental Disabilities*, 69 U. PITT. L. REV. 589, 604–05 (2008). *See also* Aaron Dhir, *Relationships of Force: Reflections on Law, Psychiatry, and Human Rights*, 25 WINDSOR REV. LEGAL & SOC. ISSUES 103, 108 (2008) ("[T]he primary responsibility for the lack of rights realization lies not with judges, not with legislators and not with clinicians. Rather, it lies with us - the lawyers who represent, and will go on to represent, persons with psychiatric disabilities.").

142. *See* Perlin, *supra* note 141, at 590 ("Just as lawyers are sanist towards clients with mental disabilities, they are sanist towards their peers with mental disabilities."); Perlin, *Lepers*, *supra* note 1, at 700 ("Even a cursory examination of the ethical issues permeating the representation of persons with mental disabilities readily evidences the omnipresence of sanism.").

143. Kermode & Spender, *supra* note 21, at 158–59.

144. BobDylan.com, *supra* note 17.

affect the way that we think about persons with mental disabilities, both in institutional and community settings.[145] The last twenty years have seen a revolution in the joining together of the international human-rights movement and the mental disability law movement.[146] Perhaps we can now turn our attention to the relationship between these two revolutions. If we can do so, then there will be more to this area of the law than, simply, another "desolation row."

145. Perlin, *supra* note 9, at 547.

146. *See, e.g.*, PERLIN, HUMAN RIGHTS, *supra* note 37; Perlin & Szeli, *supra* note 82.