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COMMENTARIES

AVERSION THERAPY AND THE INVOLUNTARILY CONFINED: REHABILITATION OR RETRIBUTION?*

In trying to solve the terrifying problems that face us in the world today, we naturally turn to the things we do best. We play from strength, and our strength is science and technology.¹

Extensive and rapid development of the behavioral and biological sciences in the twentieth century has given birth to the concept of the "therapeutic state" — a legal framework with the announced aim of the treatment and cure of deviant behavior.² The compatibility of this concept with modern penological theory, which views the social retraining of the criminal as the ultimate objective,³ has created issues inconceivable fifty years ago. The use of contemporary methods of behavior control⁴ on the involuntarily confined is one such issue. These technologies, involving use of psychiatric techniques that alter behavior,⁵ reflect the crucial problem implicit in the therapeutic approach: a total lack of boundaries resulting from its unprecedented nature.⁶ This commentary will examine aversion therapy,⁷ one of the more common behavior control techniques used on prisoners in penal institutions. It will focus on the applicable prior law, and recently addressed issues of cruel and

*EDITOR'S NOTE: This commentary received the *University of Florida Law Review Alumni Association Commentary Award* as the outstanding commentary submitted during the spring 1974 quarter.

1. B. F. SKINNER, *BEYOND FREEDOM AND DIGNITY* 1 (2d ed. 1971).

2. "The implications of the therapeutic state for the treatment of crime and criminals are dramatic. . . . Crime is viewed as a natural feature of the social landscape. Criminals are no longer 'bad,' though they must be dealt with because they are injurious to society. As the moral-religious preoccupation with moral guilt . . . now gives way to the concept of sanctions mainly as a tool of social defense, the door is opened to new experiments with the treatment of offenders." N. KITTRIE, *THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY* 39-40 (1971).

3. See *CONTEMPORARY PUNISHMENT: VIEWS, EXPLANATIONS, AND JUSTIFICATIONS* 175-227 (R. Gerber & P. McAnany eds. 1972). "The concept of 'treatment' has replaced the concept of 'punishment.'" Bergan, *The Sentencing Power in Criminal Cases*, 13 *ALBANY L. REV.* 1, 3 (1949).

4. "In its broadest sense behavior control can be viewed as a special form of behavioral change. It is treatment imposed on or offered to the patient that to a large extent is designed to satisfy the wishes of others. Such treatment may lead to the patient's behaving in a manner which satisfies his community or his society." Halleck, *Legal and Ethical Aspects of Behavior Control*, 131 *AM. J. PSYCHIATRY* 381 (1974). Behavior control has also been defined simply as getting people to do someone else's bidding. See P. LONDON, *BEHAVIOR CONTROL* 3 (1970).

5. See Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 *S. CAL. L. REV.* 616 n.1 (1972).

6. "Of the multitude of problems associated with the therapeutic model, the great bulk can be summarized under a single unifying theme: that the therapeutic approach knows no bounds." Wexler, *Therapeutic Justice*, 57 *MINN. L. REV.* 289, 293 (1972).

7. See text accompanying notes 18-19 *infra*.

unusual punishment and informed consent to the use of such techniques. Analytical shortcomings of recent decisions will be examined, and recommendations made for future judicial analysis of similar issues.

BEHAVIOR MODIFICATION

Behavior modification takes many forms.⁸ Some are noncoercive, such as milieu therapy⁹ and psychotherapy.¹⁰ These pose few problems for the involuntarily confined because an inmate can avoid the effects of such physically nonintrusive techniques with a minimum degree of mental resistance.¹¹ Major "organic" techniques,¹² however, involve physical intrusion into the body that may be impossible for an inmate to avoid. These intrusive techniques include psychosurgery,¹³ electronic stimulation of the brain (ESB),¹⁴ and drug therapy.¹⁵ Most widely used among these three, particularly in the institutional setting, is drug therapy.¹⁶

Drug therapy is less drastic than psychosurgery's irreversible alteration of the brain, seemingly involving only temporary adverse physiological effects, and is more easily administered than psychosurgery or ESB. Consequently, it is readily adaptable to institutional use. Although drug therapy includes the

8. Techniques include milieu therapy, individual and group psychotherapy, drug therapy, operant conditioning, classical conditioning, aversion therapy, electroconvulsive therapy, electronic stimulation of the brain, lobotomy, stereotactic psychosurgery, and anectine therapy. See Note, *supra* note 5, for a discussion of each of these techniques.

9. Milieu therapy involves "scientific manipulation of the environment aimed at producing changes in the personality of the patient." J. CUMMINGS & E. CUMMINGS, *EGO AND MILIEU* 5 (1962). For a discussion of milieu therapy within the context of the constitutional right of the involuntarily hospitalized to adequate psychological treatment, see Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974).

10. Psychotherapy is a means of attacking personal problems and trying to solve them largely by talking and related processes. FOUNDATIONS OF ABNORMAL PSYCHOLOGY 570-93 (P. London & D. Rosenhan eds. 1968).

11. "[T]raditional psychotherapy works slowly. It gives the patient time to contemplate the meaning of behavioral change and to resist such change." Halleck, *supra* note 4, at 381. See also Note, *supra* note 5, at 619-20.

12. These are techniques relating to or affecting internal organs of the body.

13. "Psychosurgery is a medical procedure in which brain tissue is either destroyed, removed, or cut with the intent of altering thoughts, emotions, or behavior." Spoonhour, *Psychosurgery and Informed Consent*, 26 U. FLA. L. REV. 432 (1974). See B. BROWN, L. WRENKOWSKI & L. BIVENS, *PSYCHOSURGERY: PERSPECTIVE ON A CURRENT PROBLEM* 1 (HEW Publication No. HSM 73-9119, 1973); *Psychosurgery Critics Prove Hard To Mollify*, MEDICAL WORLD NEWS, April 14, 1972, at 38-39.

14. ESB involves the implantation of electrical conductors in the brain that, when charged, stimulate the brain and induce the behavior associated with that part of the brain. A. ROSENFELD, *THE SECOND GENESIS* 195 (1969). See also P. LONDON, *supra* note 4, at 136-51. One study proposes ESB as an alternative to imprisonment. Ingraham & Smith, *The Use of Electronics in the Observation and Control of Human Behavior and Its Possible Use in Rehabilitation and Parole*, 7 ISSUES IN CRIMINOLOGY 35 (1972).

15. See A. NOYES & L. KOLB, *MODERN CLINICAL PSYCHIATRY* 620-38 (8th ed. 1973).

16. Drug therapy is one of the most widely used behavior control techniques and has been used to effect a revolution in the psychiatric care of mental patients. Note, *supra* note 5, at 623.

use of tranquilizers,¹⁷ its physically intrusive use is epitomized by "aversion therapy," a behavior control technique based on Pavlovian conditioning.¹⁸ Aversion therapy attempts to associate undesirable behavior with unpleasant stimulation, hopefully resulting in a connection between the behavior and the unpleasantness leading to a cessation of the undesirable traits.¹⁹

Two recent cases vividly illustrate the contemporary use of aversion therapy as a behavior control device, and the ability of modern drugs to provide the required unpleasant stimulation. In *Mackey v. Procunier*²⁰ a prisoner stated that he was administered, without his consent, the drug succinylcholine (anectine), which he described as a "breath-stopping and paralyzing 'fright drug.'" The inmate claimed that as a consequence of such "guinea-pig treatment," he regularly suffered nightmares in which he relived the frightening experience and awakened unable to breathe. The record indicated that defendants were engaged, without patient consent, in psychiatric experimentation with "aversive treatment" of criminal offenders.²¹ The goal was to ascertain whether, by instilling of fright and infliction of pain, accompanied by psychological suggestion, behavior patterns could be affected.²²

Other authorities indicate that the inmate's description of anectine was accurate. According to those who have been injected, the patient is overwhelmed by a feeling of suffocation, of drowning, and of sinking into death.²³ This sensation results from the nearly complete paralysis of the skeletal muscles and resultant suspension of respiration caused by the drug.²⁴ After respiration

17. See, e.g., *Nelson v. Heyne*, 355 F. Supp. 451 (1972); Field, *Benperidol in the Treatment of Sexual Offenders*, 13 *MEDICAL SCI. & L.* 195 (1973).

18. Singer, *Psychological Studies of Punishment*, 58 *CALIF. L. REV.* 405, 423, 431 (1970). Pavlovian conditioning is based on the theory that when environmental stimuli or the kinetic stimuli produced by the incipient movements of the punished act are made contiguous with punishment, they take on some of the aversive properties of the punishment itself.

19. S. RACHMAN & J. TEASDALE, *AVERSION THERAPY AND BEHAVIOR DISORDERS: AN ANALYSIS* xii (1969). See also H. SCHAEFER & P. MARTIN, *BEHAVIOR THERAPY* 4 (1969); Kushner & Sandler, *Aversion Therapy and the Concept of Punishment*, 4 *BEHAVIORAL RESEARCH & THERAPY* 179 (1966). A review of aversion therapy may be found in *MIAMI SYMPOSIUM ON THE PREDICTION OF BEHAVIOR 1967: AVERSIVE STIMULATION* (M. Jones, ed. 1967) [hereinafter cited as *MIAMI SYMPOSIUM*]. Discussions and examples of aversion therapy are also frequent in criminological literature. Vietor, *Conditioning as a Form of Psychotherapy in Treating Delinquents: Some Data from the Literature*, 7 *EXCERPTA CRIMINOLOGICA* 3 (1967).

20. 477 F.2d 877 (9th Cir. 1973). Mackey was an inmate at the California Medical Facility at Vacaville.

21. *Id.* at 878 n.1, citing Brief for Appellant at 9, 15 n.5 and accompanying text. See Note, *supra* note 5, at 663.

22. 477 F.2d at 878 n.1, citing Brief for Appellant at 9.

23. See Weiner, *The Clockwork Cure*, *THE NATION* April 3, 1972, 433, 434.

24. "During the period in which the drug is active the skeletal musculature is very nearly completely paralyzed and, in consequence, effective respiration is suspended. Scoline [anectine] has no anaesthetic effect. Enquires made of subjects following the paralysis indicate that they are aware of what is going on around them, for example, they can hear what is said and that they feel the motions of their limbs. It appears therefore that the subjects remain conscious throughout the paralysis." Campbell, Sanderson & Laverty, *Characteristics of a Conditioned Response in Human Subjects During Extinction Trials Following a Single Traumatic Conditioning Trial*, 68 *J. ABNORMAL & SOCIAL PSYCHOLOGY* 627, 628 (1964).

stops the psychological suggestion phase of the treatment begins. Here the technician makes both negative and positive suggestions, "spoken in a confident, authoritarian manner."²⁵ Negative suggestions focus on the obliteration of unacceptable behavior, while positive suggestions focus upon the patient's involvement with "patient government, taking individual responsibility, and increasing constructive socialization."²⁶ These suggestions continue until the effects of the anectine wear off. It is not surprising that one commentator has characterized anectine therapy as a more efficient form of torture than the "rack and screw."²⁷

Another recent aversion therapy case, *Knecht v. Gillman*,²⁸ arose when two Iowa inmates complained that injections of the vomit-inducing drug apomorphine, given them without valid consent, constituted cruel and unusual punishment.²⁹ The facts established that apomorphine was used in the aversive treatment of inmates with "behavior problems." Behavior that could result in an injection of apomorphine included getting up late in the morning, not playing in a softball game, giving cigarettes to other inmates, talking, and smirking.³⁰ If the staff or other inmates reported such behavior the violator would be taken to a room containing only a toilet, stripped naked, and given an intramuscular injection of apomorphine. After a short period of forced exercise, vomiting would begin and would continue for fifteen minutes to an hour.³¹ Several injections of apomorphine were given one inmate without consent. Although the other prisoner gave a signed consent to use of the drug, he had only an eighth grade education, and testified that he had absolutely no understanding of the consent form he signed.³² Moreover, any consent, however obtained, was considered irrevocable.³³

Conflicting evidence was offered concerning the usefulness of the technique. While a prison staff physician compared the physiological effects of apomorphine to aspirin,³⁴ a second expert described the use of apomorphine as worse than a controlled beating³⁵ and testified that aversive conditioning was a

25. See Reimringer, Morgan & Bramwell, *Succinylcholine as a Modifier of Acting-Out Behavior*, 77 CLINICAL MEDICINE 28, 29 (1970).

26. *Id.*

27. See Note, *supra* note 5, at 665.

28. 488 F.2d 1136 (8th Cir. 1973).

29. *Id.*

30. Brief for Appellants at 4, *Knecht v. Gillman*, 488 F.2d 1136 (8th Cir. 1973). Also included were "swearing" and "lying." 488 F.2d at 1137.

31. 488 F.2d at 1142. "Respiratory reactions may also occur along with sweating, cramping, and fainting." Brief for Appellants at 4. "The patient may become pale and somewhat faint and is always allowed to lie down if he feels it necessary. The feeling and effect of apomorphine might be compared to a short bout with the stomach flu." *Id.*

32. Brief for Appellants at 4.

33. *Id.* During the last three years over 700 injections of apomorphine have been administered at the facility. *Id.*

34. "It is significant to note that Dr. Loeffelholz compared the physiological effects of apomorphine (other than nausea) to aspirin." Brief for Appellee at 4.

35. Apomorphine is worse than a controlled beating because the one administering the drug cannot control it after it is administered. 488 F.2d 1136, 1138 (8th Cir. 1973).

highly questionable technique with a claimed success rate of only twenty to fifty per cent.³⁶

Other authorities, citing the lack of empirical data, support the latter witness' opinion of the efficacy of aversion therapy.³⁷ Additionally, although they were not discussed in *Knecht*, side effects of aversion therapy may include pain, increased aggressiveness, arousal, anxiety, sleeping difficulties and other physiological malfunctions, and development of various unexpected and often pathological behaviors.³⁸

Even though the above examples of contemporary use of aversion therapy seem shocking, a psychologist's recent proposal for future use of such therapy is even more alarming.³⁹ Under his view, aversion therapy could be used to "treat" armed robbery or "almost any criminal behavior"; such a program could make a "bank robber want to vomit every time he saw a bank, and could make an armed robber shudder every time he saw a gun."⁴⁰ Such a proposal, along with the existing use of aversion therapy, reflects a failure on the part of some in the medical and scientific sphere to consider adequately the legal rights affected by use of such techniques. Accordingly, analysis and discussion of these methods of behavior modification, which in the past have occurred primarily in a scientific context,⁴¹ must now consider as well the legal rights of prisoners subjected to such treatment.

PRIOR LAW

Until recent years a judicial policy of nonintervention — the "hands-off doctrine" — precluded review of prisoner complaints.⁴² Recent rejection of this

36. *Id.* "[G]rowing awareness of the dangers of aspiration has caused the practice of the injections of apomorphine to be dropped, and . . . at present apomorphine has no therapeutic use." Brief for Appellants at 11, citing J. DiPALMA, *DRUGS: PHARMACOLOGY IN MEDICINE* (4th ed. 1974). Possible toxic effects of apomorphine include persistent nausea, depression of the central nervous system, muscular weakness, irregular and rapid respiration, tachycardia, a fall in blood pressure, dizziness, fainting, collapse, and death during coma. *Id.* at 11-12, citing *THE EXTRA PHARMACOPOCIA* (N. Blacow ed. 1972).

37. "Although aversion therapy may produce significant, varied, and longlasting changes in behavior, its efficacy has not been settled by carefully controlled studies with substantial numbers of patients." *COMPREHENSIVE TEXTBOOK OF PSYCHIATRY* 1223 (A. Freedman, H. S. Kaplan & H. I. Kaplan eds. 1967).

38. *MIAMI SYMPOSIUM*, *supra* note 19, at 78. See also text accompanying note 23 *supra*.

39. See Singer, *supra* note 18, at 433. See also McConnell, *Criminals Can Be Brainwashed — Now*, 3 *PSYCHOLOGY TODAY* 14-18 (1969).

40. "[S]uch a program could also induce these reactions whenever the convicted thief even thought or talked about guns and banks. The program could include booster treatments after prison whenever needed. Afterwards, the offender should probably do his banking by mail." Singer, *supra* note 18, at 433.

41. London, *The End of Ideology in Behavior Modification*, 27 *AM. PSYCHOLOGIST* 913 (1972).

42. "Court review of prisoner complaints is a recent phenomena, [*sic*] as previously the courts were inclined to consider all matters concerning federal and state prison administration as beyond judicial concern." Callington, *Prison Disciplinary Decisions*, 60 *J. CRIM. L.C. & P.S.* 152, 154 (1969). See Comment, *The Inadequacy of Prisoner's Rights To Provide Sufficient Protection for Those Confined in Penal Institutions*, 48 *N.C.L. REV.* 847, 849 n.8 (1970);

policy,⁴³ however, has led to increasing use of the courts to air inmate grievances, a significant number of which have involved eighth amendment allegations of "cruel and unusual punishment."⁴⁴ Thus, the death penalty,⁴⁵ strip rooms, solitary confinement⁴⁶ and corporal punishment for prisoners⁴⁷ have all been found violative of the eighth amendment. Cases involving behavior therapy practiced on prisoners, however, were virtually nonexistent until recently, probably because such techniques have only lately received acceptance by some as legitimate rehabilitative methods.⁴⁸

In those behavior modification cases that have arisen, the central problem has been the improper characterization of techniques as "treatment" or "rehabilitation."⁴⁹ From a medical standpoint, such characterization may be correct. From a legal standpoint, however, the characterization may be both incorrect and determinative of the final result. Past cases involving assertions of a right against treatment or rehabilitation, the predecessors of recent behavior therapy cases, demonstrate this problem. In *Peek v. Ciccone*⁵⁰ a federal district court rejected contentions that forced injection of an inmate with a tranquilizing drug constituted cruel and unusual punishment.⁵¹ The injection was

Note, *Beyond the Ken of the Courts: A Critique of Judicial Refusal To Review the Complaints of Convicts*, 72 YALE L.J. 506 (1963).

43. See *Johnson v. Avery*, 393 U.S. 483, 486 (1969).

44. "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. CONST. amend. VIII. See, e.g., *United States v. Fitzgerald*, 466 F.2d 377 (D.C. Cir. 1972); *Gates v. Collier*, 349 F. Supp. 881 (N.D. Miss. 1972); *Baker v. Hamilton*, 345 F. Supp. 345, 352-53 (W.D. Ky. 1972); *Jones v. Wittenberg*, 323 F. Supp. 93 (N.D. Ohio 1971); *Holt v. Sarver*, 309 F. Supp. 362 (E.D. Ark.), *aff'd*, 442 F.2d 304 (8th Cir. 1970). See Note, *The Cruel and Unusual Punishment Clause and the Substantive Criminal Law*, 79 HARV. L. REV. 635 (1966), for a thorough treatment of the "cruel and unusual punishment" prohibition.

45. *Furman v. Georgia*, 408 U.S. 238 (1972) (Brennan, Douglas, & Marshall, JJ., concurring).

46. *LaReau v. MacDougall*, 473 F.2d 974 (2d Cir. 1972), *cert. denied*, 94 S. Ct. 49 (1973); *Landman v. Royster*, 333 F. Supp. 621 (E.D. Va. 1971).

47. *Jackson v. Bishop*, 404 F.2d 571 (8th Cir. 1968); *Nelson v. Heyne*, 355 F. Supp. 451 (N.D. Ind. 1972).

48. Some form of behavior modification is now in use in about twenty states. TIME, March 11, 1974, at 74. See also NEWSWEEK, May 20, 1974, at 77. In response to a letter from the author to Louie L. Wainwright, Director of the Florida Division of Corrections, concerning use of behavior modification techniques in Florida, the following reply was received: "At present, the Division of Corrections has no officially designated comprehensive program which uses behavioral modification techniques. Some proposals for behavioral modification programs are being discussed but are not operational at the present time." Letter from G. Ray Worley to Robert T. Cunningham, Jr., May 14, 1974.

49. The lack of distinction between the concept of "punishment" and the terms "treatment," "therapy," and "rehabilitation" exists in both legal and medical literature. See Note, *supra* note 5, at 655.

50. 288 F. Supp. 329 (W.D. Mo. 1968).

51. *Id.* at 336-37. The record indicated that three prison guards held Peek while another administered the injection. The drug injected was thiorazine, a tranquilizer prescribed to "reduce the petitioner's anxiety and hostility." *Id.*

characterized simply as "medication," and such characterization provided a shield from constitutional prohibitions.⁵²

Courts have recently begun to recognize, however, that the mere characterization of an act as treatment does not insulate it from eighth amendment scrutiny.⁵³ An example of this trend is *Nelson v. Heyne*,⁵⁴ where plaintiff inmates successfully argued that injection of a major tranquilizing drug, ostensibly to control "excited behavior," violated their eighth amendment rights. Evidence indicated the drug had potentially serious side effects,⁵⁵ and a federal district court found such action "shocking to the conscience."⁵⁶ Any extension of this decision may be limited, however, since the court was primarily concerned with the method used to administer the drug rather than with the fact of its administration.⁵⁷

RECENT DEVELOPMENT

The recent cases of *Mackey v. Procunier*⁵⁸ and *Knecht v. Gillman*⁵⁹ illustrate the continuing trend toward finding eighth amendment violations in the use of physically intrusive methods of behavior modification. In *Mackey*, where the fright-inducing drug anectine was used in an aversion therapy program,⁶⁰ the United States Court of Appeals for the Ninth Circuit reversed a federal district court's dismissal of the prisoner's complaint and remanded, stating that proof of the inmate's charges could raise serious constitutional questions relating to cruel and unusual punishment.⁶¹ Although the court examined the nature and effect of anectine therapy only peripherally, the extreme character of the technique was clearly a central concern.⁶² The court's conclusion reflected interest, not merely with the mechanics of the technique as in *Nelson*, but with the eighth amendment implications of its use.⁶³ Upon proof of the

52. *Id.* See also *Smith v. Baker*, 326 F. Supp. 787 (W.D. Mo. 1970) (injection of tranquilizer against a prisoner's will and religious beliefs denies no federal right); *Veals v. Ciccone*, 281 F. Supp. 1017 (W.D. Mo. 1968) (administration of drugs to prisoners acceptable if sanctioned by any substantial, recognized medical authority).

53. See *Knecht v. Gillman*, 488 F.2d 1136, 1139 (8th Cir. 1973), citing *Trop v. Dulles*, 356 U.S. 86, 95 (1958).

54. 355 F. Supp. 451, 455 (N.D. Ind. 1972).

55. The drugs are normally used to control psychotic and prepsychotic behavior during a course of treatment and require close supervision of the patient. *Id.* at 455. The names of the specific drugs used were not stated in the opinion.

56. *Id.* The most frequently recognized standard for cruel and unusual punishment is to inquire whether the penalty administered shocks the general conscience of civilized society. See, e.g., *William v. Field*, 416 F.2d 483, 486 (9th Cir. 1969); *Lee v. Tahash*, 352 F.2d 970, 972 (8th Cir. 1965).

57. "[N]o drug may be administered inter-muscularly without first attempting oral medication, unless ordered otherwise by a physician in each case." 355 F. Supp. at 455.

58. 477 F. 2d 877 (9th Cir. 1973).

59. 488 F.2d 1136 (8th Cir. 1973).

60. See text accompanying note 20 *supra*.

61. 477 F.2d at 878.

62. *Id.*

63. *Id.* The *Mackey* court also noted that proof of plaintiff's allegations could raise serious constitutional questions respecting impermissible tinkering with the mental processes.

plaintiff's allegations, and in light of the appellate court's holding, the district court on remand should have little difficulty finding anectine therapy "shocking to the conscience" and thus prohibited by the eighth amendment.

The second decision, *Knecht v. Gillman*, where the vomit-inducing drug apomorphine was used as an aversive stimulus,⁶⁴ confirms the contemporary judicial proclivity to focus on the eighth amendment and points to a secondary factor neglected by past courts⁶⁵ — informed consent to treatment.⁶⁶ Accordingly, based on the unacceptability of apomorphine therapy from an eighth amendment standpoint, and on the issue of consent, the Eighth Circuit Court of Appeals reversed a federal district court's dismissal of the inmate's complaint,⁶⁷ and enjoined use of apomorphine unless pursuant to specific court-established guidelines for securing informed consent.⁶⁸ These guidelines included three conditions:⁶⁹ the prisoner's written consent to the procedure, specifying the nature, purpose, risks, and effects of treatment, and accompanied by the certification of a physician that the inmate is mentally competent to understand his consent; free revocability of consent at any time; and a physician's authorization for each injection. The court declared that unless these consent requirements are met apomorphine therapy constitutes cruel and unusual punishment.⁷⁰

The ultimate result in *Knecht* is both desirable and unprecedented; if subsequent courts follow the ruling, aversion therapy will no longer be an acceptable form of behavior modification when administered without consent. The rationale of the case, however, is anomalous. The court indicated that aversion therapy administered without consent is cruel and unusual punishment. If consent is obtained, however, cruel and unusual punishment is miraculously transformed into a legitimate form of treatment.⁷¹ Despite this

64. See text accompanying note 28 *supra*.

65. See, e.g., *Nelson v. Heyne*, 355 F. Supp. 451 (N.D. Ind. 1972).

66. "The minimum requirement whenever an inmate waives a right against treatment or rehabilitation . . . is fully informed consent." Freund, *Ethical Aspects of Experimentation with Human Subjects*, DAEDALUS, spring 1969, at viii. In *A CLOCKWORK ORANGE* although Alex requested the "Ludivico Technique" (through which persons were conditioned against violence by associating it with drug-induced nausea), his "consent" was not informed, since the mechanism that was to induce conforming behavior and make him "free" was never explained to him in advance. A. BURGESS, *A CLOCKWORK ORANGE* (1972).

67. 488 F.2d at 1136-37. The case was originally assigned to a United States magistrate for an evidentiary hearing. The magistrate recommended that the complaint be dismissed but that, if the drug were to be used in the future, certain precautionary steps be taken in administering the drug. The trial court dismissed the complaint and did not adopt the magistrate's recommendations.

68. *Id.* at 1140-41.

69. *Id.* This need was predicted earlier. "[T]herapeutic efficacy ought not to be the exclusive test of legality. Moreover, legal restrictions will have to be developed with respect to those therapies deemed by the subjects to be unpleasant or aversive Aversive therapies should ordinarily require the informed consent of the patient, although it is recognized that the informed consent doctrine will be difficult to apply with a population of deviants" Wexler, *Therapeutic Justice*, 57 MINN. L. REV. 289, 313-14 (1972).

70. 488 F.2d at 1140.

71. For example, it is doubtful that if the "cat-o-nine tails" were reintroduced as "treatment" its use would be permitted with or without consent.

anomaly, *Knecht*, with the added support of *Mackey*, represents the present state of the law controlling use of this intrusive method of behavior control—prior informed consent is required.

RESOLUTION OF FUTURE ISSUES

Latent issues remain in spite of the firm holding in *Knecht*. First, one could argue that the use of coercive and ineffectual behavior technologies on prisoners should be prohibited whether or not adequate consent is obtained, particularly where the technique falls within the "cruel and unusual punishment" category. Second, the possibility of truly informed consent in the institutional setting is questionable because of the inherently coercive atmosphere, the deprivations stemming from imprisonment, the desire to attain freedom at any cost, and the basic inequality between inmate and administrator.⁷² Neither *Mackey* nor *Knecht* addressed these problems, but another recent case, *Kaimowitz v. Department of Mental Health*,⁷³ struggled with both issues, reaching a conclusion that exceeds the scope of both *Mackey* and *Knecht*.

At issue in *Kaimowitz* was psychosurgery, the irreversible surgical alteration of parts of the brain for modification and control of violent behavior.⁷⁴ The plaintiff alleged that a mental patient was being illegally detained for the purpose of psychosurgery, even though the patient had given written consent.⁷⁵ Applying a two-pronged, integrated test based on a risk-benefit analysis of psychosurgery and an examination of informed consent,⁷⁶ the Michigan trial court held that the detention was unconstitutional and that an involuntarily confined mental patient could not give truly informed consent to psychosurgery.⁷⁷

The *Knecht* court by using the two-pronged test developed in *Kaimowitz*, could have reached a more logical and well-reasoned conclusion. Applying the tests in these factually analogous cases, the primary consideration is that the benefit to the subject be considerably greater than the risk. The benefits of

72. See *Kaimowitz v. Department of Mental Health*, Civ. Action No. 73-19434-AW at 26-29 (Cir. Ct., Wayne County, Mich., July 10, 1973).

73. *Id.* For a discussion of *Kaimowitz*, see Spoonhour, *Psychosurgery and Informed Consent*, 26 U. FLA. L. REV. 432 (1974).

74. See Spoonhour, *supra* note 73, at 1. See also V. MARK & F. ERVIN, *VIOLENCE AND THE BRAIN* 27-29, 69-85 (1970). The operation proposed was an amygdalotomy, a cutting of the fibers of the amygdala located within the limbic system of the brain. Spoonhour, *supra* note 73, at 38 n.84.

75. *Kaimowitz*, a local legal services attorney, brought suit on behalf of the unnamed patient, himself, and individual members of the Medical Committee for Human Rights. See Spoonhour, *supra* note 73, at 19. The patient had been committed in 1955 without trial under the then existing Criminal Sexual Psychopath Law. He had been charged with the murder and subsequent rape of a student nurse. Civ. Action No. 73-19434-AW at 2 (Cir. Ct., Wayne County, Mich., July 10, 1973).

76. See Spoonhour, *supra* note 73, at 23.

77. Civ. Action No. 73-19434-AW at 2, 31 (Cir. Ct., Wayne County, Mich., July 10, 1973). The court found that because the risks of psychosurgery so far outweighed the possible benefits and because it was impossible to obtain competent, knowledgeable, and voluntary consent, the operation should be prohibited. See Spoonhour, *supra* note 73, at 23-24.

psychosurgery were uncertain⁷⁸ while the dangers were significant,⁷⁹ and therefore the *Kaimowitz* court ruled that psychosurgery should not be undertaken. The benefits of apomorphine therapy are equally uncertain⁸⁰ and the risks are also significant.⁸¹ It would have been appropriate, therefore, for the *Knecht* court to rule at the outset that this type of aversion therapy was impermissible. As a second step, the court in *Kaimowitz* turned to informed consent and found that the inherently coercive nature of incarceration, the effects of the phenomenon of institutionalization, and the uncertain nature of the procedure to be undertaken precluded truly voluntary and informed consent.⁸² Each of these clearly relevant factors existed in *Knecht*, but none was adequately considered.

Because recent aversion therapy cases have not applied a two-pronged test similar to that used in *Kaimowitz*, it is not surprising that antithetical conclusions have been reached — in *Kaimowitz* informed consent was held impossible, while in *Knecht* the possibility of voluntary consent was affirmed. Neither position is a panacea. The former denies that a person could voluntarily submit to a procedure that might have undesirable consequences; yet such a choice is not inconceivable considering the alternative — continued confinement.⁸³ Moreover, the extreme conclusion reached in *Kaimowitz* invoking the values of freedom of choice, thought, and action to prevent modification of behavior, is actually a refusal to permit consent in direct contradiction to these very values.⁸⁴ To contend that denial of freedom of choice is necessary to secure freedom of choice is logically incongruous.⁸⁵

78. "There is no permissive showing on this record that the type of psychosurgery we are concerned with would necessarily confer any substantial benefit on research subjects" Civ. Action No. 73-19434-AW at 16 (Cir. Ct., Wayne County, Mich., July 10, 1973).

79. "Psychosurgery flattens emotional responses, leads to lack of abstract reasoning ability, leads to a loss of capacity for new learning and causes general sedation and apathy. It can lead to impairment of memory, and in some instances unexpected responses to psychosurgery are observed. It has been found, for example, that heightened rage reaction can follow surgical intervention on the amygdala, just as placidity can." *Id.* at 17. See also A. NOYES & L. KOLB, MODERN CLINICAL PSYCHIATRY 639, 652-54 (8th ed. 1963). An exhaustive report prepared by the National Institute of Neurological Disease and Stroke concludes that psychosurgery has not been proven safe or effective in treating abnormal aggressive behavior. CLINICAL PSYCHIATRY NEWS, March 1974, at 12.

80. See note 36 *supra* and accompanying text.

81. *Id.* See also note 35 *supra* and accompanying text.

82. Civ. Action No. 73-19434-AW at 26-29 (Cir. Ct., Wayne County, Mich., July 10, 1973).

83. "[T]o deny that a person could voluntarily choose to submit to an experiment which might have undesirable consequences because his doing so might help to obtain release from involuntary confinement smacks of paternalism." Hodson, *Reflections Concerning Violence and the Brain*, 9 CRIM. L. BULL. 684, 686 n.6 (1973). This conclusion has also been reached by one commentator. See Spoonhour, *supra* note 73, at 37.

84. "There is what I would call an 'extreme thesis' . . . that it is in principle impossible to secure . . . informed consent from prisoners, and perhaps mental patients, because of the 'inherently coercive' institutional setting. . . . [T]he very value invoked before against coerced application of such behavior controls — freedom of choice with respect to thought and action — is also invoked against categorical refusal to permit the consensual use of them." Shapiro, *The Uses of Behavior Control Technologies*, 7 ISSUES IN CRIMINOLOGY 55, 69 (1972).

85. Following "treatment," Alex, in *A CLOCKWORK ORANGE*, was displayed to medical and

The position taken by the *Knecht* court affirms the possibility of free choice, yet inherent in this position are the dangers sought to be avoided by the "extreme thesis." Institutional pressure and subtle coercion are real. The desire for freedom and the willingness to undergo extreme discomfort to attain it also exist.⁸⁶ Nevertheless, it is fruitless to circumvent these issues by denying the possibility of free choice. Instead, the fears of those who adopt the extreme thesis reflect the nature of our penal system and current methods of controlling deviant behavior, both of which make free and uncoerced consent extremely difficult to obtain. Arguably, change should begin at the root of the problem — the penal system itself.⁸⁷

CONCLUSION

Until the character of our penal system is drastically altered, the problem of assuring that consent is truly informed and voluntary will remain. Courts confronted with cases involving behavior control techniques will continue to struggle with such anomalies as permitting the use of a "treatment" that, without consent, is cruel and unusual punishment,⁸⁸ and denying the possibility of free choice, a deterministic position contrary to the commonly accepted notion of free will.⁸⁹ Future courts can avoid this struggle by applying the tests used in *Kaimowitz*, but with a shift in emphasis. Rather than depending on the integration of the two tests to reach a result,⁹⁰ courts should take a more direct approach. First, a court should objectively examine the behavior control technique at issue including risks, adverse effects, and degree of intrusiveness, and weigh these factors against the benefit to the inmate. If the known and confirmable benefit to be derived does not significantly outweigh the adverse factors, then the use of the technique should be prohibited on an eighth amendment basis and the issue of informed consent need not be

prison officials: "Dr. Brodsky said to the audience: 'Our subject is, you see, impelled towards the good by, paradoxically, being impelled towards evil. The intention to act violently is accompanied by strong feelings of physical distress. To counter these the subject has to switch to a diametrically opposed attitude. Any questions? 'Choice,' rumbled a rich deep goloss [voice] . . . 'He has no real choice has he?'" A. BURGESS, *supra* note 66. See also H. HART, PUNISHMENT AND RESPONSIBILITY: ESSAYS IN THE PHILOSOPHY OF LAW 182-83 (1968).

86. Results of these institutional phenomena are also evident in the context of human experimentation. Although prisoners are not supposed to receive a reduced sentence for volunteering, in one Iowa prison a "thank-you letter" was routinely sent to the warden by the physician for each volunteer. He said: "It is possible that this letter in the prisoner's file may favorably influence the parole board." Mitford, *Experiments Behind Bars*, ATLANTIC MONTHLY, January 1973, 64, 66.

87. If use of behavior control techniques on violent prison inmates is permitted, "their violence might be subdued at the expense of exposing and reforming atrocious prison conditions that may have been the root cause of their violence and rebelliousness." Wexler, *supra* note 69, at 312.

88. See note 71 *supra* and accompanying text.

89. See J. S. MILL, ON LIBERTY 203 (Harvard Classics ed. 1909).

90. The court in *Kaimowitz* considered the two factors weighed together. See Spoonhour, *supra* note 73, at 23-24.

reached.⁹¹ Had the *Kaimowitz* court followed this procedure, the more traditional issue of informed consent would have been irrelevant and a conclusion denying the inmate's ability to exercise free choice avoided.

Second, if in applying the risk-benefit test the court finds that use of the method at issue is permissible, then it should focus on assuring that consent was voluntary and informed. Accordingly, if the court in *Knecht* had first applied the risk-benefit test and found apomorphine therapy permissible (although the court probably would have reached the opposite conclusion),⁹² then it would have been proper to consider informed consent. When this second step is reached, the court should go beyond the traditional informed consent requirements⁹³ and attempt to develop procedures adaptable to the existing realities of institutional life.⁹⁴ Avoidance of the critical first step, however, leads to such anomalies as the conclusion in *Knecht*.

This proposed two-step approach, while allowing for use of justifiable medical techniques, would permit courts to bar such reprehensible and degrading methods of behavior control as anectine and apomorphine therapy. It would also allow courts to avoid becoming entangled in contemporary movements seeking to control and eliminate deviant behavior at any price. Most importantly, this approach could provide a judicial means of asserting and reaffirming the basic humanity of all men in the face of a burgeoning scientific and technological world order.⁹⁵

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91. The eighth amendment includes nothing less than the "dignity of man" and assures that a state's punishment power "be exercised within the limits of civilized standards. The amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society." *Trop v. Dulles*, 356 U.S. 86, 100-01 (1958).

92. This conclusion would have been logical in view of the risk-benefit ratio of apomorphine. See text accompanying notes 79-82 *supra*. The same conclusion applies to *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973), in view of the risks of anectine.

93. For an overview of informed consent, see Spoonhour, *supra* note 73, at 6-18.

94. Some guidance may be found in the FDA's regulations governing experimentation with human beings. See 21 C.F.R. §130.37 (1972).

95. "In forming an institutional system to answer 'Who controls whom, why, how, and under what conditions?' we will necessarily have to consider the role of the courts and their capacity for review of legislative and other official action. The suggestion made by some that all matters of treatment be left in the unreviewed discretion of correction or mental hygiene officers is absurd. It necessarily implies an abdication of judicial function in an area where it is as needed as it could be." Shapiro, *supra* note 84, at 92.