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Applying the law therapeutically

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Abstract

Therapeutic jurisprudence is the study of the law as a therapeutic agent. Although much of therapeutic jurisprudence focuses on possible changes to the law, one important interdisciplinary dimension of the endeavor involves the therapeutic application of existing law. Examples are provided of therapeutic application of existing law, and this exercise is proposed as a promising path for applied psychology.

Key words: Mental health law, Therapeutic jurisprudence

Recently, a number of academics and practitioners interested in law/psychology interactions have turned their attention to the study of therapeutic jurisprudence. Therapeutic jurisprudence (Bibliography, 1993; Finkelman & Grisso, 1994; Perlin, 1993; Slobogin, 1995; Wexler, 1995; Wexler & Winick, 1991), which focuses on the law's impact on emotional life, is a perspective that recognizes that the law *itself* can be seen to function as a kind of therapist or therapeutic agent.

The law—which consists of legal rules (Bloom & Williams, 1994), legal procedures (Tyler, 1992), and the roles of legal actors (Gould, 1995; Wexler, 1991)—is a social force that sometimes produces therapeutic or antitherapeutic consequences, and therapeutic jurisprudence involves "the use of social science to study the extent to which a legal rule or practice promotes the psychological or physical well-being of the people it affects" (Slobogin, 1995, p. 196).

The therapeutic jurisprudence perspective grew out of mental health law scholarship, and much therapeutic jurisprudence work therefore concentrates on matters such as civil commitment (Tyler, 1992), the insanity defense (Perlin, 1994), the conditional release of insanity acquittees (Bloom & Williams, 1994; Wexler, 1991), incompetency to stand trial (Gould, 1995; Winick, 1995a), the right to refuse treatment (Susman, 1994; Winick, 1994), and the like. Recent applications, however, make it clear that the potential of therapeutic jurisprudence extends far beyond traditional mental health law; therapeutic jurisprudence is actually a mental health perspective on the law in general (Sales & Shuman, 1996; Slobogin, 1995; Wexler, 1993a, 1995), and the perspective has been applied beyond mental health law (Winick, 1995b) to criminal law and procedure (Gould, 1993; Klotz et al., 1992; Wexler, 1993b; Yates, 1994), family and juvenile law (Simon, 1995), health law (Winick, 1993), disability law (Daly-Rooney, 1994), workers' compensation law (Wilkinson, 1994), personal injury and tort law (Shuman, 1994), and even to contract law (Harrison, 1994).

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Broad Reach of Therapeutic Jurisprudence

A recent example of the broad reach of therapeutic jurisprudence is Kay Kavanagh's analysis of the "Don't Ask, Don't Tell" regulation regarding gays in the military (Kavanagh, 1995). Under the policy, recruits will not be asked about their sexual orientation, but a statement by a person that he or she is gay creates a rebuttable presumption that the servicemember intends to engage in homosexual acts, and such a statement can trigger separation proceedings.

Kavanagh advocates a different policy, one that might be called "Don't Ask, Tell if You Want to." She is concerned that denying a servicemember the ability voluntarily to disclose matters of sexual orientation perpetuates homophobia and, more to the point of the present article, operates to create superficial social interactions and relations with others. In essence, Kavanagh claims, the Government, by the policy, creates social isolation or anomie for gay servicemembers.

The reason for the isolation is that "this forced concealment entails concealment of other details that surround the secret—sexual identity—details that could lead to revelation of the secret" (Kavanagh, 1995, p. 143). To conceal the prohibited fact of homosexual orientation, Kavanagh notes that gay servicemembers will be chilled from revealing basic life events and facts. The policy will have a chilling effect on

making truly unremarkable disclosures, such as *with whom* one goes grocery shopping, shares a checking account, takes a vacation; *to whom* one apologizes for failing to do the dishes (or for failing to do them properly), for squeezing the toothpaste from the top of the tube rather than from the bottom, for leaving various household supplies scattered throughout the house rather than returning them to their appointed places; *from whom* one receives a phone call, a message, or flowers on one's birthday; and *with or without whom* one goes home for the holidays. (p. 154)

Kavanagh's proposed law reform, permitting but not requiring disclosure of sexual orientation, resembles the treatment of another possible secret—disability—by the Americans with Disabilities Act (ADA). Under the ADA, employers are to focus on job requirements and applicant abilities, not on disability, and are barred from inquiring into a prospective employee's disability. If offered a position, the employee can work without disclosing the disability or, if he or she needs a "reasonable accommodation" in the workplace to perform (e.g., the modification of equipment or of a work schedule), the employee can reveal the disability to the employer and request an adjustment or accommodation. Even then, under the ADA's confidentiality provision, the disability would need to be disclosed only to the employer, the employee's supervisor, and perhaps to safety personnel (Daly-Rooney, 1994).

Nonetheless, like Kavanagh's analysis of the psychological benefits that might flow to many from voluntary disclosure of sexual orientation, Daly-Rooney's therapeutic jurisprudence analysis of the confidentiality provision of the ADA suggests that an employee with a disability may often profit from waiving confidentiality and from voluntarily disclosing the disability to relevant co-workers. Secrecy, again, may lead to isolation and superficial social relations. Daly-Rooney gives an example of a nondisclosing employee with mild retardation who lives in a group home. If, to protect her secret, she declines a co-worker's offer of a ride home on a rainy day, she will likely appear strange or unfriendly.

Moreover, drawing on the psychological insight that providing people with a voice in a process leads them better to accept the outcome as fair (see Tyler, 1992; Wexler, 1991), Daly-Rooney posits that an employee with a disability might be best integrated into the workplace if the employee waives the confidentiality provision of the Act and divulges something about the disability to relevant co-workers. The co-workers, who after all probably know more than the new employee (and perhaps even more than the employer) about the requirements of the given job, could then help ascertain the essential functions of the job and could help design reasonable accommodations for the employee with a disability. This interaction might decrease rumors about the new employee and might decrease resentment by the co-workers, who now have had a voice in the process and have some sort of stake in the success of the designed accommodation.

Note that a key difference between the Kavanagh and the Daly-Rooney pieces is that Kavanagh advocates a change in the law *itself* (see Wexler, 1993c), whereas Daly-Rooney, writing about a law that *already* embraces "Don't Ask, Tell if You Want to," advocates "law reform" through what might be called the therapeutic application of existing law (Wexler, 1995)—in this case, the voluntary waiver of the ADA's confidentiality provision, and the disclosure of the disability to relevant co-workers.

The Therapeutic Application of Existing Law

The remainder of the present article will focus on the therapeutic application of existing law as a promising path for applied psychology. Perhaps the enterprise will seem more comfortable and familiar to psychologists and other mental health professionals if we focus, for the moment, on some concrete examples that fall solidly within the "core" of traditional mental health law—topics with which mental health professionals are likely more versed than they are with the ADA or with the regulation relating to gays in the military. Let us, then, turn to two more traditional topics: the *Tarasoff* (*Tarasoff v. Regents of University of California,* 1976) issue and the issue of a patient's right to refuse mental health treatment.

Tarasoff

The California *Tarasoff* case established a therapist's duty to warn or otherwise protect the potential victim of a patient's predicted violence. The decision was severely criticized by mental health professionals as constituting an antitherapeutic rule of law. Alan Stone (1976), for example, claimed the *Tarasoff* duty "will imperil the therapeutic alliance and destroy the patient's expectation of confidentiality, thereby thwarting effective treatment and ultimately reducing public safety" (p. 368).

In an article written more than 15 years ago (Wexler, 1979), using an approach that clearly foreshadowed the therapeutic jurisprudence perspective, I challenged Stone's view. Noting that *Tarasoff*-type threats are overwhelmingly made against potential victims who are family members or their equivalents, I wrote:

> Principally, my purpose is to assert that the enmity of Stone and others toward *Tarasoff* is bottomed largely on their adherence to an "individual pathology" model of violent behavior which, the literature suggests, is theoretically and therapeutically unwarranted. More important, what *is* apparently warranted, according to those who have seriously studied the type of interpersonal violence that is therapeutically preventable, is an approach that focuses on troubled *relationships*. Ideally, such an approach should involve both the patient and the potential

> victim and should therefore often take the form of "couple" or "family" therapy. Finally, it is my thesis that, if taken seriously and followed widely, the *Tarasoff* decision, despite its many obvious drawbacks, has the clear-cut potential of prompting and prodding practicing therapists to terminate their continued clinging to an outmoded "individual pathology" model of violence, and to accept the paradigm of "interactional" or "couple" violence already endorsed by the professional literature. (p. 4)

I foresaw *Tarasoff,* which is triggered when a patient threatens violence against a specified other, possibly playing out along the following lines:

> 1. After *Tarasoff,* a typical therapist, despite intrapsychic therapeutic inclinations, is likely to focus far more than before on the potential victim and on the extent to which harm to the victim can be averted.
> 2. For fear of *Tarasoff* liability in the event he or she takes no action and a threatened victim is later seriously injured or killed by a patient, the therapist will presumably be induced, even in fairly borderline cases, to seek some acceptable means of alerting the potential victim of a patient's serious or possibly serious threat.
> 3. Ideally, of course, the therapist would wish to act in a manner acceptable to the patient—in a manner, that is, not disruptive of their ongoing therapeutic relationship.
> 4. Fortunately, because the typical potential victim is a family member who presumably knows the patient is in therapy and who also typically knows, at least to some extent, of the patient's hostility toward the victim, a skillful therapist ought often to be able to secure the patient's consent to notify the potential victim.
> 5. If the patient's consent to the divulgence is obtained, *Tarasoff* can of course be satisfied without sacrificing the patient's trust and without the therapist running the risk of violating ethical or legal obligations to keep a patient's confidences.
> 6. When the victim is contacted, the therapist may first learn, as some therapists are apparently now first learning post-*Tarasoff,* of the victim's contributory or provocative role in the patient's potential violence.
> 7. In addition or alternatively, the therapist may learn from the victim certain significant facts about the patient's behavior.
> 8. If the therapist ascertains a meaningful presence of victim precipitation, he may seek—and obtain—the patient's consent to have additional contact with the potential victim, and the potential victim, particularly if he or she is a member of the patient's family, may be very willing to cooperate.
> 9. Even if victim contribution is not apparent, if the potential victim provides the therapist with important information about the patient, that information may be used to enhance therapy. Often, too, the patient may have an explanation that will lead the therapist to seek additional dialogue with the potential victim, and which may then provide evidence of victim contribution.
> 10. In any event, if the above chain of events begins to occur with any regularity, the typical therapist treating a potentially violent patient will find him- or herself, because of the pressure of *Tarasoff,* transformed from a practitioner of "intrapsychic" psychotherapy to a practitioner of a presumably preferable "interactionist" model of treating interpersonal violence. (pp. 26–28)

What I clearly realize now (even more so than when I wrote over 15 years ago) is that if I was right in thinking, contrary to Stone, that *Tarasoff* might be a therapeutically advantageous development, it would be so only if clinicians skillfully discharged the *Tarasoff* obligation in an appropriate manner. The therapeutic application of *Tarasoff* is by no means self-executing; it is entirely in the hands of mental health professionals.

Tarasoff will surely not have therapeutic yields if mental health professionals apply it in what Perlin (1992, p. 57) calls a "passive-aggressive style of behavior." Some commentators have noted that, to escape *Tarasoff*-type legal liability, "some clinicians have become reluctant to probe into areas of their patient's lives dealing with violence, while others have altered their record-keeping (either by obscuring information that might suggest violence or by 'padding' a record with information so as to support a decision not to warn)" (Perlin, 1992, p. 58).

But the *Tarasoff* case *can* in many instances be applied in a clinically sound manner. For example, Wulsin, Bursztajn, and Gutheil (1983) present a clinical report of a Mr. A, a 20-year-old single man admitted to the Massachusetts Mental Health Center's day hospital:

> When Mr. A's hallucinations took the form of commands to kill his mother, we as part of the treatment staff became concerned about a possible duty to third parties. . . . In keeping with the principle of maintaining the therapeutic alliance whenever possible, especially in legal matters, we elected to involve the patient maximally in the process. To this end, we proposed a draft of a letter that would inform Mr. A's mother of the danger to her and that would also serve to document our response to her son's threats. In keeping with an alliance-seeking approach, Mr. A's therapist went over the letter and the attendant rationale with him. The letter stated that the patient "feared he might harm [his mother]." Mr. A agreed with the content of the letter and insisted on talking to his mother before we mailed the letter, fearing the letter would cause his mother to wish never to speak to

him again. His mother first responded to the letter by saying that he should be "locked up with the key thrown away." During the ensuing conversation, however, she stated openly, "I love you"; Mr. A responded, "I love you, too," and both began to cry.

Thereafter, Mr. A abided by a temporary agreement with the therapist not to see his mother outside the treatment setting; but he continued telephoning her and the family every day. Although his mother volunteered information to us by telephone, she otherwise refused to participate actively in her son's treatment. No civil commitment or further intervention was necessary for Mr. A. (p. 602)

The original *Tarasoff* debate—between Stone and myself—was on the rule of law level: is the *Tarasoff* rule antitherapeutic, as the conventional wisdom would have it, or might it actually, in the aggregate, be therapeutic? The present discussion, however, takes *Tarasoff* as a given; regardless of whether it is overall a good or bad thing so far as therapy and therapists are concerned (after all, its principal purpose is to protect public safety, not to enhance therapy), the present discussion looks at the discretionary roles of mental health professionals and asks how mental health professionals may best—most therapeutically—be able to apply, implement, and enforce the existing *Tarasoff* obligation. Surely the clinically sensitive Wulsin, Bursztajn, and Gutheil approach seems preferable to the "passive-aggressive" approach taken by some other therapists.[1]

The Right to Refuse Mental Health Treatment

The right of a hospitalized psychiatric patient to refuse mental health treatment is another rule of law or legal doctrine that has engendered much controversy. Mental health professionals often worry that according patients such a right will lead to the refusal of needed treatment, resulting in patients rotting with their rights on (Winick, 1994, p. 99 note 1). Similarly, mental health professionals often claim that, if forced to accept mental health treatment, patients will improve and retrospectively thank their doctors for having provided the needed treatment (Winick, 1994, p. 99 note 2). Winick (1994, p. 100), on the other hand, has argued that the recognition of a right to refuse treatment might empower patients in ways that have therapeutic value.

Once again, however, it may be enlightening to change the analytical exercise: regardless of whether a right to refuse treatment is in general considered therapeutically beneficial or detrimental, if a jurisdiction for whatever reason *recognizes* a firm right to refuse treatment, how might that rule be applied or implemented by mental health professionals to maximize its therapeutic potential? If we search for the "most therapeutic application" of a legal right to refuse treatment, what might we come up with?

A therapist can, of course, simply instruct a patient to take certain medication, and if the patient declines, the therapist can allow the patient to rot, rights and all. Winick (1994), however, has suggested that mental health professionals use the right to refuse treatment to "reshape the therapist–patient relationship into a tool that is both more humane and more effective" (p. 132).

> The right to refuse treatment can increase the likelihood that therapists will respect the dignity and autonomy of their patients, and recognize their essential role in the therapeutic process. This reshaping of the therapist's role can increase the potential for a true therapeutic alliance in which therapists treat their patients as persons. The result can be more patient trust, confidence, and participation in decision-making in ways that can cause patients to internalize treatment goals. A therapeutic relationship restructured in this fashion can enhance the patient's intrinsic motivation and the likelihood that the goal-setting effect, commitment, and the reinforcing effects of cognitive dissonance will occur.
>
> A real therapist–patient (or counselor–offender) dialogue concerning treatment planning and decision-making can only bolster the patient's faith in the therapist and in his or her dedication to the patient's best interests. This faith and the expectations it generates may be essential to producing the Hawthorne effect or other interactive mechanisms that can increase the likelihood of therapeutic success. Without trust, the therapeutic opportunities provided by the therapist–patient relationship are drastically reduced. (Winick, 1994, p. 112)

It is a heavy dose of therapist–patient dialogue and of according patients considerable "voice" (Tyler, 1992) in the decision-making process that characterizes nurses' behavior with patients in Susman's (1994) study of the resolution of right to refuse medication conflicts in three Maryland psychiatric hospitals. Susman, a criminologist and consultant to St. Elizabeth's Hospital in the District of Columbia, found, ironically, that patients considered the informal procedures used by nurses to be fairer than the dispute resolution process provided by the legislatively mandated, supposedly rights-protective Clinical Review Panel (CRP). The CRP is established by statute to review a patient's treatment refusal and to recommend a course of action. It is headed by a psychiatrist (other than the patient's own physician) and is convened by a member of the patient's treatment team. The CRP reviews the patient's medical record and has the patient's doctor appear. The patient may be invited to appear,

[1] These examples should provide a powerful reminder to lawyers, law reformers, policymakers, and legal theorists: reforming rules of law—whether through legislation, administrative regulation, or judicial doctrine—will only accomplish therapeutic ends if the new rules will be applied or enforced therapeutically. Of course, this also raises the issue of the amount of discretion that should be accorded legal actors (Wexler, 1993c), as well as the issue of the extent to which the legal environment may enhance or constrain the exercise of discretion.

principally to explain why he or she is refusing medication, perhaps to determine if the patient is a "symptomatic refuser" (Susman, 1994, p. 125). The CRP's decision binds the treatment team and the patient (Susman, 1994, pp. 127–128, note 3).

As noted, Susman found patients much more supportive of the informal procedure used by the nurses than they were of the procedures used by the psychiatrist-headed CRP. He postulates this fairness may have consequences beyond those examined in his study:

> It may in fact aid treatment and recovery; fairness may enhance the authority of doctors, nurses, and other staff members, as well as increase the legitimacy of psychiatric hospitals and the psychiatric profession. Furthermore, fair processes in the hospital context may increase compliance with medical decisions among patients and may improve the prospects of patients for reintegrating into the community upon release from the hospital. . . . (Susman, 1994, pp. 122–123)

Susman's patient interviews underscored the importance of the quantity and the quality of staff–patient interaction in patient assessments of fairness (p. 117). He suggests the CRP proceedings could be improved by affording patient's a greater voice and in the CRP explaining its decision to the affected patient:

> The relatively large proportion of patients who expressed a feeling that the doctors' legal procedures were unfair may, in addition to reacting to mute processes, also be responding to the professionalism of the hospital staff. This perverse result may have occurred because the proceedings are conducted by medically trained personnel who are no doubt careful of the medical details necessary to produce a therapeutically sound outcome to their deliberations. But scrupulous attention to clinical detail may inadvertently thwart the need of patients to tell in their own terms their side of the story.
>
> The clinical review panel may often limit the opportunities for expression by patients because of time constraints and medical proprieties. They must be sensitive to the ordinary work schedules of the other members participating in the dispute resolution process and consequently may take an overly narrow approach to the medical issues at hand. These may prompt them to limit patients' opportunities to speak. The clinical review panel members are also knowledgeable about psychiatric matters and may restrict patients' opportunities to present information or tell their story when such would be medically irrelevant or inappropriate. In these situations, the panel would be acting in a medically professional and appropriate manner but unwittingly interfering with patients' sense of what a satisfying and fair procedure should be.
>
> Acceptance of unfavorable decisions rendered by the clinical review panel could probably be enhanced if the doctors provided patients with a rationale for the decision, especially one that indicated to them that their side of the dispute was considered when the decision was made. Further research could clarify these matters. (Susman, 1994, pp. 117–118)

The crucial point is that Susman is not recommending legislative repeal or reform of the CRP or of Maryland's qualified right to refuse treatment. He states simply that "what can be confirmed from the present body of procedural justice theory in psychiatric hospitals is that there is a developing body of knowledge, from the perspective of therapeutic jurisprudence, that could lend itself to the creation of principles of justice that should be utilized in administrative dispute resolution as well as by courts in deciding cases" (Susman, 1994, p. 123).

When Susman speaks of therapeutic jurisprudence, he is referring to that dimension of therapeutic jurisprudence emphasized in the present article: the therapeutic application of existing law. The CRP law can be applied more therapeutically than it now is:

> In the research reported here, it was found that patients could judge procedures fair even when the results were unfavorable from their standpoint. And even when the outcome of the dispute was favorable, they did not invariably also believe that the procedure was fair. But overall, more patients found the dispute resolution norms of nurses to be fairer than the doctors' process of dispute resolution, mandated and endorsed as an effective way to protect patients' autonomy and self-respect. This points to some inherent difficulty in balancing the state's interests and patients' rights. Psychiatrists using the clinical review process to override patients' objections to treatment would benefit from a short training course on procedural justice theory and other dimensions of therapeutic jurisprudence. Utilizing the theory and perspective of therapeutic jurisprudence in the conduct of clinical review panels could greatly increase patients' sense of fairness of the deliberations. (Susman, 1994, p. 121)

Relative Familiarity of the Legal Terrain

If psychologists increase their emphasis on applying the law therapeutically, as I hope they will, it is probably only natural that initial interest will concentrate on "core" mental health law areas, such as the just-discussed areas of *Tarasoff* and the right to refuse treatment. Such areas are likely to be familiar to mental health professionals, and to seem particularly relevant to them, because those legal areas impact not only on their clients, but also impact directly on the mental health professionals themselves: when a *Tarasoff* obligation is triggered, a mental health professional is required, under threat of legal liability, to take some action to protect an

endangered third party; in the right to refuse treatment context, a patient's treatment refusal may frustrate a mental health professional's suggested course of action.

It is important to recognize, however, that many laws that do not directly touch mental health professionals—and that are not within the "core" of mental health law—may impact dramatically on the lives of clients. To the extent that mental health professionals deal regularly with clients affected by such laws, and to the extent that clients might be able to take some action to be able to cope more therapeutically with such laws, those laws too ought to be carefully examined from the perspective of the therapeutic application of existing law.[2]

Take as an example the very "Don't Ask, Don't Tell" military regulation discussed earlier. Kavanagh (1995) has argued forcibly that the regulation ought to be changed. But, in the meantime, what about gay and lesbian servicemembers for whom a military career is important *today?* Can mental health professionals and lawyers help improve the day-to-day lives of those servicemembers?

Remember, Kavanagh's chief concern is that the existing policy antitherapeutically promotes superficiality in social relations because it "naturally" chills the disclosure of "the day to day life events that people who work together often share with each other" (p. 154). Kavanagh notes, however, that "the new policy does not explicitly prohibit the disclosures [she identifies as] so natural and crucial. Nevertheless, the natural result of the requirement that gay men, lesbians and bisexuals not reveal their sexual orientation is to preclude disclosure of related information in an effort to conceal the prohibited fact" (p. 154, note 54).

But if we are operating under the existing policy, mental health and legal professionals might wish to advise their clients that the "natural result of the requirement" is not the *legally obligatory* result. Apparently, so long as a gay servicemember can learn to comfortably refrain from stating explicitly his or her gay identity and can learn to deflect or comfortably refuse to answer an inquiry about sexual orientation—an inquiry made more likely by disclosure of daily life events—the day-to-day life event disclosures should be legally permissible.

Working together and with gay clients, legal and mental health practitioners might suggest various "scripts" that those gay clients interested in maximum disclosure could rehearse and role play before embarking on real-world disclosures. The development of legally acceptable and therapeutically beneficial disclosures (Pennebaker, 1990) within the constraints of the existing law ought to be an exciting cooperative therapeutic jurisprudence venture for mental health and legal academics and professionals.

Conclusion

Psychologists and other mental health professionals can play a major role in the development of therapeutic jurisprudence. They can help therapeutic jurisprudence—and ultimately themselves and their clients—in a number of ways. For example, they can carefully attend to how the law is actually operating (on themselves, their clients, or both), and can suggest reforms in the law that would serve justice and yet better promote mental health.

A recent Massachusetts statewide conference was just such a therapeutic jurisprudence exercise in law reform "from the bottom up" (Finkelman & Grisso, 1994), as opposed to the more typical law reform effort, which is spawned by armchair academics. At the conference, psychologists working in the Massachusetts mental health system were asked to use the therapeutic jurisprudence lens to examine the laws they work with and to come up with suggestions for reform (e.g., Haycock, 1994; Packer, 1994).

Often, of course, the proposed reforms will involve suggested changes in the law itself. But, as the present article demonstrates, creative thought can many times lead to suggestions for reform through a different *application* of the existing law.

The process of reform by means of a more therapeutic application of existing law is far easier, both in terms of researching the effectiveness of the reform and in terms of effectuating the desired policy change, than would be the case with legislative reform. Moreover, the process is often likely to be far less controversial than legislative reform.

The relative ease of the enterprise, as compared with legislative revision, is well illustrated by Daly-Rooney's (1994) suggestion that a waiver of confidentiality under the Americans with Disabilities Act may often facilitate the integration into the work setting of an employee with a disability. As I have noted elsewhere (Wexler, 1995), Daly-Rooney's

> thesis could be tested without going to the legislature to change the law. If certain employers were persuaded to implement the law according to Daly-Rooney's proposal on an experimental basis, the results could be compared with other comparable companies that merely continued doing business as usual. Ultimate law reform might be accomplished by therapeutic jurisprudence scholars persuading certain administrators of the ADA, who in this case are employers, to urge employees with disabilities to consider the waiver of the confidentiality provision. The

[2] The development of *legal* interest in therapeutic jurisprudence has followed a similar path, initially covering topics within "core" mental health law and now embracing a mental health approach to law in general. The ripple effect in legal scholarship was anticipated:

> It seems only natural (at least to those of us who specialize in mental health law) that initial forays into therapeutic jurisprudence take place within the core content areas of mental health law. Obviously, however, therapeutic jurisprudence will also have application in forensic psychiatry generally, in health law, in a variety of allied legal fields (criminal law, juvenile law, family law), and probably across the entire legal spectrum. (Wexler & Winick, 1991, p. x)

> matter is subject to individual tailoring because, for some employees, confidentiality will outweigh the interest in co-worker involvement, but for others it will not. Moreover, this change is easier to accomplish than changing the confidentiality law itself. Changing the confidentiality law itself would be tremendously controversial and would raise all sorts of justice concerns. The administrative solution, on the other hand, leads to a convergence between justice and therapeutic concerns: Confidentiality is preserved for those who deem it important to them, and yet divulgence and co-worker involvement are made available to those who wish to follow that route for hoped-for therapeutic gains. Furthermore, . . . the suggested change might help an untold number of employees with disabilities and might, indeed, be ultimately transformative of the workplace environment. (p. 236)

Contemplating how the existing law might be applied in a more therapeutic manner is likely something that mental health professionals already occasionally do, at least with respect to laws that affect themselves as well as their clients. The present process of applying laws therapeutically is, however, probably performed in a highly erratic and unsystematic manner.

Psychologists and other mental health professionals should now begin to engage in the exercise expressly, routinely, and broadly (e.g., even in areas where the law impacts adversely on clients but does not directly affect psychologists). The possibility of creative and therapeutic application of existing law should regularly be considered as an alternative to formal law reform and should be a matter explicitly discussed, researched, and written about.

The therapeutic application of existing law is an endeavor that can bring together practitioners and academics. Moreover, as the development of "scripts" for gay military personnel illustrates, the endeavor is ideally a cooperative, interdisciplinary one that can unite professionals and scholars from the mental health field with their counterparts in the field of law (Sales & Shuman, 1996).

Finally, to the extent that, even without legislative action, existing law may be applied more therapeutically by altering the actions of mental health professionals or their clients, this dimension of therapeutic jurisprudence can be imported into practice *today*. The therapeutic application of existing law, then, raises the exciting possibility of an academic pursuit being able immediately to involve legal and mental health practitioners and clients/consumers in practical, cooperative, action-oriented scholarship, research, and reform.

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