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THE MYTH OF MENTAL DISORDER: TRANSSUBSTANTIVE BEHAVIOR AND TAXOMETRIC PSYCHIATRY

*Steven K. Erickson**

INTRODUCTION

In 1961, psychiatrist Thomas Szasz wrote what would become one of the most controversial books in psychiatry that directly questioned whether traditional concepts of mental illnesses existed. *The Myth of Mental Illness*[1] claimed that while psychiatry openly held mental illnesses as diseases under the rubric of the medical model,[2] they really were mere arbitrary descriptions of behaviors that the profession itself had proclaimed to be illnesses. Szasz argued that since there were no identified lesions in the brain that could be attributed to mental illnesses, there was no evidence of disease.[3] Without disease, mental disorders were not illnesses as traditionally understood in medicine.[4] Consequently, mental illnesses were theoretical formulations describing behaviors that were *declared* by the profession as abnormal rather than

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1. THOMAS S. SZASZ, THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT (1961).

2. Generally, the medical model holds these tenets: (1) sufficient deviation from the normal results in disease; (2) disease is due to known or unknown natural causes; (3) elimination of these causes will result in a cue or improvement for the patient. *See*, George L. Engel, *The Need for a New Medical Model: A Challenge for Biomedicine*, 196 SCI. 129 (1977) (describing the traditional medical model and calling for a new model that would become known as the biopsychosocial model).

3. SZASZ, *supra* note 1, at 72. Szasz argues that the absence of mental illnesses in anatomy, biochemistry, and physiology textbooks suggests that they are not of biological origin.

4. *Id.*

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based upon any empirically discovered finding.[5] As such, mental illnesses, according to Szasz, were inherently, culturally, and socially bound and open to manipulation by the dominant social class.[6] Thus, the professional formulations of mental illnesses were inherently a form of social control whereby society classified as mentally ill those with socially undesirable behavior. As Szasz famously put it, "[i]f you talk to God, society calls it praying; if God talks to you, society calls you schizophrenic."[7]

Of course, Szasz's claim was made at a time when there was much social change occurring in America and elsewhere. The 1960s was a time when many questioned long held political and social values, especially values that reinforced authority figures.[8] What was once considered immutable social tradition was placed on its head. Many argued that social norms really were methods of social control that benefited the upper-class.[9] Simultaneously, the monolithic state institutions that once held (often for life) hundreds of thousands of mentally ill citizens were a dying epoch as the deinstitutionalization movement led to community treatment as the predominate paradigm of psychiatric care.[10] Coinciding with the civil rights movement, the migration of the mentally ill from state institutions to the community followed the emergent belief that individual autonomy was a fundamental right, and hence a Constitutional one, and should be zealously guarded among society's disenfranchised: the poor, ethnic minorities, and the mentally ill.[11]

5. For a great review of Szasz's arguments, see Eric J. Dammann, *"The Myth of Mental Illness:" Continuing Controversies and Their Implications for Mental Health Professionals*, 17 CLINICAL PSYCHOL. REV. 733, 734-37 (1997).

6. SZASZ, *supra* note 1, at 72.

7. THOMAS S. SZASZ, THE SECOND SIN 113 (1973).

8. *See* DAVID GARLAND, THE CULTURE OF CONTROL 75-94 (2001) (describing the shifting social and political climate in the United Kingdom and United States on penal philosophy during the late 20th century).

9. For an interesting empirical analysis of social class, protest, and the 1960s see Darren E. Sherkat & T. Jean Blocker, *The Political Development of Sixties' Activists: Identifying the Influence of Class, Gender, and Socialization on Protest Participation*, 72 SOC. FORCES 821 (1994).

10. *See* E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 8-11, 91-140 (1997).

11. Probably the most noted case that established personal autonomy (related to reproductive rights) as a "penumbra" of the Constitution is the Griswold case. Griswold v. Connecticut, 381 U.S. 479, 483 (1965). *See also* O'Connor v. Donaldson, 422 U.S. 563 (1975) (holding that the state cannot confine a nondangerous mentally ill person against their will); Rogers M. Smith, *The Constitution and Autonomy*, 60 TEX. L. REV. 175, 175-84 (1982) (reviewing the numerous Supreme Court decisions of the 1960s and 1970s that recognized a wide variety of Constitutional rights based on autonomy); KANT PATEL & MARK E. RUSHEFESKY, HEALTH CARE POLICY IN AN AGE OF NEW

Putting aside Szasz's pronouncements, the reality of deinstitutionalization actually entailed the serendipitous discovery of effective medications in the 1950s that made community living possible for the mentally ill rather than any recognition of individual autonomy by society. Treatment, not acknowledged autonomy, was largely responsible for the transformation of crazy behavior into mere odd conduct that could be tolerated by society at large.[12] And like so many social movements, other forces were in play that likely did more to hasten the exodus of the mentally ill from the state institutions. The 1960s saw the creation of Medicaid which specifically excluded payments to psychiatric patients in state institutions.[13] Along with the enactment of the Community Mental Health Centers Act[14] in 1963, which provided federal funding for community mental health treatment, the financial carrot was set by the government to end costly institutional care for the mentally ill. As one noted psychiatrist put it, the stage was set for an unholy alliance between the political left who favored civil liberties and the political right who desired fiscal austerity that was to become the end of large-scale intuitional care irrespective of other concerns.[15]

As the years progressed, it became obvious that the Pollyannaish hope that all of the institutionalized mentally ill could reintegrate back into society once the shackles of political oppression and psychiatric paternalism were thrown off was overly optimistic.[16] As many

TECHNOLOGIES 41 (2002) (discussing the influence of women's, civil, and ethnic minorities' rights movements during the 1960s on subsequent health law policy).

12. *See* William Gronfein, *Psychotropic Drugs and the Origins of Deinstitutionalization*, 32 SOC. PROBS. 437 (1985). Although Gronfein concludes that psychotropic drugs did not have a direct influence on discharge rates from state hospitals from the 1940s to 1980s, he also concludes that medications made deinstitutionalization politically and publicly viable; but see ANDREW SCULL, SOCIAL ORDER/MENTAL DISORDER (1989) for an argument that medications did have a direct effect on deinstitutionalization.

13. 42 U.S.C. § 1396d(a) (2004). The exclusion applies to inpatient psychiatric care for people aged 21-65. *See* Susan M. Jennen, *The IMD Exclusion: A Discriminatory Denial of Medicaid Funding for Non-Elderly Adults in Institutions for Mental Disorders*, 17 WILLIAM MITCHELL L. REV. 339, 340-49 (1991) (explaining the history of the inpatient psychiatric care exclusion despite a lack of a regulatory definition of "Institutions of Mental Diseases" (IMD) contained in 42 U.S.C.A. §1396 until 1988). The exclusion has survived Constitutional challenge. *See* Kantrowitz v. Weinberger, 430 F.2d 1034 (D.C. Cir. 1976) (holding that the IMD exclusion does not violate federal constitutional rights of due process or equal protection).

14. 42 U.S.C. § 2688 (1963), *superseded by* Pub. L. No. 94-63 § 66 (1975), and *codified by* 42 U.S.C. § 246.

15. Interview with J. Richard Ciccone, Director of the Psychiatry and Law Program, University of Rochester, in Rochester, N.Y. (Mar. 30, 2006).

16. *See* Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 377 (1982) ("[D]einstitutionalization harbored an idealized

advocates and mental health professionals proclaimed, there was the stark reality of the "obviously mentally ill" person who fervently believed his food was poisoned, his doctors guilty of implanting electronic probes in his genitals, and himself to be Jesus Christ despite the best intentions of community treatment.[17] The growing number of the "obviously mentally ill" persons roaming the streets, often homeless, preoccupied with intruding thoughts of persecution and bizarre notions of grandiosity (that even the most sympathetic libertarian found unfathomable) mitigated against any purest Szaszian position.[18] Nevertheless, Szasz was onto something. If mental illnesses do indeed lack physical markers that can be observed in the laboratory (as we will see some do and some do not), then they are not discovered in an empirical sense but proclaimed (or invented as Szasz held) by established authorities.[19] Then the questions naturally flow: Who decides what is a mental illness? How is mental illness defined? How is one person determined to be mentally ill while others are not? What Szasz's thesis acknowledged was that "mental illness" had evolved over time and has been influenced as much by social and political factors as by science.[20] As such, psychiatry's decree that mental illnesses were illnesses on par with cancer or heart disease was faulty at best and a fraud at worst.

Despite these concerns, the law has long recognized the existence and importance of mental illness.[21] Blackstone held that prosecution of

notion of 'community' and tended to exaggerate the extent to which labeling a person mentally ill produces and perpetuates pathology. Consequently, they were overly optimistic in their assessment of the ability of released patients to survive, unaided, in society."); Alexander Gralnick, *Build a Better State Hospital: Deinstitutionalization Has Failed*, 36 HOSP. & COMMUNITY PSYCHIATRY 738 (1985).

17. *See* Darold A. Treffert, *The Obviously Ill Patient in Need of Treatment: A Fourth Standard for Civil Commitment*, 36 HOSP. & COMMUNITY PSYCHIATRY 259 (1985).

18. *See generally* Rhoden, *supra* note 16, at 386-93; *but see* Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63 (1991) (arguing that homelessness among persons with mental illness was more related to housing and economic factors than untreated illness).

19. *See* SZASZ, *supra* note 1, at 12; Drammann, *supra* note 5, at 734-37. Drammann explains that Szasz's contention was that while science proved and discovered phenomena, psychiatry invented and declared behaviors as illnesses.

20. *See* Thomas S. Szasz, *The Classification of "Mental Illness": A Situational Analysis of Psychiatric Operations*, 33 PSYCHIATRIC Q. 77 (1959) (arguing that social and cultural systems invariably impact the development of psychiatric nosology).

21. *See* Derek Bolton, *Problems in the Definition of 'Mental Disorder'*, 51 THE PHIL. Q. 182, 182-83 (2001) (discussing Locke's conception of mental illness); Nigel Walker, *The Insanity Defense Before 1800*, 477 ANNALS AM. ACAD. POL. & SOC. SCI. 25, 25-26 (1985) (stating that the insanity defense dates back at least to the pre-Norman conquest of 1066 days); *see generally* ISSAC RAY, A TREATISE ON THE MEDICAL JURISPRUDENCE OF INSANITY (1871).

a "madman" was morally reprehensible since punishment was only just when the recipient of the punishment knew why he was being punished.[22] Modern history shows that the law has rarely doubted the existence of mental illness, of madmen, but has struggled with its definition and its disposition.[23] Thus, law and science both have a historical appreciation of madness, yet each understanding is rooted within its own epistemological history. Law is a discipline of the humanities, based upon beliefs, arguments, and deduction. Truth, in law, is derived not so much by production of observable phenomenon, but by persuasion and argument. On the other hand, modern psychiatry posits itself as a natural science, based in empiricism, observation, and experimentation. Science pursues truth by investing in verifiable theories that through consensus become established laws that explain material phenomenon. Yet this transformation is fairly recent, and old habits die hard. Psychiatry's growth from mainly treating institutionalized citizens to its psychoanalytical heyday of the 1950s

22. William Blackstone, *Of the Persons Capable of Committing Crimes*, in 4 COMMENTARIES 2 (1769) (discussing the historical view of *furious furore solum punitur* ("madness alone punishes a madman") and that madness as a deficiency of the will should stay the criminal prosecution at any time during a criminal proceeding, including the carrying out of execution). Most scholars look to the *Rex* case for establishing the wild beast test. Rex v. Arnold, 16 How. St. Tr. 695, 764-65 (1724) ("If a man be deprived of his reason, and consequently, his intention, he cannot be guilty . . . [he] does not know what he is doing, no more than an infant, than a brute, or a wild beast."). Yet some have argued that the wild beast test was never validly articulated. *See* Ira Mickenberg, *A Pleasant Surprise: The Guilty But Mentally Ill Verdict Has Both Succeeded In Its Own Right and Successfully Preserved the Traditional Role of the Insanity Defense*, 55 U. CIN. L. REV. 943, 996 n.3 (1987) ("It has been persuasively argued, however, that the phrase 'wild beast,' as employed in Arnold and other eighteenth century British cases is merely illustrative, and was never meant to establish a specific test for the determination of legal insanity."). Indeed, the Supreme Court recently affirmed this position in *Clark v. Arizona*, 126 S. Ct. 2709 (2006), by upholding Arizona's insanity statute which jettisoned the cognition prong in favor of a sole moral prong. *Cf.* William J. Stuntz, *The Political Constitution of Criminal Justice*, 119 HARV. L. REV. 780 (2006) (noting that within the past thirty years the courts have mostly ruled in criminal constitutional matters relating to procedural and not substantive issues). Notwithstanding, mental sanity has been an enduring feature of American criminal law. *See* People v. Tortorici, 92 N.Y.2d 757, 773-74 (N.Y. 1999) (Smith, J., dissenting), *cert. denied*, 528 U.S. 834 (1999) (discussing the *sua sponte* responsibility of the courts in mental competency matters as a fundamental component of American criminal law: "[a]kin to every criminal defendant's unilateral rights to decide whether to proceed without the benefit of counsel, whether to enter a plea of guilty to the charge(s) or whether to offer his or her testimony at trial, the fundamental right of the accused to be mentally competent at trial is a right which is individually owned and unilaterally exercised by every criminal defendant, independent of any action by trial counsel."); Thus, mental sanity can be seen as important in a procedural sense as in the competency issues and substantive as seen in the various *mens rea* components and the insanity defense.

23. *See* Lee S. Weinberg & Richard E. Vatz, *The Insanity Plea: Szaszian Ethics and Epistemology*, 3 THEORETICAL MED. & BIOETHICS 1573, 424-30 (1982) (discussing the history of the insanity defense); Bolton, *supra* note 21; Walker, *supra* note 21.

marked an impressive expansion of its influence in popular culture, law, and morality. Whereas in its early years, psychiatry was rooted in a simplistic biological model of mental disease, Sigmund Freud brought modern psychiatry out to the masses. Neuroses, ego, unconscious motivations – these ideas of Freudian psychoanalytical drives were not merely a new model of behavior. Rather, these revolutionary concepts provided psychiatry the power to opine with ostensible scientific authority about *all* behaviors. The origins, motivations, implications of any behavior were now within the purview of psychiatric expertise and judgment. This led to an exponential growth in the number and type of behaviors that were declared by the profession as indicative of mental pathology, and hence, open to psychiatric interpretation.

The consequence of this effect is that our current popular and scholarly thinking is replete with notions that all behaviors can be explained through science. Discussions about behavior and science inevitably lead to claims that behavior is caused by something other than free will and choice.[24] Since modern psychiatry has become the authority on all behaviors – even those beyond the manifestation of disease – the pull is to classify all *illegal* or *antisocial* behavior as indicative of some type of biological abnormality irrespective of the scientific weight supporting such claims. Thus, an insidious mindset has taken hold in our academic and popular thinking whereby all undesirable conduct is deemed *caused* by a sick mind somehow. Scholars eagerly point to studies suggesting associations between *some* biological abnormality and undesirable behavior as proof of an underlying, albeit mysterious, biological agent that is implicitly responsible for the behavior.[25]

While the last twenty-five years have witnessed a vast deflation of Freud's theory among practicing psychiatrists, those influential years remain ingrained within the profession and popular culture. The principle among these is the idea that psychiatry can and should have something to say about all behavior and its explanations are superior to others. In the United States and elsewhere, these explanations have provided comfort to those who view the notion of free will too close to the idea of morality since *mens rea* evolved from ecclesiastic law, and hence, under the influence of organized religion. Appearing scientifically objective, modern law has increasingly adopted concepts eagerly provided by the field of psychiatry, including the numerous

24. *See* DEREK PEREBOOM, LIVING WITHOUT FREE WILL (2001).

25. *See* Alison Abbott, *Into the Mind of a Killer*, 410 NATURE 296, 298 (2001).

sexual paraphilias and the antisocial personality to help achieve politically desirable ends. As law has incorporated these psychiatric concepts into its jurisprudence, the creditability of both law and psychiatry has faltered. One example is the pedophile, a diagnosable mental illness under current psychiatric taximetrics despite little evidence of a biological origin or effective treatment.[26] Under the numerous sexually violent predator (SVP) laws, pedophiles are civilly committed for psychiatric treatment after serving their criminal sentences since it is presumed, with the aid of its validation as a psychiatric illness, that adult sexual preference for children is a mental illness.[27] On the opposite extreme is the unquestionably psychotic Andrea Yates who was convicted of murder and faced a possible death sentence until public outrage and a convenient, albeit serious error, forced a second trial that ended in her acquittal by reason of insanity.[28] These occurrences inevitably lead to popular and scholarly skepticism of both disciplines – law and psychiatry – that hint that something is askew and lead many to a nihilistic realism about both.

This article argues that three factors are primarily responsible for this current state of affairs: (1) the proliferation of mental disorders in the nosology[29] of psychiatry; (2) the departure from traditional notions of illness in psychiatry towards a vague definition of "mental disorders"; (3) the inclusion of "personality disorders" and other phenomenon as diagnosable mental disorders that, at first blush, appear arbitrarily construed and sit in place of what is (or once was) considered poor moral character. When psychiatry turned away from the term "mental illness" to the expansive "mental disorder," it opened a Pandora's Box whereby almost any behavior can be deemed an affliction of the mind – and used by law to meet its own political ends. If law is a vehicle in which political ideas are executed (and I think it is), psychiatry has unwittingly given law the means to achieve politically efficient ends for dealing with many socially and politically difficult problems. Whether

26. Interestingly, what science mostly knows about pedophilia and the sexual disorders has nothing to do with etiology (i.e., cause) but mostly with assessing the risk that a person will commit the aberrant sexual behavior again. Thus, psychiatric research in this area has mostly focused on what the law considers important instead of what medical science presumably does. *See* AMERICAN PSYCHIATRIC ASSOCIATION, DANGEROUS SEX OFFENDERS: A TASK REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION (1999).

27. *See id.*

28. Yates v. Texas, 171 S.W.3d 215 (Tex. Ct. App. 2005) (holding that a new trial was required due to the prosecution's psychiatric expert's perjury); *Woman Not Guilty in Retrial in the Deaths of Her 5 Children*, N.Y. TIMES, July 27, 2006, at A20.

29. Nosology is the branch of medicine that deals with classification of disease.

through the de facto indefinite incapacitation of pedophiles[30] or as an aggravating factor in criminal sentencing of "antisocial" people,[31] the law openly rebukes the shortcomings of psychiatric diagnoses while readily utilizing its dubious classification schemes to achieve its own ends.[32]

Part I discuses the theoretical frameworks of law and science. I discuss how law is a discipline of the humanities, and thus builds upon a framework of logic, deduction, and belief. Free will, a fundamental component of American criminal law, endures not due to some empirical finding, but out of belief, historical influence of ecclesiastic law,[33] and its necessity in forming culpability, which lies at the heart of criminal liability.[34] Or to put it differently, the legal system requires a belief in free will because public opinion demands it.[35] Such demands are

30. *See* Kansas v. Hendricks, 521 U.S. 346, 372 (1997) (Kennedy, J., concurring) (discussing the constitutionality of sexual predator civil commitment laws: "[n]otwithstanding its civil attributes, the practical effect of the Kansas law may be to impose confinement for life.").

31. Antisocial and psychopathic behavior has been held relevant in criminal trials and sentencing phases despite its propensity as character evidence. *See, e.g.*, U.S. v. Barnette, 211 F.3d 803 (4th Cir. 2003). The erosion on the prohibition of character evidence is ongoing, *see*, Judson F. Falknor & David T. Steffen, *Evidence of Character: From the "Crucible of the Community" to the "Couch of the Psychiatrist"*, 102 U. PA. L. REV. 980 (1954); *cf.* Aviva Orenstein, *Deviance, Due Process, and the False Promise of Federal Rule of Evidence 403*, 90 CORNELL L. REV. 1487 (2005).

32. *Compare* Kansas v. Hendricks, 521 U.S. 346, 360 (1997) ("The mental health professionals who evaluated Hendricks diagnosed him as suffering from pedophilia, a condition the psychiatric profession itself classifies as a serious mental disorder."), *with* Addington v. Texas, 441 U.S. 418, 429 (1979) ("Given the lack of certainty and the fallibility of psychiatric diagnosis, there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous."). More to the point, perhaps, is that the deep skepticism the courts eschew towards psychiatry evaporates nearly instantly when psychiatric ideas serve a desirable end. *But see* Clark v. Arizona, 126 S. Ct. 2709, 2734 (2006) (quoting Powell v. Texas, 392 U.S. 514, 537 (1968) ("It is simply not yet the time to write into the Constitution formulas cast in terms whose meaning, let alone relevance, is not yet clear . . . to doctors.")); *Hendricks*, 521 U.S. at 359 ("[T]he term 'mental illness' is devoid of any talismanic significance . . . . [T]he Court itself has used a variety of expressions to describe the mental condition of those properly subject to civil confinement."). Although the court in *Hendricks* held that it was not bound by psychiatric classifications in upholding the Kansas statute and its mental abnormality provision, the very idea that pedophilia is a mental abnormality and not merely a moral failing is borne by psychiatry and its long preoccupation with sexual behavior. One wonders whether the court would have easily came to the same holding had the psychiatric nosology foregone classifying any sexual behavior as a mental disorder –or even expressly forbade it.

33. In terms of criminal law, the greatest effect of ecclesiastic law was its concern for culpability and intent over strict liability. *See* NORMAN J. FINKEL, INSANITY ON TRIAL 5-7 (1988).

34. Culpability seems to most contemporary scholars and the lay public as an absolute necessity in criminal law for the most serious crimes; yet, it is arguably the most difficult element of a crime to discern in terms of guilt or innocence. From sex offenders to diminished capacity, the strongest opinions among the lay and learned are often associated with areas that have the least scientific weight to support them.

35. One way to empirically examine the free will paradigm is by looking at deterrence.

political and not purely deduced from observation and represent cultural and historical influences. While free will is not solely a social construction as it can be inferred from observation of behavior across cultures, it cannot be proven in a pure scientific sense. Modern psychiatry, on the other hand, posits itself as a natural science which draws upon empiricism, observation, and experimentation. Indeed, the exponential growth in understanding mental disorders such as schizophrenia, bipolar disorder, and major depression have occurred primarily through biological psychiatry which is most faithful to the tenets of the scientific method. In these major mental disorders, biological psychiatry has demonstrated that a disease process has eroded the normal operations of the brain. In other areas that psychiatry claims as mental disorder, such as antisocial personalities, what biological evidence exists is weak and scientists are hard-pressed to show how these deficits are indicative of a disease process.

These differing approaches between law and psychiatry lie in tension, as can be most clearly seen in examining the insanity defense. The law is interested in whether the defendant knew right from wrong at the moment of the alleged wrongdoing.[36] Modern psychiatry views psychotic behaviors as outward manifestations of a *disease process* that impairs rational thinking. The law is concerned with individual choice and free will, a concept that rests mostly upon belief in its existence. Psychiatry is concerned with rationality via the processing of sensory data within the brain to achieve an accurate representation of the

Presumably, if deterrence works then free will among rational agents can be assumed. The success of anti-drunk driving campaigns suggests deterrence works. *See* Jonathan P. Shepherd, *Criminal Deterrence as a Public Health Strategy*, 358 THE LANCET 1717 (2001). Likewise some argue that there is a negative relationship between crime rates and incarceration rates. *See* Steven D. Levitt, *The Effect of Prison Population Size on Crime Rates: Evidence from Prison Overcrowding Litigation*, 111 Q. J. ECON. 319 (1996). There is also evidence that perceived deterrence in drug courts is associated with better outcomes. *See* Douglas B. Marlowe et al., *Perceived Deterrence and Outcomes in Drug Courts*, 23 BEHAV. SCI. & L. 183 (2005). However, others have maintained that evidence for deterrent effects is weak. Jane Goodman-Delahunty, *Dealing with the Guilty Offender*, *in* PSYCHOLOGY AND LAW: AN EMPIRICAL PERSPECTIVE 445, 450-53 (Neil Brewer & Kipling D. Williams eds., 2005).

36. Indeed, knowing right from wrong appears to be the foremost question in the insanity test and other questions, including questions of cognitive ability to understand and appreciate one's own actions and behaviors, have been held as superfluous. *See*, Clark v. Arizona, 126 S. Ct. 2709, 2722-23 (2006) ("Though Clark is correct that the application of the moral incapacity test (telling right from wrong) does not necessarily require evaluation of a defendant's cognitive capacity to appreciate the nature and quality of the acts charged against him, his argument fails to recognize that cognitive incapacity is itself enough to demonstrate moral incapacity. Cognitive incapacity, in other words, is a sufficient condition for establishing a defense of insanity, albeit not a necessary one.").

external world. By examining the normal and mentally disordered brain, psychiatry claims it can identify the locations and processes whereby the brain goes awry. But these claims are made entirely through comparisons of people considered normal to those who are determined disordered under the guise that normality is a verifiable fact. Again, in the presence of signs of disease this claim is not that farfetched; but in its absence, the claim is troublesome. Law can claim things because it does not posit itself as a science; when psychiatry does so, it is a different affair altogether. It is not that the two disciplines speak the same truth but in different languages – they speak entirely different truths that underscore their epistemological differences.

Part II discusses the evolution of psychiatry using the evolution of psychiatric diagnoses as a backdrop. Essential to this understanding is the fact that psychiatry as a formal discipline is a fairly new phenomenon. Within about 200 years, psychiatry has grown from a cadre of physicians caring for institutionalized persons, to one of the leading authorities on behavior, motivations, and how the brain interfaces with the metaphysical mind. Much of this growth occurred during the Freudian school's zenith during the 1940s and 1950s. During this period two critical events happened that forever changed mental health in the United States. First and foremost, Freudian psychoanalysis brought professional psychiatry out of the institutions and into the communities. Professional mental health was no longer reserved for those afflicted by serious mental illnesses; rather, it was culturally permissive for anyone to seek out the wisdom of the profession. This simple but sudden transition made psychiatry a private and profitable industry with the lure set for mental health to become part and parcel of everyday living. Problems that occurred as a matter of routine living – disputes between spouses, questions about child-rearing, sexual drives – were now psychiatric matters. The other critical event was the discovery of effective drugs in treating many mental illnesses. This had the effect of lending psychiatry the credibility that it could successfully treat what it designated as mental illnesses and began the era of biological psychiatry.

Central to understanding psychiatry's growth and influence in modern culture is an appreciation regarding the evolution of the diagnostic manuals the professional has used in deciding what qualifies as a mental illness. The American Psychiatric Association's Diagnostic

and Statistical Manual of Mental Disorders (DSM)[37] is the cornerstone of psychiatric taxonomy. This psychiatric "bible" determines what behaviors will receive precious funding from federal agencies such as the National Institute of Mental Health as well as who can be committed against their will. The current Fourth Edition relies heavily upon the biopsychosocial model of mental illness that emphasizes that mental illnesses have biological, psychological, and social aspects.[38] This, however, is a departure from the 1952 first edition which was heavily laden with Freudian notions of mental illness. I will examine the development of the DSM, most notably, the explosion of diagnosable mental disorders from about 100 in the First Edition to almost 300 in the current version.[39] I will argue that while the present edition is more biologically focused than its processors, it has lost sight of mental illnesses as *diseases* – and as such the classification scheme itself is in question. Thus, the present edition includes diagnoses such as "caffeine intoxication"[40] and "substance induced anxiety disorder"[41] – behaviors reminiscent of what Szasz said were the "tragedies of life"[42] but hardly illnesses as commonly understood.

Part III discusses why the term "mental disorder" is a myth: it incorporates behaviors that are not illnesses as traditionally construed and lack substantive biological manifestations of a disease process. Under the present classification scheme, pedophilia is a mental illness alongside with schizophrenia and manic-depression. In looking at law and psychiatry, mental disorders as currently construed hardly seem faithful to Blackstone's conception of the "wild beast"[43] that clearly pointed to a person so bereft of sanity that the law should take notice and treat differently. The modern use of dubious notions of mental disorders

37. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS – TEXT REVISION (4th ed. 2000) [hereinafter DSM-IV-TR].

38. *See* Engel, *supra* note 2.

39. *See* Rick Mayes & Allan V. Horwtiz, *DSM-III and the Revolution in Classification of Mental Illness*, 41 J. HIST. BEHAV. SCI. 249, 251 (2005) (reporting the First edition of the DSM with 106 diagnoses at 130 pages in length with the Fourth Edition with 297 diagnoses at 886 pages); Lloyd H. Rogler, *Making Sense of the Historical Changes in the Diagnostic and Statistical Manual of Mental Disorders: Five Propositions*, 38 J.HEALTH & SOC. BEHAV. 9, 13-16 (1997) (stating that the growth of the DSM is partially due to the inclusion of more disorders and the splitting into subcategories of previously unitary disorders).

40. DSM-IV-TR, *supra* note 37, at 232-34. The DSM-IV states the obvious: Ingestion of caffeine can lead to, *inter alia*, restlessness, nervousness, excitement, insomnia, flushed face, muscle twitching, and increased heart rate.

41. *Id.* at 483.

42. SZASZ, *supra* note 1, at 1574.

43. *See* Blackstone, *supra* 22 and accompanying text.

encourages psychiatric defenses in criminal law such as the various "syndrome" defenses[44] that push the envelope of creditability and engender abuse by political forces seeking their own objectives. I will present several examples of how vague "mental disorders" have been used by law to pursue apparent political ends. My thesis is that modern psychiatry has transformed many forms of amoral character into classified mental disorders; from actions of the imperfect, free agent into behaviors of the afflicted. This effect is far more insidious than most people realize. It is not just what the official psychiatric manual classifies as a mental disorder that matters. Rather, it is the underlying belief that all behavior can be explained under a psychiatric lens and that this explanation *is superior* to others. This outlook has pervasive and perverse consequences about how individuals and institutions approach social problems, including illegal behavior. As many decry how the law deals with mental illness, the law represents the most illustrative demonstration of how law and science operating in a political world differ in theoretical frameworks and how those approaches play out in our imperfect world.

Part IV presents some ideas for reform and discusses why these reforms are unlikely to happen.

I. LAW, SCIENCE, AND EPISTEMOLOGY

Conflict between law and science entails disagreements not just about conclusions of important questions such as whether people with severe mental illnesses may be incapable of appreciating right and wrong. Rather, they are steeped in traditions and practices fundamentally at odds with one another. Law frequently asks normative questions, science describes what is observed in nature. The goals of law may include perfecting justice, for science it is perfecting our understanding of material phenomenon. Law is not science, and science should not usurp law's claim to normative questions. The goals of each discipline are inconsistent even when they appear identical because of their different approaches to understanding the problem to begin with.

Law, despite the various schools of thought that may argue otherwise, is inherently a humanity and not a science.[45] As such, law's

44. *See* David McCord, *Syndromes, Profiles and Other Mental Exotica: A New Approach to the Admissibility of Nontraditional Psychological Evidence in Criminal Cases*, 66 OR. L. REV. 19 (1987).

45. *See* Gino C. Speranza, *The Medico-Legal Conflict Over Mental Responsibility*, 13 GREEN BAG 123, 125 (1901) ("Law is one of the humanities.").

penchant lies with logic, deduction, persuasion, and belief. Despite the sociological jurisprudence of Pound, law continues to operate upon a system of *prior* beliefs that holds certain things true.[46] The free moral agent, who acts without duress and chooses action *A* over *B* is *arguendo* the cornerstone of law. From contracts to criminal law, the free moral agent is necessary for law's function and legitimacy. In this sense, when a person commits a criminal act like homicide, substantive criminal law places considerable weight on the actor's *mens rea* in affixing liability and punishment. To put it differently, the fundamental question in law is not whether to treat the defendant differently because of a mental illness, but rather whether the individual had the requisite *mens rea* at a point in time (during the *actus rea*).[47] For law, a guilty mind is necessary insofar as it provides legitimacy for differential punishment.[48] In Western legal traditions, punishment requires that the agent possess free will.[49] This is

46. *See* Thomas A. Green, *Freedom and Criminal Responsibility in the Age of Pound: An Essay on Criminal Justice*, 93 MICH. L. REV. 1915 (1995) (arguing that law never embraced the empiricism of the social sciences as argued for by Pound and subsequent Realists).

47. Notwithstanding strict liability, of course. In terms of the insanity defense, while there have been a series of different "tests" the enduring one is the *M'Naughten* Case, R. v. McNaughten, 8 Eng. Rep. 718 (Eng. Rep. 1843), which excuses criminal behavior if under a defect of reason or disease of the mind a person at the time of the offense did not know the nature or quality of the act or did not know that the act was wrong; *cf.* N.Y. PENAL LAW § 40.15 (Consol. 2006) that sets forth New York's insanity test as: At the time of such conduct, "he lacked criminal responsibility by reason of mental disease or defect. Such lack of criminal responsibility means that at the time of such conduct, as a result of mental disease or defect, he lacked substantial capacity to know or appreciate either: 1. The nature and consequences of such conduct; or 2. That such conduct was wrong." Note that both the *M'Naughten* and New York test construe mental illness as a disease.

48. *See, e.g.*, N.Y. PENAL LAW § 125.00-125.60 (2006) (designating the types and degrees of homicide in New York). Notably, strict liability offenses rarely, if ever, are designated as high felony crimes.

49. *See* Stephen J. Morse, *Inevitable Mens Rea*, 27 HARVARD J.L. & PUB. POL'Y 51, 62 (2003) (arguing that *mens rea* is required because only it can give meaning to purposeful movements). *But compare* Deborah W. Denno, *Crime and Consciousness: Science and Involuntary Acts*, 87 MINN. L. REV. 269 (2002) (arguing that neuroscience findings question whether traditional notions of consciousness, and thus, agency are correct), *and* Peter Arenella, *Convicting the Morally Blameless: Reassessing the Relationship Between Legal and Moral Accountability*, 39 UCLA L. REV. 1511, 1611 (1992) ("The specter of determinism has had a tremendous impact on moral responsibility theorists who work within the liberal paradigm. Operating under determinism's constant threat to undermine liberal accounts of moral desert, these theorists have been obsessed with the problem of defining what type of control over action is morally significant."), *with* Peter Westen, *Getting the Fly Out of the Bottle: The False Problem with Free Will and Determinism*, 8 BUFF. CRIM. L. REV. 599, 652 (2005) ("The supposed problem of free will and determinism is as false as the question, 'What is the expanding universe expanding into?' It is a problem that we have created for ourselves by posing questions in terms that are inconsistent with the presuppositions that we must necessarily invoke in addressing them."), *and* Joseph S. Alper, *Genes, Free Will, and Criminal Responsibility*, 46 SOC. SCI. & MED. 1599 (1998) (arguing that genetic explanations of behavior do not negate traditional views of free will due to the complexity of genetic/environmental interactions that produce behavior).

so, not based upon any observable or verifiable fact, but because of the belief that it is so.

Contrast this with modern psychiatry,[50] which most believe has departed from its cult of personality a la Freud.[51] Modern psychiatry claims to be a natural science based upon empiricism, observation, and experimentation. Thus, it is concerned with measurable events that occur in the world. Given this premise, mental illnesses are understood as behaviors resulting from a disease process in the brain.[52] Schizophrenia, a mental illness defined by hallucinations, delusions, and impaired thinking is now considered by most behavioral scientists to be a product of structural and functional impairments of the brain.[53] For modern psychiatry then, actions of a mentally ill person are manifestations of this disease process – and part of that process often involves impairment of cognition.[54] What matters here is that cognition,

50. Modern psychiatry has become synonymous with biological psychiatry. *See* Deborah W. Denno, *Criminal Acts in a Post-Freudian World*, 2005 U. ILL. L. REV. 601, 652 (2005) ("[T]he DSM-IV and leading psychiatric journals now predominantly stress the biological component of mental illness.").

51. *See* Carl I. Cohen, *The Biomedicalization of Psychiatry: A Critical Overview*, 29 COMMUNITY MENTAL HEALTH J. 29, 29-30 (1993) (noting that biological psychiatry is now the dominant version of psychiatry); Samuel H. Barondes, *The Biological Approach to Psychiatry: History and Prospects*, 10 J. NEUROSCIENCE 1707, 1707-08 (1990) (discussing the rise of biological psychiatry). Freudian psychiatry was not based on empiricism, rather it was entirely theoretical. *See* E. FULLER TORREY, FREUDIAN FRAUD: THE MALIGNANT EFFECT OF FREUD'S THEORY ON AMERICAN THOUGHT AND CULTURE 240-54 (1992) (arguing that Freudian psychiatry was both illegitimate and harmful to patients); *cf.* Alan A. Baumeister & Mike F. Hawkins, *Continuity and Discontinuity in the Historical Development of Modern Psychopharmacology*, 14 J. HIST. NEUROSCIENCES 199 (2005) (arguing the Freudian psychiatry did not constitute a paradigm and that the rise of biological psychiatry was the culmination of a linear growth of knowledge, and hence, there has been no true paradigm "shift").

52. Again, I presume that modern psychiatry is synonymous with biological psychiatry, a view that some may disagree with. In terms of the full panoply of "mental disorders," there are surely some diagnoses that are not products of diseases of the brain such as Adjustment Disorder or Bereavement, *see* DSM-IV-TR, *supra* note 37, at 679-740, but may represent some transient biological change or process reflective of (usually) an event that a person observes and contemplates about. As I will discuss in Section IV, however, I do not construe these as mental illnesses.

53. *See* Christos Pantelis et al., *Structural Brain Imaging for Multiple Pathological Processes at Different Stages of Brain Development*, 31 SCHIZOPHRENIA BULL. 672 (2005) (reviewing the wealth of studies reporting numerous and significant abnormalities in brains of those afflicted with schizophrenia including progressive changes that occur during the earliest stages of the disease, often before the initiation of pharmacotherapy). See also STEVEN R. HIRSCH & DANIEL WEINBERGER, SCHIZOPHRENIA (Blackwell Science Ltd. 2003) (1995) for a general discussion on the various brain abnormalities associated with schizophrenia.

54. *See* TONMOY SHARMA & PHILIP HARVEY, COGNITION IN SCHIZOPHRENIA: IMPAIRMENTS, IMPORTANCE AND TREATMENT STRATEGIES (2000); MICHAEL F. GREEN, SCHIZOPHRENIA FROM A NEUROCOGNITIVE PERSPECTIVE: PROBING THE IMPENETRABLE DARKNESS (1998); KEITH S.

from a psychiatric perspective, is not an idea but instead a measurable enterprise of the brain. Generally speaking, impaired cognition in the brain of a person with schizophrenia or other severe mental illness equates with deficiencies in attention, information processing, memory, planning, and intelligence.[55] These elements of cognition are *measurable*[56] and have salience to legal questions insofar as they explain irrational behavior. Moreover, from this perspective, the concern in terms of "*mens rea*" is not understood in terms of whether a defendant possessed knowledge of right or wrong at a specific time. Instead, a brain injured by mental illness is damaged because of a progression of disease that results in impairment, and subsequent behavior is a visible product of the pathogenic process inside the brain. This, of course, does not mean that all behavior from a person afflicted with a mental illness, such as schizophrenia, is excusable or deficient. What it does illustrate, however, is that psychiatry views the behavior in these individuals as heavily influenced by a disease that is often degenerative and lifelong.[57] As such, even during periods of lucidity, behaviors of a person afflicted with an illness such as schizophrenia are affected and bear the markings of the disease[58] lending understanding to important social and legal questions.[59] While law wants to know whether a person with a mental

DOBSON & PHILIP C. KENDALL, PSYCHOPATHOLOGY AND COGNITION (1993); HIRSCH & WEINBERGER, *supra* note 53.

55. *See* GREEN, *supra* note 54, at 41-57; SHARMA & HARVEY, *supra* note 54, at 3-126.

56. Green's book provides an excellent explanation in non-technical language how cognition is measured. GREEN, *supra* note 54.

57. *See* James D. Hegarty et al., *One Hundred Years of Schizophrenia: A Meta-Analysis of the Outcome Literature*, 151 AM. J. PSYCHIATRY 1409 (1994) (reporting less than half of those with schizophrenia have overall improvements in premorbid functioning); George Bartzokis, *Schizophrenia: Breakdown in the Well-regulated Lifelong Process of Brain Development and Maturation*, 27 NEUROPSYCHOPHARMACOLOGY 672 (2002) (reporting on the life-long reduction of grey matter in the brains of schizophrenia patients); Robert K. McClure et al., *Neurodevelopmental and Neurodegenerative Hypotheses of Schizophrenia*, 16 CURRENT OPINION IN PSYCHIATRY S15 (2003) (discussing the re-emergence of the neurodegenerative hypothesis of schizophrenia).

58. *See* Brian Kirkpatrick et al., *The NIH-MATRICS Consensus Statement on Negative Symptoms*, 32 SCHIZOPHRENIA BULL. 214 (2006) [hereinafter *Consensus Statement*]; Tonmoy Sharma & Lena Antonova, *Cognitive Function in Schizophrenia, Deficits, Functional Consequences, and Future Treatment*, 26 PSYCHIATRIC CLINICS N. AM. 25 (2003) (reviewing studies that strongly suggest an enduring cognitive dysfunction in schizophrenia and cognition as a strong predictor of functional, long-term outcome).

59. *See generally* Singleton v. Norris, 319 F.3d 1018 (8th Cir. 2003), *cert. denied*, 115 S. Ct. 419 (U.S. 1994) (holding that it is constitutionally permissible to forcibly medicate a mentally ill convict to be competent for execution); *but see* Riggins v. Nevada, 504 U.S. 127, 137-38 (1992) (holding that a mentally ill defendant should be allowed to forego forcible medication to allow the jury to "assess Riggins" demeanor fairly) *and* Sell v. U.S., 539 U.S. 166 (2003) (holding that the state may forcibly medicate mentally ill defendants only under certain limited circumstances). The issue of cognition, mental illness and constitutionality has been, in my opinion, grossly

illness had moral capacity during a crime,[60] science cannot answer that question in the purest sense since morality is not a scientific question. Nor does psychiatry conceive of behaviors occurring during a single point in time in isolation of other factors as particularly meaningful. Thus, whether a defendant like Andrea Yates had called the police after she killed her children and admitted that she had done something wrong[61] matters a lot to legal conceptions of insanity, but little to science. From a scientific perspective, Yates had a demonstrable history of psychosis, which is an illness that severely undermines perception and judgment that is best understood by examining behaviors in totem. From a legal perspective, one could argue that Yates was indeed sane;[62] from a scientific one, she was clearly crazy.

A. Competency as an Exemplar

One way to understand the premise of mental disease as I have outlined is by examining competency. The law holds that only competent persons may make contracts, make health care decisions, or stand trial in criminal proceedings.[63] Psychiatric and psychological scholarship is replete with empirical studies, reviews, and commentaries on the issue of competency[64] while the law, generally, makes short shrift of it.[65] This can be explained partly because the law views agents in an

misconstrued in a one sided, erroneous argument that antipsychotic medications are "mind altering drugs" when the overwhelming scientific evidence is to the contrary. Nonetheless, such arguments point to the importance of cognition and mental illness in the law. *See generally* Thomas G. Gutheil & Paul S. Appelbaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medications*, 12 HOFSTRA L. REV. 77 (1983) *and* Steven K. Erickson et al., *Legal Fallacies of Antipsychotic Drugs* (Dec. 5, 2006) (unpublished manuscript, on file with the Yale Univ. Sch. Med. Psychiatry Working Paper Series), *available at* http://ssrn.com/abstract=949229.

60. *See* Clark v. Arizona, 126 S. Ct. 2709, 2722-23 (2006) (discussing moral capacity in the insanity defense).

61. *See* Jim Yardley, *Texas Jury Convicts Mother Who Drowned Her Children*, N. Y. TIMES, Mar. 13, 2002, at A7 (discussing the impact of Yates' confession and 911 call).

62. *See, e.g.*, Park Dietz Associates, Report of Dr. Dietz Regarding Andrea Yates, Feb. 25, 2002, http://www.parkdietzassociates.com/files/Report_of_Dr._Park_Dietz_re._Andrea_Yates__2002.pdf (claiming that Yates was sane at the time of the murders).

63. *See* John Petrila, *From Constitution to Contracts: Mental Disability Law at the Turn of the Century*, *in* THE EVOLUTION OF MENTAL HEALTH LAW 75, 75-100 (2001).

64. A search of the psychology/psychiatry database *PSYCHINFO* under the heading "competency" indicated 5,632 hits. American Psychological Association, APA PsycNET, http://psycnet.apa.org/ (visited Apr. 1, 2006).

65. There are likely two indications of this: 1. The seminal U.S. Supreme Court decision on competency to stand trail, *Dusky v. United States*, was a half-page, *per curium* decision (*see* Dusky v. United States, 362 U.S. 402 (1960) ("[T]he test must be whether he has sufficient present ability

efficient dichotomy of either competent or incompetent and sets the bar fairly low.[66] It is dichotomous and presumed rudimentary. Psychiatry makes much ado about competency because it understands competency as entailing rationality, which can be profoundly affected by mental illnesses.[67] But this profundity is not merely one of severity; it is the sensitive fluidity and fragility of the mental state enmeshed in muted symptoms that are directly pertinent to competency that also bears concern.[68] That is to say, mental illnesses can (and often do) cause irrational behavior, but the impairments that lead to the behavior vacillate frequently and often without demonstrable outward manifestations.[69] A person with schizophrenia who is lucid one day and over the next few days becomes convinced that the judge and lawyers are all involved in a communist plot to destroy him does so often in secret. To reveal his knowledge of this plot against him would be ever foolish. But it is not that one day all is fine and the next day is filled with Gulags, the K.G.B., and fear of assassinations. The delusions overcome his sanity progressively as his brain slowly misappropriates events in the environment into defective, cognitive perceptions. And that is the easy case. Many mental illnesses, such as schizophrenia, substantially degrade vital cognitive components such as information processing and abilities to engage in planned behavior. This

to consult with his lawyer with a reasonable degree of rational understanding--and whether he has a rational as well as factual understanding of the proceedings against him."); and 2. Despite some additional case law (notably, *Drope v. Missouri*, 420 U.S. 162 (1975), *Medina v. California*, 505 U.S. 437 (1992), and *Sell v. United States*, 539 U.S. 166 (2003)), the trend has been decidedly against expansion of the original minimal criteria set forth in *Dusky*. The unfortunate result is an erosion of the competency doctrine. *See, e.g.*, People v. Tortorici, 92 N.Y.2d 757, 773-74, 686 N.Y.S.2d 246, 97 (N.Y. 1999), *cert. denied*, 120 S. Ct. 94 (1999) (*cert. denied* despite uncontroverted evidence that the *prosecution's* psychiatric expert produced memoranda to trial judge during the trial in which he stated that the defendant was incompetent to stand trail. The New York Court of Appeals held there was no abuse of discretion by the trial court); *see also, A Crime of Insanity* (PBS television broadcast Oct. 17, 2002 on Frontline) (transcript available at http://www.pbs.org/wgbh/pages/frontline/shows/crime/etc/script.html) (providing an overview of *People v. Tortorici*). *Compare with*, Pate v. Robinson, 383 U.S. 375, 385; 86 S. Ct. 836, 842 (1966) (holding that a defendant's competency is so crucial to legitimate criminal adjudication that where there exists a "bona fide doubt" as to the defendant's competency, a hearing, even *sua sponte* by the court is required on Constitutional grounds); *Drope*, 420 U.S. 162 (determining that medical opinions are vital to determining a defendant's competency in a criminal matter).

66. Again, the *Dusky* decision, which established the substantive part of the competency to stand trail, suggests that while a "rational as well as factual understanding" is constitutionally required, a strong argument can be made that the test is neither complex nor demanding. *Dusky*, 362 U.S. at 402.

67. *See* Stephen J. Morse, *Rationality and Responsibility*, 74 S. CAL. L REV 251 (2000) (discussing rationality in terms of mental capacity in the mentally ill).

68. *See* GREEN, *supra* note 54, at 25-26.

69. *Id.*; *see also Consensus Statement*, *supra* note 58.

pathological degradation occurs almost entirely *sub silentio* and has direct relevance to legal questions such as competency, but is often overlooked.[70]

The importance of these differences between the law and psychiatry lies not with details, such as whether the law treats competency as overly simplistic[71] or psychiatry misconstrues legal relevancy with clinical judgment.[72] Instead, it is important to note the different approaches each discipline undertakes towards issues such as competency. Law seeks efficient rules founded upon persuasive doctrines because they encompass values, such as fairness and justice, that are rooted in larger rules (perhaps of recognition)[73] adjudged as authoritative. The goal is not aggregating data to reach a consensus. As such, the findings of scientific research are only useful insofar as they clarify difficult questions of fact. Alternatively, they are almost universally obstructive when they suggest permutations to legal doctrine. Consequently, when science attempts to provide answers to legal questions, it often does so in an unaccommodating manner wholly inconsistent with law's objectives. Is caffeine addictive? Science tells us that the answer is probably yes because mounting evidence suggests withdrawal from caffeine produces physiologic changes associated with addiction.[74] What is the law to do with this empirical conclusion?[75] Of equal importance, what does psychiatry do with it? As will be discussed, *infra*, the trend is troublesome.

70. Surprisingly, there have been little neuropsychological or neuropsychiatric studies examining cognition and competency. There has been one notable study, however. *See* Paul G. Nestor et al., *Competence to Stand Trial: A Neuropsychological Inquiry*, 23 L. & HUM. BEHAV. 397 (1999).

71. *See* Godinez v. Moran, 509 U.S. 389, 398 (1993) ("And while the decision to plead guilty is undeniably a profound one, it is no more complicated than the sum total of decisions that a defendant may be called upon to make during the course of a trial.").

72. *See* Elizabeth S. Scott & Thomas Grisso, *The Evolution of Adolescence: A Developmental Perspective on Juvenile Justice Reform*, 88 J. CRIM. L. & CRIMINOLOGY 137, 152 (1997) ("[some] argue that minors are less capable of sound judgment, because of impulsiveness and a reduced capacity to appreciate the consequences of their acts, and thus are less culpable than adult offenders.").

73. *See generally* H.L.A. HART, THE CONCEPT OF LAW 91 (1961).

74. *Compare* Aviel Goodman, *Addiction: Definition and Implications*, 85 BRIT. J. PSYCHIATRY 1403 (1403) *with* DSM-IV-TR, *supra* note 37.

75. *See, e.g.*, Stephen J. Morse, *Addiction, Genetics, and Criminal Responsibility*, 69 L. & CONTEMP. PROBS. 165, 171 (2006) ("Criminal law's concept of the person, including the addict, is the antithesis of the medical model's mechanistic concept.").

B. The Tribulation of Free Will and Tributary of Rationality

The 1990s was dubbed by the scientific community as the "decade of the brain" given the tremendous advances in our understanding of how the brain works and influences universal experiences of perception, sensation, and judgment.[76] These discoveries were indeed impressive, aided much by refined technologies that allowed researchers unprecedented access to the delicate chemical processes occurring on almost infinitely vast scales.[77] Science has indeed learned much about the brain and many renowned scholars have imputed that these continued discoveries are the death nail for many ontological ideas important to law.[78] But the rush to these imprudent conclusions is foolish and neglectful: foolish because the analytical reasoning from scientific results to erudition about the human condition is often fraught with mistake; neglectful because such conclusions ignore how science can provide new methods which validate entrenched social norms.[79]

Volumes have been written by many wise scholars about the nature of free will and its vexing premise in an evolving scientific world. Briefly put, many have questioned whether free will exists and whether its inclusion as a precept in law can survive our growing understanding of the mind and human behavior.[80] But as one wise scholar has insisted, these questions wholly misconstrue the relevancy of such empirical findings.[81] Law holds that people act for reasons and presumes that such persons have the potential to be guided by beliefs, discernment, and logic. While even a dog can learn to avoid food it desires because of past negative conditioning, only humans can provide reasons for their behavior. This is true not because a laboratory experiment informs us so, but because our collective experiences as humans informs us so. Thus, culpability under the law is inherently a moral and political

76. *See generally* Edward G. Jones & Lorne M. Mendell, *Assessing the Decade of the Brain*, 284 SCI. 739 (1999).

77. *Id.*

78. *See* Matthew Jones, *Overcoming the Myth of Free Will in Criminal Law: The True Impact of the Genetic Revolution*, 52 DUKE L.J. 1031 (2003).

79. *See* Joshua Greene & Jonathan Cohen, *For the Law, Neuroscience Changes Nothing and Everything*, 359 PHIL. TRANSACTIONS: BIOLOGICAL SCI. 1775 (2004).

80. *See* Jones, *supra* note 78 (arguing that genetic influences on behavior make traditional notions of criminal liability outdated and suggesting that future punishment will solely be justified by utilitarian arguments); Arenella, *supra* note 49; RICHARD DOUBLE, THE NON-REALITY OF FREE WILL (1990).

81. *See* Morse, *supra* note 67, at 252-53 ("When we [speaking of law] want to know why an agent intentionally behaved as she did, we do not desire a biophysical explanation, as if the person were simply biophysical flotsam and jetsam. Instead, we seek the reason she acted, the desires and beliefs that formed the practical syllogism that produced intentional conduct.").

question implemented under substantive criminal law.[82] Law's power lies in its assumption that people are rational creatures who understand rules and can conform their behavior accordingly.[83] Mental capacity to accomplish this requirement is presumed because a coherent regimen of law is only possible under such an assumption. Free will is manifest through rational behavior and irrational behavior indicates the possibility of a fundamental disturbance of the mind which renders free will powerless or destroys it entirely.

Thus, the important contribution of science and psychiatry to legal questions lies in its adduction of empirical findings to legal principles. Science is helpful when it can coalesce salient observations that help law achieve its goals of determinacy, efficiency, and moral legitimacy.[84] During the past twenty-five years there has been a veritable flood of empirical findings in the discipline of psychiatry. As a consequence, psychiatry was transformed from its Freudian past to its present state as a natural science. The importance of this transformation cannot be overstated. Often overlooked is the fact that Freud's theories of behavior were not true because of any scientific finding, but because he and his followers envisioned all behaviors as congruent with their ontological vision of humanity. In this sense, Freud's theories share a similarity with law since both fundamentally rest upon normative dictum.[85] Modern psychiatry, however, rests on scientific principles, namely, hypotheses that are testable, replicable, and falsifiable.[86] Its modern contribution to law, then, lies in its promise to validate, clarify, and summarize clinical understandings of behavior within legal frameworks. To put it a different way, modern psychiatry's transformation to a natural science means that "proof" of its claims regarding illnesses of the mind must satisfy the trial of the scientific method; it must also apply its findings outside of the scientific paradigm to that of law to preserve its legitimacy in law.

82. *See generally* Meir Dan-Cohen, *Responsibility and the Boundaries of the Self*, 105 HARV. L. REV. 959 (1992) (discussing culpability as it relates to responsibility, which itself exists in a political and social context).

83. *See* Morse, *supra* note 67, at 253.

84. The recent Supreme Court decision in *Clark v. Arizona*, 126 S. Ct. 2709, 2712 (2006), presents an interesting view of how the Court construes morality and insanity insofar as moral capacity is deemed synonymous with cognitive capacity.

85. Of course, the empirical legal studies movement and even natural law scholars would beg to differ. Yet I believe that even if they are right, the propensity of law is one of *a priori* reasoning. *See* Green, *supra* note 46, at 2045-47 ("Wharton's pact with the angels survives," and "[W]e mainly indulge the presumption [of free will] that underpins the law.").

86. *See* THE AMERICAN HERITAGE DICTIONARY (4th ed. 2005).

Such an undertaking is vexing if not impossible as the paradigms of science and law, as previously discussed, are inherently in tension. Even the founder of sociological jurisprudence himself seemed to understand this as he posited, "there will be much experimenting, some fumbling and much dissatisfaction."[87] Despite the impression that science and law do speak different languages, I do not find them entirely incompatible, for law does exist in the empirical world and science is contemplated by people who reason and judge by their humanity. What is necessary, therefore, is that contributions of one to the other remain faithful to their essential principles and modest in their demand that the one accommodate the other. To clarify this position, I present the following example.

As mentioned previously, the law can exist only if it presumes that people are rational beings – that their behavior is guided by justifiable beliefs executed by a mind that can perceive accurately the world in which it operates.[88] There will likely be disagreements among scholars for generations or longer as to what constitutes rationality (surely history is a testament to this). Nonetheless, it is my sense that when we speak of rationality we are talking about the ability of the mind to engage in goal directed behavior when it can accurately comprehend the world in which it exists. This implies that cognition is vital to rationality insofar as the mind is not conceived as working divorced from its biological processes. Of course, this brings up the mind-brain dualism of Descartes which has perplexed scholars for centuries. This quandary is, I think, beyond an answer with certitude and one of the mysteries that will likely intrigue perpetually.[89] Rather than enter that everlasting contemplation, it is

87. RAYMOND FOSDICK ET AL., CRIMINAL JUSTICE IN CLEVELAND 559, 588 (Roscoe Pound & Felix Frankfurter eds., 1922).

88. *See* Morse, *supra* note 67, at 255; *cf.* Jose L. Bermudez, *Normativity and Rationality in Delusional Disorder*, 16 MIND & LANGUAGE 457, 462 (2001) ("Rational agents with determinate goals in mind and reasonably defined conceptions of how those goals can be achieved by behaving in the relevant ways."); David Hodgson, *Responsibility and Good Reasons*, 2 OHIO ST. J. CRIM. L. 471, 474 (2005) ("While it is true that the commonsense notion of rationality does involve such things as the ability to perceive accurately and reason instrumentally, it also (and crucially) involves consciousness, and, in particular, the ability to make conscious decisions and exercise conscious control over one's actions."). There has been much discussion of late about intentionality and its relation to rationality and mental illness. This seems correct to me, yet I remain skeptical that it is entirely normative. *See* Bolton, *supra* note 21 for a general discussion.

89. But I think that Dr. Andreasen gets it right when she says: "One heuristic solution, therefore, is to adopt the position that the mind is the expression of the activity of the brain and that these two are separable for purposes of analysis and discussion but inseparable in actuality." Nancy C. Andreasen, *Linking Mind and Brain in the Study of Mental Illnesses: A Project for Scientific Psychopathology*, 275 SCI. 1586, 1586 (1997).

more fruitful to discuss a more salient notion when examining law and mental illness.

One way modern psychiatry provides relevant understanding to the law is by explaining how mental illnesses affect cognition, and hence, rationality.[90] Many mental illnesses, such as schizophrenia, have profound effects on cognitive processes. What matters here is that these processes are *measurable* and *discoverable* in harmony with scientific principles. This is in contrast to claims made by psychiatry in the past, such as concluding that seeing a reflection in an inkblot was tantamount to narcissistic personality.[91] Moreover, these findings have direct relevancy to important legal questions, such as competency and insanity defenses. Thus, in this example, psychiatry can prudently dispense its understandings of behavior to law's domain. This is so because psychiatry can be faithful to its scientific principles while also imparting its understandings of behavior in a manner that understands the importance of law's presumption of rationality to its own enterprises. Law and science are different animals so to speak, but science can inform law about human behavior and law can (and should) learn these important lessons. Yet, science must be science, and thus, only claims supported by the scientific method should be held out as scientific truths. Much of undesirable behaviors now classified by psychiatry as mental disorders fail this vital test. Understanding how this happened begins with a brief history of the institution of psychiatry and its growth as a powerful political force in popular culture.

II. ILLNESS, DISORDER, AND INSTITUTIONS

If we lived in a perfect world, science would remain faithful to its method and law perhaps would be synonymous with natural law. Of course, we do not live in such a world. Rather, the present state of psychiatry has as much to do with the political institution it created as with science. Understanding the conflict between law and psychiatry requires an understanding of psychiatry's tremendous growth during its relatively short history. This history is a story of the rise of a noble profession, its fall from public favor, and resurrection through the power of biological sciences and drugs. It is also a story of how a medical

90. There are surely others. As will be discussed, *infra*, the demarcation between what is relevant or not lies, I think, in psychiatry's faithfulness to the idea of disease.

91. *See* Steven K. Erickson, *Psychological Testimony on Trial: Questions Arise About the Validity of Popular Testing Methods*, 75(6) N.Y. ST. B. J. 19, 22 (2003). James M. Wood et al., *The Misperception of Psychopathology: Problems With the Norms of the Comprehensive System for the Rorschach*, 8 CLINICAL PSYCHOLOGY: SCI. & PRAC. 350, 362 (2001).

profession became the leading authority on behavior by its timely assumption as the expert.

Psychiatry has long struggled with defining mental illnesses. The father of American psychiatry, Benjamin Rush, noted the hardship he would endure in formulating his understanding of mental illnesses at the outset of his famous treatise, *Medical Inquiries and Observations Upon the Disease of the Mind*:[92]

> In entering upon the subject of the following Inquires and Observations, I feel as if I were about to tread upon consecrated ground. I am aware of its difficulty and importance, and I thus humbly implore that BEING, whose government extends to the thoughts of all his creatures, so to direct mine, in this arduous undertaking, that nothing hurtful to my fellow citizens may fall from my pen, and this work may be the means of lessening a portion of some of the greatest evils of human life. [93]

Despite Rush's incantation of the evils of mental disease, his pen would soon write what was a clear departure from centuries of ascribed dogma that mentally disordered behavior was the manifestations of moral failings. For Rush lived in a time when there was growing interest in finding the physical cause that drove the behavior of madmen. As Rush stated in the succeeding pages—and in the very title of his treatise—madmen were *afflicted* with a disease of the mind. Moreover, the mind resided in the brain whose injury could destroy the mind. Sounding very similar to today's scholars, Rush put forth that mental disease affected the "faculties and operations" of the mind including "understanding, memory, imagination, passions, the principle of faith, will, the moral faculty, conscience, and the sense of Deity."[94] Reflecting an almost pure reductionism for his day, Rush then held that these faculties operated through "sensation . . . perception, association, judgment, reasoning and volition."[95] Further, these operations relied upon "attention, reflection, contemplation, wit, consciousness."[96]

Rush's quest to understand insanity among the putative madmen of his day was soon rivaled by other psychiatrists who wanted to expand the notions of insanity. Rush's formulations were concerned with

92. BENJAMIN RUSH, MEDICAL INQUIRES AND OBSERVATIONS UPON THE DISEASE OF THE MIND (1812).

93. *Id.* at 9.

94. *Id.* at 10.

95. *Id.* For an interesting discussion on volition in psychiatric disorders, see also Scott Henderson, *The Neglect of Volition*, 186 BRIT. J. PSYCHIATRY 273 (2005).

96. Rush, *supra* note 92, at 10.

psychosis, much of what would be considered today as schizophrenia and manic-depressive illness, while subsequent thinkers opened the possibility that criminal behavior was indicative of mental disease. In writing his treatise on insanity, psychiatrist James Pritchard ushered in the idea of moral insanity.[97] Pritchard was interested in why some people committed crimes despite heavy moral pressure of condemnation and likely severe punishment by society. Displaying the ironic optimism that science would reveal a pathological basis for all abnormal behavior, while steadily trenched in the moral beliefs of his Quaker upbringing, Pritchard conceived of a mental illness that affected persons primarily through their feelings and judgments. Pritchard wrote of people afflicted of this "moral insanity":

> There are those affections of the understanding of rational powers, but there is likewise a form of mental derangement in which the intellectual faculties appear to have sustained little or no injury, while the disorder is manifested principally or alone, in the state of feelings, temper, or habits . . . [m]oral and active principles of the mind are strangely perverted or depraved; the power of self-government is lost or greatly impaired.[98]

While Pritchard could hardly be blamed for his desire to understand the unrepentant criminal, his creation of moral insanity foreshadowed two movements that would later lay at the crux of controversy for psychiatry. The first of these was his attempt to classify the mentally ill in divergent categories. Pritchard saw mental illness as occurring once in the traditional sense of lunatics and once again in the morally depraved.[99] These groups were similar only in that they both suffered from a perceived defect in essential reasoning that deserved medical *and legal* consideration. From that point on, the "mad" and "bad" were very different; from their symptoms to prognosis they were worlds apart. Yet Pritchard's treatise also foretold psychiatry's penchant to explain amoral behavior and transgressions by way of a sickness model.[100] The obvious question to Pritchard and his contemporaries was why anyone would engage in amoral behavior – especially extreme cruelty such as sadistic

97. Interestingly, this concept of moral insanity sounds somewhat similar to the "moral capacity" enounced by the Supreme Court in *Clark*; yet few believe that the court was attempting to broaden the insanity defense to include the psychopathic criminal. *See* Clark v. Arizona, 126 S. Ct. 2709, 2722-23 (2006).

98. JAMES COWLES PRICHARD, TREATISE ON INSANITY AND OTHER DISORDERS AFFECTING THE MIND 11 (1837).

99. *Id.*

100. *Id.*

rape – when it was presumed that healthy biology with plenty of social reinforcement strongly urged conforming to moral, orderly behavior.[101] Some contemporaries have argued that this behavior may have a quite rational, evolutionary basis.[102] Moreover, Pritchard's vision that certain people with a strong predilection towards antisocial behavior may be indicative of a categorical group with physiological anomalies was insightful for his time.[103] Yet it also foreshadowed how psychiatry would "medicalize" behavior that it deemed abnormal despite little or no empirical findings to lend credence to its conclusions. Psychiatry wanted to explain these behaviors through a quasi-medical lens because once it had transformed these behaviors into medical diagnoses; it could then seek to restore normality through psychiatric approaches. Of course, it also could remove moral judgment in favor of medical judgment and give itself tremendous power in science, law, and society by being the arbiters of behavior.

A. Building an Institution

Power often comes to institutions when they have the ability to declare that certain things are so — a form of *ipse dixit* that comes with the complexity of a corpus of knowledge propagated by the very institution itself. The law is like this. It is not unfathomable that most people could probably navigate the original tax code whereas today it seems a labyrinth only chartable by the astute tax attorney.[104] Thus, the

101. The moral insanity persona that Prichard posed was later explored in the legendary book by Hervey Cleckley and later by Robert Hare. It has been transformed into the psychopathic personality that is ubiquitous in modern culture. *See* HERVEY M. CLECKLEY, THE MASK OF SANITY: AN ATTEMPT TO REINTERPRET THE SO-CALLED PSYCHOPATHIC PERSONALITY (1941); ROBERT D. HARE, WITHOUT CONSCIENCE: THE DISTURBING WORLD OF THE PSYCHOPATHS AMONG US (Guilford Press 1999) (1934).

102. *See* Stuart Kinner, *Psychopathy as an Adaptation: Implications for Society and Social Psychology*, *in* EVOLUTIONARY PSYCHOLOGY AND VIOLENCE: A PRIMER FOR POLICYMAKERS AND PUBLIC POLICY ADVOCATES 288 (Richard W. Bloom & Nancy Dess eds., 2003).

103. Within the past fifteen years, a substantive body of research has demonstrated that some people with antisocial personalities with certain qualities are at a very high risk of recidivism. This has led to the development of one of the best instruments – in terms of reliability and validity – that identifies such individuals, the Hare Psychopathy Checklist (PCL). ROBERT D. HARE, HARE PCL-R (2nd ed. 2003). This is not mere intellectual amusement, as the PCL is used extensively in psychiatric assessments for the courts. *See* James F. Hemphill & Stephen D. Hart, *Forensic and Clinical Issues in the Assessment of Psychopathy*, *in* HANDBOOK OF PSYCHOLOGY: FORENSIC PSYCHOLOGY 87, 606 (Alan M. Goldstein & Irving B. Weiner eds., 2003). Additionally, there is some indication of abnormal brain physiology among these "psychopaths." See CHRISTOPHER J. PATRICK, HANDBOOK OF PSYCHOPATHY 251-334 (2005) for a great review of these findings.

104. *See* Theodore J. Forstmann & Stephen Moore, *Abolish the Tax Code, Not the IRS*, Cato Institute, *available at* http://www.cato.org/dailys/5-13-98.html (visited Apr. 7, 2006) (noting that

power of the bar. For psychiatry, history shows that power lies in its classification of abnormal behavior followed by its guiding the rest of us through its nosology[105] and offering treatment that is often lifelong.

1. Early Origins and Practices

Perhaps the first instance of classification of mental illness in the United States can be traced to the census. During the hygiene movement of the early 1800s, Congress became concerned with many social problems that were viewed as affecting the fabric of society.[106] In 1840, the census created seven categories of official mental diseases: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy.[107] As the prevalence of schizophrenia and other severe mental illnesses continued to rise through the Nineteenth Century,[108] the psychiatric professional felt the demands to better define mental illness and its origins. Eminent psychiatrists such as Emil Kraepelin and Paul Eugen Bleuler, among others, responded by publishing textbooks with the aim of describing and classifying various mental illnesses.[109] In addition, in 1913 the Committee on Statistics of the American Medical Publishers Association (AMPA) was formed under the Census Bureau and charged with the task of organizing the chaotic state of information on mental illnesses.[110] Up to this time, there had been little coherent structure in how mental illnesses were described or categorized, with several competing schools of thought vying for recognition in how mental illnesses should be conceived overall.[111]

the first version of the U.S. tax code was 1 page whereas the current version is lengthier than the entire Encyclopedia Britannica).

105. Nosology is the branch of medicine that classifies diseases.

106. *See* Gerald N. Grob, *Origins of DSM-I: A Study in Appearance and Reality*, 148 AM. J. PSYCHIATRY 421 (1991).

107. *Id.*

108. *See* E. FULLER TORREY & JUDY MILLER, THE INVISIBLE PLAGUE: THE RISE OF MENTAL ILLNESS FROM 1750 TO THE PRESENT (Rutgers University Press 2001) (1937) (examining the precipitous rise of severe mental illnesses in the U.S. and U.K.).

109. *See* EMIL KRAEPELIN & ALAN R. DIEFENDORF, CLINICAL PSYCHIATRY: A TEXTBOOK FOR STUDENTS AND PHYSICIANS (J.S. Cushing & Co. 1912) (1907); PAUL EUGEN BLEULER, TEXTBOOK ON PSYCHIATRY (1924).

110. *See* Grob, *supra* note 106.

111. *See* Ming T. Tsuang et al., *Toward Reformulating the Diagnosis of Schizophrenia*, 157 AM. J. PSYCHIATRY 1041, 1042 (2000) (discussing the differences between Bleuler and Kraepelin's conception of schizophrenia. "Bleuler's emphasis on theory as a means for determining the diagnostic relevance of signs and symptoms contrasted sharply with Kraepelin's reliance on empirical observations.").

Shortly after the formation of the AMPA, along with the National Committee for Mental Hygiene, the first standardized psychiatric classification scheme was published in 1918.[112] The *Statistical Manual for the Use of Institutions for the Insane*[113] was a biologically-oriented, non-diagnostic manual that mainly served as a descriptive administrative document for the federal government.[114] The manual contained twenty-two categories of mental illnesses that were almost entirely related to severe mental illnesses, including thirteen various forms of psychosis. Despite its limitations for clinicians, the AMPA's manual would endure for thirty-five years with periodic updates.[115]

2. World War II and the Ideological Shift

World War II was a transformative period in the United States and for all nations. In the United States, women went to work in the factories as most young and middle-aged men went to fight a worldwide enemy. But it also was a time of industrial and cultural transformation. The nation was becoming urbanized as the industrial revolution became entrenched in the American fabric. From 1880 to 1940 the number of people living in cities tripled while the size of urban communities rose by about sixty percent.[116] Similarly, the population was becoming denser as more people migrated to cities to avail themselves of the economic benefits of industrial work.[117] Psychiatry was changing as well. As its infatuation with Freudian psychoanalysis became firmly rooted,[118] psychiatrists began to focus on the problems of everyday life.[119] More importantly, however, was the impact of mental health

112. *See* Grob, *supra* note 106.

113. COMMITTEE ON THE STATISTICS OF THE AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION AND BUREAU OF STATISTICS OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, STATISTICAL MANUAL FOR THE USE OF INSTITUTIONS FOR THE INSANE (1918) [hereinafter AMPA MANUAL].

114. *See* HERB KUTCHINS & STUART KIRK, MAKING US CRAZY 426 (1997).

115. *See* Grob, *supra* note 106.

116. United States Department of Census, *Population: 1790-1990*, http://www.census.gov/population/censusdata/table-4.pdf (reporting an increase of urban population from 22,106,265 persons in 1890 to 74,705,338 in 1940 and for rural areas from 36,059,474 in 1890 to 57,459,231 in 1940).

117. United States Census, *Population, Housing Units, Area Measurements, and Density: 1790-1990*, http://www.census.gov/population/censusdata/table-2.pdf (reporting a population density of 17.8 persons per square mile in 1890 to 37.2 in 1940).

118. *See* TORREY, *supra* note 51, at 92-103.

119. *See* Arthur C. Houts, *Fifty Years of Psychiatric Nomenclature: Reflections on the 1943 War Department Technical Bulletin, Medical 203*, 56 J. CLINICAL PSYCHOL. 935, 940 (2000) (discussing the transformation of psychiatric practice in the 1940s, Houts states: "Rather than being

assignments in the armed forces. In 1941 there were thirty-five neuropsychiatric assignments in combined forces of the army, navy, and marines; by 1945 that number had swelled to 2,400.[120] Psychiatrists in the armed forces soon became disenchanted with the AMPA's manual given that it was aimed at treating the severe mental illnesses of those confined in state institutions. Soldiers were suffering from the stresses of war, not schizophrenia and it was not long before psychiatrists found the novel psychoanalysis as a better means of achieving relief for battle-worn soldiers.[121] When the war ended, this cadre of impromptu Freudian psychiatrists returned home and implemented their new passion with zeal in post-war America.[122] Soon this powerful group began to flex its ideological muscle, and led by the psychiatrist William Menninger, in 1946 they established the Group for the Advancement of Psychiatry (GAP).[123] Built on the presumption that "psychiatry should transcend institutional care and treatment of the mentally ill"[124] Menninger and his followers rallied for an overhaul of the profession.[125] Realizing the power of Freud's ideas, the psychoanalysts moved psychiatric practice from the state hospital to the community,[126] from the mentally ill to the worried-well,[127] in order to help the average man and woman overcome the tribulations of psychosexual development.[128]

This ideological shift, like many things in life, was fortuitous as it enjoyed popularity during the largest growth of psychiatry (and psychology)[129] in American history. In 1949, the National Institute of

confined to severe forms of mental illness, mental-disordered problems were viewed as arising from life's circumstances.").

120. *See* Grob, *supra* note 106, at 427.

121. Houts, *supra* note 119, at 940 (noting that of the 11,400,000 people serving in the armed forces in World War II, 1,000,000 were admitted to hospitals for psychiatric problems).

122. *See* Grob, *supra* note 106, at 427.

123. *Id.*

124. *Id.* at 428.

125. Menninger's influence was powerful in both his political force and ideas. Menninger bluntly held that psychiatry could and should help the "average" person deal with the problems of life – a dramatic departure from previous notions that reserved psychiatric help for those afflicted with mental disease. *See* William C. Menninger, *Psychiatric Experiences in the War, 1941-1946*, 103 AM. J. PSYCHIATRY 577, 579 (1947).

126. *See* Grob, *supra* note 106, at 426-30 (noting that two thirds of the pre-World War II members of the American Psychiatric Association had been employed in state mental hospitals whereas by 1956, only 17% were so employed with the majority employed in outpatient settings).

127. *See* TORREY, *supra* note 10, at 8-11 (noting that the 19th century concept of mental illness as a brain disease was replaced early by a spectrum concept that subsumed mental illness under the broad heading of 'mental health').

128. *See* SIGMUND FREUD, THREE ESSAYS ON THE THEORY OF SEXUALITY (James Strachey trans., 1949).

129. An important footnote is the fact that clinical psychology was nearly absent prior to

Mental Health (NIMH) was established from legislation passed in 1946.[130] As an institute within the federal National Institute of Health, NIMH provides the central, fiscal mechanism for research and training of American psychiatrists mainly through institutional grants to academic medical centers. As sociologist Paul Starr notes, NIMH grew faster than any of the other NIH Institutes in post-World War II America:

> Of the various divisions of NIH, none grew faster than the National Institute of Mental Health (NIMH), created in 1949 under legislation passed three years earlier. . . . Between 1948 and 1962, NIMH research grants rose from $374,000 to $42.6 million, training grants were up from $1.1 million to $38.6 million, but state grants rose only from $1.7 million to $6.6 million.[131]

NIMH was a force in psychiatry, not merely because of money, but because it drove research and training. Thus, the ideology of America's academic psychiatry department, housed in the numerous medical centers across the nation, would play a crucial role in defining mental illness in the subsequent years. As historian Gerald Grob explained:

> That psychodynamic insights quickly dominated the teaching of psychiatry in medical schools was apparent from a GAP survey in 1959–1960. Out of 93 U.S. and Canadian institutions, 88 taught psychodynamics, 87 taught personality growth and development, and 77 taught psychotherapy and clinical syndromes. The number of hours in the curriculum devoted to psychiatry also quadrupled between 1940 and 1969. Virtually every chairperson of a department of psychiatry stated unequivocally that the psychodynamic frame of reference (as contrasted with the descriptive or organic) was dominant.[132]

More importantly, however, was influence that Freudian thought had on popular culture. "Slip of the tongue," the "unconscious," and "ego" are just a few examples of how Freud's ideas have permeated American culture. Likewise, literature, movies, and many of the disciplines of the humanities have the indelible mark of Freud and his declaration of human agency. And crucially, during this period,

World War II, reserved mainly as an experimental social science. However, propelled by Freudian conceptions of behavior, clinical psychology grew rapidly in the postwar years. *See* SEYMOUR B. SARASON, THE MAKING OF AN AMERICAN PSYCHOLOGIST: AN AUTOBIOGRAPHY (1988).

130. National Mental Health Act, 60 Stat. 421 (codified as amended in scattered sections of 42 U.S.C.), *available at* http://history.nih.gov/01Docs/historical/LegislativeChronologyLaws.htm.

131. PAUL STARR, THE SOCIAL TRANSFORMATION OF MEDICINE 344-46 (1982).

132. Grob, *supra* note 106, at 429-30. Note that "psychodynamic" is, generally speaking, synonymous with Freudian psychoanalysis.

psychiatry itself became a powerful force in medicine, science, law, and various other fields. Once liberated from the care and treatment of the mentally ill in state institutions, psychiatry was free to comment about human sexuality, the power of institutions, religion, and almost anything of popular concern. Psychiatry became the interpreter of human actions, normal or abnormal, and soon care of the mentally ill was left to the few physicians who remained in the burgeoning state hospitals.

B. Every Institution Needs a Bible

After World War II, Menninger and Group for the Advancement of Psychiatry (GAP) began to push for a new manual of classification for mental illnesses. The community psychiatrists working outside of the state mental institutions were no longer treating the psychotic or profoundly retarded, instead they were treating the populace with psychoanalysis and its variants. In 1950, the first draft of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was circulated and then published in 1952.[133] Heavily influenced by the postwar publication of the Army's *Technical Manual, Medical 203*[134] in 1946, the DSM was very different than its predecessor, *Statistical Manual for the Use of Institutions for the Insane*. Published under the auspices of the American Psychiatric Association instead of the quasi-governmental AMPA, the DSM took a radically different approach to psychiatric nosology. Whereas the AMPA's manual was mainly an outgrowth of the census form, the DSM-I was psychiatry's first attempt to derive a diagnostic classification manual with the clinician as its intended user.[135] As a consequence, the twenty-two specific diagnoses in the AMPA manual were discarded in favor of three broad categories: organic brain syndromes, functional disorders, and mental deficiency. Moreover, the DSM's diagnoses were built upon the theoretical framework of Freudian psychoanalysis, which assimilated the newly popular idea of mental health within the bulwark of psychiatric expertise.[136] Psychiatry had

133. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS (1st ed., 1952) [hereinafter DSM-I].

134. Office of the Surgeon General, Army Service Forces, *Psychiatric Disorders and Reactions*, WAR DEPT. TECHNICAL BULLETIN, MEDICAL 203, *reprinted in*, 56 J. CLINICAL PSYCHOL. 935, 935-67 (2000) [hereinafter *Technical Manual, Medical 203*]. Scholars have noted that the Technical Manual reflected a psychoanalytical bent and "was not influential because of its empirical merits." Houts, *supra* note 119, at 944. *See also* WALTER E. BARTON, THE HISTORY AND INFLUENCE OF THE AMERICAN PSYCHIATRIC ASSOCIATION 133-35 (1987).

135. *See* DSM-I, *supra* note 133.

136. Houts, *supra* note 119, at 943 (noting the transformation of psychiatry from biologically oriented pre-World War II to Freudian psychoanalysis postwar).

transformed itself from a discipline of scientists treating presumed biological diseases to one of experts discerning normative questions of psychological health among those with no apparent illness.

Building upon the growing number of psychiatrists and clinical psychologists working primarily in private offices[137] and clinics along with the popularity of Freud, the DSM would become essential by legitimizing and perpetuating an expansive model of mental disorder.[138] By subsuming mental health under its authority, psychiatry entered the postwar era armed with a new optimism that social welfare could be improved by copious application of therapeutic "talk therapy." Under this novel view, individuals were not afflicted with a disease that robbed them of rationality by destroying the brain; rather individuals were aversely affected by relationships within systems that arrested their progressive development.[139] If one was mentally ill, it was inherently due to environmental factors that could be explained outside of biology. Since god was dead[140] in this modern world, a new institution had to fill the vacuum that explained why the interpersonal mattered. If psychotherapy was concerned with the average citizen's psyche – in some sense – all people were mentally sick[141] and could benefit from psychiatric treatment. Perhaps by happenstance, this new psychiatry required lengthy treatment, often years, which guaranteed a lucrative future for the generous number of psychiatrists leaving the armed forces. It surely was fortuitous that Freudian analysis lent itself to the worried well who could afford it as the number of people with severe mental illnesses filled the asylums, bereft of any meaningful treatment.[142]

To understand this moment of psychiatric history entails underscoring the establishment of the DSM. The power of any

137. *See* Gronfein, *supra* note 12.

138. The DSM has been called by many "the bible" of psychiatry and arguably no other product of psychiatry has been more hotly debated. *See generally* HERB KUCHINS & STUART KIRK, THE SELLING OF DSM: THE RHETORIC OF SCIENCE IN PSYCHIATRY 1-12 (1992).

139. Surely some would argue that this is a simplification, but I view it as quite accurate. While Freud argued that individual instinctively desired aggression, sex, and other primitive drives, it was society, represented by the superego, that kept these behaviors under control, but that also caused distress in the individual. *See* SIGMUND FREUD, CIVILIZATION AND ITS DISCONTENTS (James Strachey Trans., 1962) (1961).

140. FRIEDRICH NIETZSCHE, THE GAY SCIENCES (1882), *reprinted in* THE IDLER'S COMPANION: AN ANTHOLOGY OF LAZY LITERATURE 208-10 (Tom Hodgkinson & Matthew De Abaitua eds., 1997).

141. *See* FREUD, *supra* note 128 (describing "man" as the sick animal).

142. *See* Joseph P. Morrissey & Howard H. Goldman, *Care and Treatment of the Mentally Ill in the United States: Historical Developments and Reforms*, 484 ANNALS AM. ACAD. POL. & SOC. SCI. 12, 19 (1986) (reporting that in 1950, 150,000 people were located in state psychiatric hospitals – a 240% increase since 1903).

influential book lies not just in its ideas but in its power to transform those who read it and are willing to be governed by its epistemology which invariably becomes institutionalized. The birth of the DSM was a watershed for psychiatry because it solidified the prevailing psychiatric thought into an institution of enormous power. Several factors of this moment are of particular note. First, the importance of DSM's creation in 1952 compared to the previous taxonomies of mental illnesses rested with its institutional authority and sovereignty. The authority of the American Psychiatric Association – the author of the DSM – lies in its ability to declare certain behavior abnormal. The first edition of the DSM was much like law in this way since the biological mechanisms of mental illnesses were poorly understood and mostly abandoned in the first edition. Thus, it held certain behaviors abnormal either because historically they had been considered such or because they were part of a larger entity – a disorder perhaps – that fit a theoretical model. Thus, a neurotic person could be pronounced so not just on the authority of psychiatry alone, but because the therapist, individually, and psychiatry as an institution, could assert expertise as to *why* and *how* a behavior existed. This was done not because some discovery in a laboratory informed the psychiatric profession that it was true, but because the powers within the profession pronounced it so. The sovereignty that the DSM enjoyed was due to the fact that it was authored solely by the psychiatric association itself. Whereas previous classification manuals such as the AMPA's manual[143] were complied with direct governmental agency direction, the DSM was solely the product of the profession itself.

More crucially however, is that with the invention of the taxon[144] "disorder," psychiatry was now free to greatly expand behaviors that could be included in the DSM.[145] Once the profession supplanted disease with the captious idiom disorder, all mental phenomena were open to the speculation that they were illnesses in need of psychiatric

143. AMPA MANUAL, *supra* note 113.

144. Taxon generally refers to the science of taxonomy, which is the scientific classification of groups into ordered categories. In a more specific sense, the field of taxometrics is an emergent subfield in science that utilizes statistical methods to arrive at certain categories. This approach holds a dichotomous view in which diseases or mental disorders are either present or not. In contrast, the DSM is generally viewed as a dimensional approach since each diagnosis requires several factors to be present before the diagnosis can be said to be present in a person. *See* NORMAN B. SCHMIDT, ROMAN KOTOV, & THOMAS E. JOINER, TAXOMETRICS: TOWARD A NEW DIAGNOSTIC SCHEME FOR PSYCHOPATHOLOGY (2004).

145. *See* William C. Follette & Arthur C. Houts, *Models of Scientific Progress and the Role of Theory in Taxonomy Development: A Case Study of the DSM*, 64 J. CONSULTING & CLINICAL PSYCHOL. 1120, 1122 (1996) (discussing the taxon of mental disorder).

intervention. So too, did this fuzzy idiom allow the line between mental and physical be transgressed without critical appraisal. Thus, any behavior that produced discomfort or socially undesirable behavior could be asserted as representing a disordered psyche irrespective of biological evidence. Whereas the old psychiatry of Pritchard and Rush presumed biological disease despite lacking actual evidence given the technology of their day, the psychiatry of early DSM actually disposed of this supposition. This would be fertile ground for Szasz and others, who a mere decade later levied heavy accusations against the psychiatric institution by undermining its legitimacy through deconstructing the DSM.

C. Drugs, Liberation, and Exodus

While psychiatry surely benefited from the en masse infusion of practitioners and institutional funding it enjoyed from the federal government in the 1950s, it was the serendipitous discovery of psychiatric drugs that would lead to its greatest transformation. As Freud's ideas permeated popular culture, especially in America, the state psychiatric asylums were in disarray. During the late 1940s and early 1950s state psychiatric hospitals reached epic populations, with about 560,000 Americans housed in long-term, state psychiatric institutions.[146] While psychotherapy was embraced by outpatient clinics primarily benefiting affluent clientele who mostly suffered from anxiety and moderate depression, state hospitals had become warehouses filled with patients with severe mental illnesses.[147] What was so tragic about the state hospitals during this time was how far they had departed from their noble mission of providing humane care within an asylum.[148] Current opinions of asylums are almost uniformly negative because of what state hospitals had become in the late 1940s and early 1950s – snake pits,[149] cuckoo's nests,[150] and the shame of the states.[151] Yet, if there is one inevitable fault of human history, it is that so much of recent memory is

146. *See* Gronfein, *supra* note 12, at 437.

147. *See* TORREY, *supra* note 10, at 8-11; 91-140.

148. Perhaps one impetus to failure among institutions are mandates that result in a loss of control by the institutions themselves. As one scholar has noted, involuntary commitments by the courts and a safety conscious society left state asylums unable to control inflow and outflow of patients, resulting in unmanageable growth. *See* Gronfein, *supra* note 12, at 442. Analogous to this, one can imagine the present state of prisons in the United States and their inability to control inflow and outflow.

149. THE SNAKE PIT (Twentieth Century-Fox Film Corporation 1948).

150. ONE FLEW OVER THE CUCKOO'S NEST (Warner Bros. 1975).

151. ALBERT DEUTSCH, THE SHAME OF THE STATES (1948).

biased towards the recent past. The asylum was created at a time when many people with severe mental illnesses had few places to go and treatment of any sort was almost nil.[152] The state hospital was an asylum in the true sense: a place of refuge for the chronically ill and unwanted who often could not care for themselves.[153] What had happened to these once venerable institutions is what happens to so many institutions and noble ideas: time passes, demand outstrips supply, and new social problems supplant old ones. So sadly, the state asylums had indeed become bedlam by the 1950s: overcrowded, under-funded, and bastions of neglect.

But that was soon to change. In the late Nineteenth Century through the 1930s, a number of French and German scientists were searching for new types of dyes to stain slides for microscopes. [154] These phenothiazine dyes were noted for their various medicinal properties, including the treatment of malaria during World War I, when the traditional quinine treatment became unavailable due to military embargos.[155] In the 1930s, phenothiazines were explored for their possible antihistaminic properties in an effort to discover new treatments for surgical shock.[156] After several formulations, chlorpromazine was discovered and used in surgery by a French army surgeon named Henri-Marie Lamborit.[157] Lamborit noted that chlorpromazine was a highly effective sedative and soon suggested to his psychiatric colleagues that it be tried on their psychiatric patients. Its effect was monumental. In the spring of 1952, a pair of French psychiatrists, Jean Delay and Pierre Deniker, presented and published their experiences with this new drug.[158] One of their case reports was typical of how this new drug would transform psychiatry:

> Giovanni A., a 57-year-old manual worker with a long history of mental pathology, admitted for "giving improvised political speeches, getting into fights with strangers and walking along the street with a

152. *See* Aaron Rosenblatt, *Concepts of the Asylum in the Care of the Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 244 (1984).

153. *See* William Vogel, *A Personal Memoir of the State Hospitals of the 1950's*, 42 HOSP. & COMMUNITY PSYCHIATRY 593 (1991) (claiming that the state hospitals served an important charitable function by providing palliative care for the disenfranchised).

154. *See* Francisco Lopez-Munoz et al., *History of the Discovery and Clinical Introduction of Chlorpromazine*, 17 ANNALS CLINICAL PSYCHIATRY 113, 114 (2005) [hereinafter *Clinical Introduction of Chlorpromazine*].

155. *Id.*

156. *Id.* at 116-17.

157. *Id.*

158. *Id.* at 120; Jean Delay et al., *Utilisation en Therapeutique d'une Phenothiazine d'Action Centrale Selective*, 110 ANNALES MEDICO-PSYCHOLOGIQUES 112 (1952).

> plant pot on his head proclaiming his love of liberty." After a 9-day treatment with chlorpromazine, he was able to maintain a normal conversation, and within 3 weeks he was in such a calm state that he was able to be discharged.[159]

What Lamborit and his colleagues had discovered would become the first successful treatment for many severe mental illnesses and would eventually usher in a new era of biological psychiatry. That transformation, however, would have to overcome the stronghold of Freud, which by the 1950s had been firmly ensconced in the United States. Chlorpromazine would come to the Americas via Canada where a series of studies by the psychiatrist Heinz Lehmann documented significant improvement in two-thirds of patients given the drug.[160] The pharmaceutical giant, Smith Kline, introduced chlorpromazine in the U.S. in 1954 under the trade name Thorazine. During that year, doctors from McLean Hospital in Boston and Sidney Hillman Medical Center in Philadelphia published favorable studies[161] of the new drug. Soon Thorazine was widely used in state hospitals across the country, producing seventy-five million dollars of revenues for Smith Kline in 1955.[162]

The discovery and clinical application of psychotropic drugs completely transformed psychiatry and mental illness. In 1956, a year after Thorazine was introduced in the United States, the number of patients at state hospitals fell for the first time since the early 1900s.[163] This was a rapid reversal given that since the birth of the new century, the census of America's state hospitals had been massively increasing.[164] The introduction of Thorazine was so monumental to psychiatry that a prominent psychiatrist from Harvard medical school claimed one year after its introduction that Thorazine had "totally changed psychiatric practice."[165] Indeed, Thorazine brought science to psychiatry and directly challenged the authority of Freud's ideas. It did so because in one year, Thorazine managed to do what decades of Freudian ideology

159. *Clinical Introduction of Chlorpromazine*, *supra* note 154, at 120.

160. *Id.* at 123-24.

161. Willis H. Bower, *Chlorpromazine in Psychiatric Illness*, 251 NEW ENG. J. MED. 689 (1954); N. William Winkelman, *Chlorpromazine in the Treatment of Neuropsychiatric Disorders*, 155 J. AM. MED. ASS'N 18 (1954).

162. *Clinical Introduction of Chlorpromazine*, *supra* note 154, at 127.

163. *Id.* at 129.

164. *Id.* In 1900, there were about 150,000 people in state psychiatric hospitals, whereas in 1955 there were about 500,000.

165. *See* Mark D. Altschule, *Use of Chlorpromazine and Reserpine in Mental Disorders*, 254 NEW ENG. J. MED. 515 (1956).

and a century of psychiatric thought was unable to do: it brought hope to the severely mentally ill in a manner that was manifestly obvious.[166] Simultaneously, scientists also discovered and used the first antidepressant, ipronizid, and the utility of lithium salts for manic-depression became readily apparent.[167] While drug therapy was no panacea – it was neither a cure nor a complete treatment – it made such an appreciable impact on the symptoms of so many mental illnesses that its force would soon be felt throughout psychiatry and the country.[168]

The force of drug therapy in psychiatry occurred during a time when society was changing forcefully too. The 1960s was a period of tremendous change and it would affect the very nature of how mental disorders were construed, treated, and utilized by political powers. The widespread clinical application of drug therapy was a monumental wave that forever changed the landscape of psychiatric practice. But as often is the case in society governed by the rule of law, the enactment of far-reaching statutes had their own profound effects as well—perhaps more so. In 1961, the Joint Commission on Mental Illness and Health formally adopted deinstitutionalization of state hospitals as federal policy.[169] In 1963, Congress enacted the Community Mental Health Centers Act[170] which along with the enactment of Medicaid in 1965[171] provided strong fiscal leverage to promote outpatient care for the mentally ill. Medicaid provided matching fiscal dollars to the states for proving health care to the poor and expressly excluded most inpatient psychiatric treatment from reimbursement.[172] Known as the "IMD

166. *See, e.g.*, Gronfein, *supra* note 12, at 443-44 for several descriptions of utter amazement by hospitals workers in the 1950s at the beneficial effects of Thorazine.

167. *See* Erik Jacobsen, *The Early History of Psychotherapeutic Drugs*, 89 PSYCHOPHARMACOLOGY 138, 141-42 (1986).

168. *See generally* Michael Rosenbloom, *Chlorpromazine and the Psychopharmacologic Revolution*, 287 J. AM. MED. ASS'N 1860 (2002) (reporting that within eight months of Thorazine's introduction to the United States, eight million patients had received the drug and with an efficacy rate of seventy percent).

169. JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH (1961). *See also*, Rhoden, *supra* note 16, at 378 n.14 and accompanying text (discussing the commission's findings and recommendations related to hospitalization).

170. Community Mental Health Centers Act of 1963, Pub. L. No. 88-164, 77 Stat. 282, 290-94 (1963).

171. Grants to States for Medical Assistance Programs, Pub. L. No. 89-97, §§ 121 et seq., 79 Stat. 343, 343-53 (1965) (codified at 42 U.S.C. § 1396-1369(d) (2000)).

172. Pub. L. No. 101-239, § 6403(d)(2), 103 Stat. 2258, 2264 (1989) (codified at 42 U.S.C. § 1396d(a)(16) & (h) (2000)). Medicaid funding for "inpatient psychiatric hospital services for individuals under age 21" is available only for:

> (A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in . . . this title or in another inpatient setting that the Secretary has specified in regulations;

exclusion" (institutional medical disease), this policy reflected a historical distrust of federal support for state mental institutions and the belief that such institutions were the responsibility of the states through their *parens patria* powers.[173] Thus, the stage had been set to provide strong fiscal incentives for states to provide outpatient care while providing little federal monies for continuing the inpatient asylums. The public shock and outrage over the decrepit asylums of the late 1940s along with the success of drugs like Thorazine served to justify these federal policies.[174]

The overall effect of these forces was that the delivery of mental health care changed dramatically. State mental hospitals opened their backdoors and closed the front ones.[175] Care for the severely mentally ill moved from centralized state-run institutions to a hodgepodge of community care centers that relied almost entirely on federal funding.[176] Drugs such as Thorazine provided hope for those with the malignant forms of mental illness and signaled the beginning of the drug therapy approach for clinical treatment of mental illnesses. What soon would become obvious to many, however, was that for the severely mentally

> (B) inpatient services which, in the case of any individual (i) involved active treatment which meets [certain specified] standards . . ., and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and
>
> (C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

42 U.S.C. § 1396d(h)(1).

173. *See* Schweiker v. Wilson, 450 U.S. 221, 242 (1981) (Powell, J., dissenting) (citing S. Rep. No. 404, 89th Cong. 1st Sess. pt. 1, at 20 (1965)); Joanmarie I. Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J. L. & MED. 159, 165 (2003).

174. See Rhoden, *supra* note 16, at 380-81 for a description of the deplorable conditions of state hospitals as a political factor fueling deinstitutionalization.

175. *See* William Gronfein, *Incentives and Intentions in Mental Health Policy: A Comparison of the Medicaid and Community Mental Health Programs*, 26 J. HEALTH & SOC. BEHAV. 192 (1985) (describing the influence of Medicaid on admission and discharge rates in state hospitals during the 1950s and 1960s).

176. *See* TORREY *supra* note 10, at 91-140 (describing the proliferation of CMHC and decline of state hospitals); Samuel Slipp, *The Hospital Without Walls: An Aftercare Program for Chronic Schizophrenic Patients*, 6 GROUPS: A J. GROUP DYNAMICS & PSYCHOTHERAPY 21 (1976) (describing the idea of a "hospital without walls" which would become a calling card for community treatment for the severely mentally ill).

ill, drugs alone were not curative.[177] What the state hospitals had provided for good or naught was a restricted environment that precluded many from foregoing treatment or choosing illicit drugs instead to cope with their symptoms.[178]

D. Psychiatry Under Fire

Despite the remarkable progress that psychiatry made in treating mental illnesses in the 1950s and 1960s, it was under scrutiny by various factions which seriously questioned its legitimacy.[179] To understand why, one must keep in mind other social conditions that occurred concurrently. The 1960s was a time of social unrest during which authority was openly challenged.[180] The civil rights movement sought to undermine and reorganize institutions that were perceived as perpetuating racism.[181] The Vietnam War and student protests placed many young Americans in direct opposition to their government.[182] In sum, it was a season of upheaval and unrest. The horrors of the state asylums were well known to the public and many critics questioned whether psychiatry was merely a form of social control.[183] Many psychiatrists themselves questioned the traditional wisdom of psychiatric causation and classification.[184] Psychiatrists R.D. Laing[185] and Theodore Lidz[186] proposed that schizophrenia was not a brain disease but a psychological injury caused by improper parenting. Szasz and his contemporaries would write scathing critiques of psychiatry at a time when new psychotherapies were in fashion.[187] Many of these new therapies sought to go beyond the rigid models of Freud and

177. *See, e.g.*, Gary R. Bond et al., *Assertive Community Treatment for People with Severe Mental Illnesses: Critical Ingredients and Impact on Patients*, 9 DISEASE MANAGEMENT & HEALTH OUTCOMES 141 (2001) (discussing the limits of psychiatric medicines and describing a comprehensive model for community treatment).

178. *Id.*

179. *See* Mayes & Horwitz, *supra* note 39, at 252-54; *see also* Henry J. Steadman, *The Psychiatrist as a Conservative Agent of Social Control*, 20 SOC. PROBS. 263 (1972).

180. *See* MICHAEL W. FLAMM, LAW AND ORDER: STREET CRIME, CIVIL UNREST, AND THE CRISIS OF LIBERALISM IN THE 1960'S 64-66 (2005).

181. *See* Aldon D. Morris, *A Retrospective on the Civil Rights Movement: Political and Intellectual Landmarks*, 25 ANN. REV. SOC. 517 (1999).

182. *See* FLAMM, *supra* note 180, at 112-13.

183. *See* SZASZ, *supra* note 1, at 12; Drammann, *supra* note 5, at 734-37.

184. *See* Szasz, *supra* note 20.

185. R. D. LAING, THE DIVIDED SELF: AN EXISTENTIAL STUDY IN SANITY AND MADNESS (1965).

186. THEODORE LIDZ, SCHIZOPHRENIA AND THE FAMILY (1965).

187. *See* CARL ROGERS, ON BECOMING A PERSON (1961); B. F. SKINNER, ABOUT BEHAVIORISM (1975).

biomedicine and explained behavior as an intensely personal matter wherein the patient was the expert of their own emotions and behavior.[188] The enormously popular philosopher Michael Foucault proposed that mental illnesses were merely labels that allowed the powerful to stigmatize undesirable or asocial people.[189]

The institution of psychiatry only further incriminated itself during these trying times. In 1968, the American Psychiatric Association published the Second Edition of the DSM (DSM-II).[190] Whereas the first edition had three broad categories of mental disorders, the new edition had ten, with a total of 162 diagnoses.[191] What is remarkable about this growth was that the intervening years was not during a time when American psychiatry was engaged in scientific experimentation but under the influence of Freud. Since Freudian theory was just that – theory – the proliferation of new disorders absent an empirical foundation was astonishing. What had changed between the editions, however, was the adoption of the Freudian paradigm and its institutionalization into America's social consciousness.[192] So too, had it grown in influence and power as it left the small world of severe, mental illnesses of the state hospitals and became a ubiquitous part of American culture.

Although psychiatry had evolved much since the 1940s, it could not keep pace against the backdrop of social change in the 1960s and 1970s. After several years of protest by gay activists at the American Psychiatric Association's annual meetings, the association's membership voted in 1973 to delete the contested diagnosis of homosexuality.[193] Instead, beginning with the seventh printing of the DSM-II, homosexuality would be referred to as a "sexual orientation disturbance" and formally disposed of as a mental disorder.[194] Of course, it was never clear what separated a disturbance from a disorder, just as it was not entirely clear what differentiated a mental disorder from a mental illness or mental disease. What is obvious in hindsight was that the DSM was

188. *See* Carl R. Rogers, *The Concept of the Fully Functioning Person*, 16 PASTORAL PSYCHOL. 21 (1965) (discussing his therapeutic vision of client-centered therapy).

189. MICHEL FOUCAULT, MADNESS AND CIVILIZATION: A HISTORY OF INSANITY IN THE AGE OF REASON (1961).

190. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS (2nd ed., 1968) [hereinafter DSM –II].

191. *Id.*

192. *See* TORREY, *supra* note 51.

193. *See* Mayes & Horwitz, *supra* note 39, at 258-59; *see also* George Mendelson, *Homosexuality and Psychiatric Nosology*, 37 AUSTRALIAN & NEW ZEAL & J. PSYCHIATRY 678 (2003) (describing the historical background of homosexuality's classification as a mental disorder).

194. *Id.*

on a progressive trajectory of broadening the rubric of its classification scheme to include behaviors that had little, if any, biological basis in a disease model of medicine. Additionally, the deletion of homosexuality from the DSM indicated that psychiatry was susceptible to political forces which could successfully abolish a mental disorder that had existed for centuries. Irrespective of the ethical implications of classifying homosexuality as a mental disorder, the psychiatric association had erased a supposedly scientific diagnosis by the stroke of a pen.[195] In a Szaszian time, this action would haunt psychiatry for years and lend creditability to its mounting critics.

The courts also played a role in psychiatry's tribulation. During the 1960s and 1970s a number of seminal court decisions radically changed the balance of power between professional psychiatric judgment and patient autonomy. These decisions mirrored the shifting cultural and institutional views on behavior, morality, and authority. In 1962, the Supreme Court decided *Robinson v. California*, holding unconstitutional a California statute criminalizing addiction.[196] Soon there was much discussion about whether all conduct putatively derived from addiction – including possession and theft – should be held unconstitutional on Eighth Amendment grounds.[197] In 1972, the Eastern District of Wisconsin decided *Lessard v. Schmidt*,[198] a watershed case in psychiatric civil commitment. In *Lessard*, the District Court held most of Wisconsin's civil commitment statute unconstitutional.[199] Wisconsin's civil commitment statute was typical of the time with vague commitment criteria, few requirements for formal hearings, and generally few patient protections.[200] The *Lessard* decision was considered a warning shot by most of the states and soon commitment statutes nationwide were substantively changed with the net effect that commitment became more difficult and inpatient stays much shorter.[201] Following numerous other cases,[202] it became clear by the late 1970s that psychiatry was in crisis.[203]

195. *See* EDWARD SHORTER, A HISTORY OF PSYCHIATRY: FROM THE ERA OF THE ASYLUM TO THE AGE OF PROZAC 313 (1998) ("[W]hat had been considered for a century or more a grave psychiatric disorder ceased to exist.").

196. Robinson v. California, 370 U.S. 660 (1962).

197. *See* Herbert Fingarette, *Addiction and Criminal Responsibility*, 84 YALE L. J. 413, 414-15 (1975) (discussing various court decisions and commentators proposing to extend *Robinson*).

198. Lessard v. Schmidt, 349 F. Supp. 1078 (1972).

199. *Id.* at 1103.

200. *See* Steven K. Erickson et al., *Beyond Overt Violence: Wisconsin's Progressive Civil Commitment Statute as a Marker of a New Era in Mental Health Law*, 89 MARQ. L. REV. 359, 362-64 (2005) (discussing the statute, the *Lessard* decision, and the reformed statute post-*Lessard*).

201. *Id.* at 365-69.

202. *See, e.g.*, Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1967) (holding that insanity

E. Redemption Through Biology

It is often the case that, through a confluence of factors, an institution can be fundamentally transformed. Such was the case for psychiatry in the 1980s. After two decades of ridicule, a new formulation of psychiatry was ready to sweep through the field that would eventually change every facet of its nature. During the 1970s when psychiatry was in peril, a number of psychiatrists at Washington University in St. Louis and the New York State Psychiatric Institute in Syracuse began the clarion call for biological psychiatry.[204] The biological psychiatrists started their mission by sweeping aside the discredited formulations of Freud, favoring instead a return to Emil Kraepelin, the early pioneer who sought to classify mental illnesses based on symptoms instead of a presumption of human nature.[205] As drug therapies were refined and new technologies, such as brain imaging, introduced novel methods of examining the brains of the severely mentally ill, biological psychiatry offered the legitimacy of science to a battered profession.[206] In 1980, the American Psychiatric Association published its Third Edition of the DSM (DSM-III).[207] But this was no mere update of the venerable book. The DSM-III discarded its Freudian conceptions in favor of the Kraepelin model of symptom clustering.[208] Whereas previous editions had included a "neurosis" category that originated from the precepts of Freud, the DSM-III favored

acquittees have a constitutional right to treatment); O'Connor v. Donaldson, 422 U.S. 563 (1975) (requiring the criteria of mental illness and dangerousness for involuntary commitments); Addington v. Texas, 441 U.S. 418 (1979) (holding that clear and convincing must be the standard of proof for involuntary civil commitments).

203. *See* Mayes & Horwitz, *supra* note 39, at 252-54 (describing the "crisis of legitimacy in psychiatry circa 1970.").

204. *See* ROGER K. BLASHFIELD, THE CLASSIFICATION OF PSYCHOPATHOLOGY: NEO-KRAEPELINIAN AND QUANTITATIVE APPROACHES (1994).

205. Samuel H. Barondes, *The Biological Approach to Psychiatry: History and Prospects*, 10 J. NEUROSCIENCE 1707 (1990) (describing the flaws of Freud's ideas and the rise of biological psychiatry); Wilson M. Compton & Samuel B. Guze, *The Neo-Kraepelinian Revolution in Psychiatric Diagnosis*, 245 EUR. ARCHIVES PSYCHIATRY & CLINICAL NEUROSCIENCE 196 (1995) (describing the ebb and flow of Kraeplin's influence in psychiatry and his principles of diagnostic classification).

206. *See* Rogler, *supra* note 39, at 11 (discussing the problems of psychodynamic formulations that "represented the interposing of unverified assumptions of causality into the diagnostic function" and the "evocative" nature of DSM-I and DSM-II because the definitions contained therein were presented with the assumption of knowledge about them); Mayes & Horwitz, *supra* note 39, at 258-66 (discussing how DSM-III and biological psychiatry was a response to the crisis of legitimacy in psychiatry).

207. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3rd ed. 1980) [hereinafter DSM-III].

208. *Id.*

a multi-tiered "axis" that purportedly grouped various mental disorders according to common symptoms and possibly underlying pathology.[209]

What did not change, however, was its appetite for growth. The DSM-III was almost 500 pages in length with 265 diagnoses – a growth of over fifty percent from the DSM-II.[210] Included in this panoply of disorders was an entire section of "personality disorders" that previously had not enjoyed categorical prominence.[211] Under prior formulations of the DSM, personality was enmeshed within the theoretical framework of neurosis. With the advent of the DSM-III, which claimed not to be associated with any particular theoretical lens,[212] personality disorders were presented as a scientific reality.[213] Moreover, the presence of such personality disorders, like all diagnoses in the DSM, was based upon a dichotomous categorization of present or absent.[214] That is, a person was deemed disordered when they met a core number of symptoms – perhaps 3 out of 5, or 5 out of 7. Thus, diagnosis was based entirely upon behavior – observed and reported – and not on laboratory tests.[215] While the absence of diagnostic tests was nothing new in psychiatry (there still exists no single laboratory test for *any* mental disorder),[216] the absence of a theoretical underpinning for such disorders as "antisocial personality disorder" or "narcissistic personality disorder" begs the

209. *See* Mayes & Horwitz, *supra* note 39, at 261-63 (discussing the deletion of neurosis from the DSM).

210. *Id.* at 251.

211. *See* W. John Livesley et al., *Categorical Distinctions in the Study of Personality Disorder: Implications for Classification*, 103 J. ABNORMAL PSYCHOL. 6, 7; 12-14 (1994).

212. *See* Follette, *supra* note 145, at 1122-23 (discussing the "atheoretical" nature of DSM-III).

213. There has been much discussion regarding the charge that the DSM has "invented" mental disorders without empirical support. *Compare* Jerome C. Wakefield, *The Myth of DSM's Invention of New Categories of Disorder: Houts Diagnostic Discontinuity Thesis Disconfirmed*, 39 BEHAVIOUR RES. & THERAPY 575 (2001) *with* Arthur C. Houts, *The Diagnostic and Statistical Manual's New White Coat and Circularity of Plausible Dysfunctions: Response to Wakefield Part 1*, 39 BEHAVIOUR RES. & THERAPY 575 (2001) *and* Nick Manning, *Psychiatric Diagnosis Under Conditions of Uncertainty: Personality Disorder, Science, and Professional Legitimacy*, 22 SOC. HEALTH & ILLNESS 621 (2000).

214. *See* Thomas A. Widiger, *The DSM-III-R Categorical Personality Disorder Diagnoses: A Critique and an Alternative*, 4 PSYCHOL. INQUIRY 75 (1993) (discussing the categorical nature of diagnosis in the DSM).

215. *See* Office of the Surgeon General, *Mental Health: Report of the Surgeon General*, United States Department of Health and Human Services, *available at* http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2.html (visited Apr. 10, 2006) ("The diagnosis of mental disorders is often believed to be more difficult than diagnosis of somatic, or general medical, disorders, since there is no definitive lesion, laboratory test, or abnormality in brain tissue that can identify the illness. The diagnosis of mental disorders must rest with the patients' reports of the intensity and duration of symptoms, signs from their mental status examination, and clinician observation of their behavior including functional impairment.").

216. *Id.*

question: how are these disorders of personality formulated and what makes them disorders?[217]

Nonetheless, the DSM-III was congruent with biological psychiatry's view of human behavior as a verifiable and empirical enterprise of the brain.[218] It also returned psychiatry to the field of medicine by presupposing that mental disorders were discoverable by the scientific method.[219] And biological psychiatry, aided by the emergence of molecular biology and genetics in the late 1980s and 1990s, delivered results.[220] Soon, scientific journals were inundated with studies reporting variations and abnormalities of various physiological processes in persons with DSM disorders. A common presumption that became doctrine held that *any* physiological abnormality associated with a DSM diagnosis was evidence of the pathological process occurring in the brain. The mantra in science that "correlation does not equate causation" was always proclaimed, but in a scientific world were *everything* is correlation and nothing entirely proven, this cautionary statement meant little.[221]

III. THE MYTH OF MENTAL DISORDER

When Szasz wrote the *Myth of Mental Illness* in 1961 he directly challenged psychiatry's legitimacy during a time when Freudian ideas dominated the understanding of human behavior and there were few biological explanations for abnormal conduct.[222] Much has changed since then, yet Szasz remains steadfast.[223] One striking criticism that

217. *See* Widiger, *supra* note 214, at 76 ("In fact, there was no empirical support for the threshold of 9 of the 11 personality disorders diagnoses. They were based simply on the expert consensus.").

218. *See, e.g.*, Andreasen, *supra* note 89, and accompanying text.

219. For a general overview, see Eric R. Kandel, *A New Intellectual Framework for Psychiatry*, 155 AM. J. PSYCHIATRY 457 (1998).

220. *Id.*

221. Surely this premise is true in all of science insofar as scientific laws are never absolute in that causation is imputed when hypotheses are tested through experiments and reproducible observations are produced repeatedly over time. Then theory becomes scientific law. What is different in psychiatry is that science knows so little about the brain and even less about the mind.

222. *See* Douglas Mossman, *Unbuckling the "Chemical Straitjacket:" The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033, 1047-59 (2002) (reviewing the advances in the biological explanations of mental illnesses).

223. *Compare* Robert Michels, *Szasz Under Fire: The Psychiatric Abolitionist Faces His Critics*, 352 NEW ENG. J. MED. 1273, 1273 (2005) (reviewing Szasz's new book: "[t]his book, some 60 years later, continues that attack [on psychiatry]."), *and* Thomas Szasz, *Psychiatric Fraud and Force: A Critique of E. Fuller Torrey*, 44 J. HUMANISTIC PSYCHOL. 416 (2004) (disputing the biological psychiatry proponents), *with* E. Fuller Torrey, *Psychiatric Fraud and Force: A Reply to Szasz*, 45 J. HUMANISTIC PSYCHOL. 397, 401 (2005) ("[i]n 2004, in light of current research, his

Szasz set forth was the failed attempts to discover physical markers of mental illnesses and what that meant for psychiatry's legitimacy as a science.[224] To Szasz, psychiatry's talk about mental disorders made no sense because psychiatry held the supposition that behaviors were manifestations of the brain, hence, physical enterprises of the brain.[225] If there was such a thing as mental illnesses under this view, then a biological aliment – an identifiable lesion located in the brain – was a necessary component.[226] Yet, science had failed to discover such lesions for most mental illnesses. Moreover, if such a lesion existed, then mental illnesses were in fact physical diseases of the brain, not *mental* disorders of the metaphysical mind. Curiously, those illnesses with known physical lesions or abnormalities that cause psychiatric behavior are rarely treated by psychiatry. Parkinson's disease, Alzheimer's disease, porphyria, endocrine disorders – all are treated by other medical disciplines yet have key psychiatric components. Psychiatry seems to flourish in the domain of presumed biological illnesses that are conceptually tied to behaviors. This rather subjective proposition has lent critics, including Szasz, much fodder over the years, but are they right?

An important question to pose relates to the definition of disease. A common view in science is that a disease relates to a pathological process that in some manner robs an organism of its normal functioning.[227] Thus, one can deduce that the organism in question has the propensity for a healthy state and, if properly treated, will be restored to that normal state. In looking at Blackstone's "madmen"[228] or the "wild beast,"[229] what comes to mind are the psychotic disorders of DSM. That is, those people so afflicted with madness or insanity that their very

unchanging views appear as an anachronism and allow critics to discard his entire corpus of work, much of which is still valuable. An inability to change one's thinking when confronted with markedly changing data is not a virtue.").

224. *See* Thomas Szasz, *What Counts as Disease? The Gold Standard of Disease Versus the Fiat Standard of Diagnosis*, 10 THE INDEP. REV. 325, 327 (2005).

225. *See* Drammann, *supra* note 5, at 736.

226. Szasz, *supra* note 224.

227. Granted, there are many definitions of disease and much controversy surrounding them. *See* Caroline Whitbeck, *Causation in Medicine: The Disease Entity Model*, 44 PHIL. SCI. 619, 622-25 (1977) (reviewing entities [pathogens] as causation of disease). Nonetheless, the notion of pathogen and disease is strongly linked in medical history. *See* Robert Kock, Uber die Atiologie der Tuberkulose, in VERHANDLUNGEN DES KONGRESSES FUR INNERE MEDIZIN (1882) (describing his seminal *Koch Postulates*); *cf. with* STEDMAN'S MEDICAL DICTIONARY 492 (26th ed. 1995) ("Disease: An interruption, cessation, or disorder of body functions, systems, or organs.").

228. *See* Blackstone, *supra* note 22.

229. *See* Rex v. Arnold, 16 How. St. Tr. 695, 764-65 (1724); *supra* note 22, and accompanying text.

personhood is degraded or destroyed. There is no consideration that these people, in their ideal state, would in fact be insane.[230] That is, if properly treated, they would resume their full identity which does not include the pathogenic process. Consequently, their essence as a person exists beyond insanity. Contrast this view with temperament or personality whereby any "illness" or "disorder" is typically viewed as intimately enmeshed with the personhood of the actor.[231] Separating the supposed illness from the person seems difficult if not impossible; the illness is easily subsumed into the personal identity of the afflicted. It may be that such ill-tempered people deserve pity but it is hardly the case that they are viewed as affected by a pathogenic disease process.[232] Yet, in the current DSM, these two groups – the psychotic and the personality defective – are both under the rubric of mental disorder.[233]

What this means of course is that psychiatry has silently enmeshed the two together and engages in a back and forth whereby the psychotic person is considered afflicted with psychosis that is pervasive in their personhood and the personality disordered person is imbued with disease of his temperament. Yet neither is true. Untreated psychosis can surely have enduring and broad effects on a person.[234] Moreover, psychotic disorders like schizophrenia are indeed chronic, life altering illnesses.[235] But any reasonable clinician will tell you that psychosis neither intertwines with personality nor dominates it. That is, a person with schizophrenia retains her personhood after the onset of the illness and between periods when she becomes psychotic. A person who believes, despite compelling evidence to the contrary, that he is the President of the United States and Jesus Christ simultaneously for a few weeks and then rejects that belief after receiving a medicine that is known to affect

230. When I say ideal I mean if it were possible to "cure" or remove entirely the disease. Sadly though, treatment of psychotic illnesses rarely achieves full remission. *See*, Sharma & Antonova, *supra* note, 58.

231. *See, e.g.*, DSM-IV-TR, *supra* note 37, at 685 ("A personality disorder is an enduring pattern of inner experience and behavior.").

232. Not in any traditional sense of causation. Personality and disease may be linked insofar as personality *types* may be associated with *risk* of certain diseases, but there is no creditable evidence that personality disorders themselves are *caused* by pathogens. *See generally* HOWARD S. FRIEDMAN, PERSONALITY AND DISEASE (1990).

233. *See* DSM-IV-TR, *supra* note 37.

234. *See* Srinivasan T. Tirupati et al., *Psychopathology in Never-Treated Schizophrenia*, 47 COMPREHENSIVE PSYCHIATRY 1 (2006) (reporting widespread and disabling psychopathology in an untreated group of subjects with schizophrenia without any history of treatment).

235. *See* DSM-IV-TR, *supra* note 37, at 309 ("Complete remission [of schizophrenia] is probably not common in this disorder."); Kim T Mueser & Susan R. McGurk, *Schizophrenia*, 363 THE LANCET 2063, 2063; 2066 (2004) (reporting lifelong impairment with schizophrenia as one of the world's top ten causes of disability).

the brain, is evidently afflicted with a disease despite an absence of a lesion. It is the profound distortion of reality and its direct response to medication that has a restorative propensity which suggests so. This "obviously mentally ill"[236] person is not engaged in an alternative speculation about the meaning of life when his behaviors fail the test of intentionality[237] so clearly and to his detriment.[238] Couple this with the compelling research that demonstrates multiple and substantial abnormalities in the brains of persons with these illnesses and it becomes apparent that psychoses are brain diseases.[239] Now, returning to Szasz's charge of the mental and physical duality – it seems that the term mental is useful only insofar as it relates to a disturbance of behavior. As Nancy Andreasen points out, separating the mind and brain is only useful in abstract discussion since in reality they cannot be divorced from one another.[240] Therefore, a physical disease can affect the mind, but there will never be any marker for mental phenomena because the markers we are interested in are physical ones. That does not mean, however, that mental illnesses do not exist. What it does mean is that evidence of a disease in the brain is necessary to give legitimacy to any claim of a mental impairment. Moreover, merely finding some brain abnormalities in the brain of a group of subjects is not tantamount to a disease, as is the case in emerging research on psychopathic personality.[241] Simply put, psychiatry needs to clearly state which mental illnesses are likely brain diseases and which are emotional difficulties and discard the disingenuous term of "disorder." It is not

236. *See* Treffert, *supra* note 17.

237. See Bolton, *supra* note 21, at 185-87 for a discussion of intentionality and mental illness. *See supra* note 13 and accompanying text.

238. There is a wealth of research that suggests that schizophrenia is associated with an overall poor life course. *See*, HIRSCH & WEINBERGER, *supra* note 53, at 101-41; Thomas H. Jobe & Martin Harrow, *Long-Term Outcome of Patients with Schizophrenia*, 50 CANADIAN J. PSYCHIATRY 892 (2005) (reporting overall poor outcomes including increased risk of suicide and early death).

239. There have been numerous studies that have documented structural and functional brain abnormalities in schizophrenia and bipolar illness. *See* Pantelis, *supra* note 53; Stephen M. Strakowski, *The Functional Neuroanatomy of Bipolar Disorder: A Review of Neuroimaging Findings*, 10 MOLECULAR PSYCHIATRY 105 (2005); Paul M. Thompson et al., *Mapping Adolescent Brain Change Reveals Dynamic Wave of Accelerated Gray Matter Loss in Very Early-Onset Schizophrenia*, 98 PROC. OF THE NAT'L ACAD. OF SCI.S 11650 (2001).

240. Andreasen, *supra* note 89.

241. For instance, there have been finings that psychopaths have abnormal brain activity. *See* JAMES BLAIR ET AL., THE PSYCHOPATH: EMOTION AND THE BRAIN 81-95 (2005) (reviewing brain-imaging findings in psychopathy). While the evidence is preliminary, there is some evidence suggesting that psychopaths have difficulty in emotion processing and impulsivity. At first blush, I cannot see how this could led to criminal exculpation, *but see* Morse, *supra* note 67, at 264 (discussing the necessity of emotional in moral and legal culpability).

that psychiatry should abandon any efforts to understand or even treat emotional difficulties, but claiming that "antisocial personality disorder"[242] and schizophrenia[243] are both "mental disorders" appears faulty and disingenuous.

But does any of this matter? It does in terms of giving psychiatric illnesses like schizophrenia their due recognition by medicine, philosophers, and the politicians.[244] It also matters in terms of correcting the popular misconceptions about psychiatric illness and behavior.[245] Our culture has unconsciously assumed that many behaviors are *caused* by something awry in the brain. This has led many into the belief that they are hopeless to overcome their biological propensities without the aid of professional mental health. But also it matters to the law; or to put it differently, it matters if one wants to prevent the perversion that science and law can visit upon each other. The sections below will hopefully demonstrate that vice.

A. Disorder By Any Other Name

The Fourth Edition of the DSM (DSM-IV)[246] in 1994 and its "text revision" in 2000 (DSM-IV-TR),[247] the current version, continued the new descriptive approach embraced by DSM-III. Presently, the DSM contains 297 diagnoses in 886 pages.[248] Thus, in the forty-two short years since its inception, the DSM diagnoses have ballooned by almost 300% and the book itself has increased by 800% in length. More importantly, however, is that the core mental illnesses that concerned Benjamin Rush's seminal treatise – the severe mental illnesses: schizophrenia and manic-depression – are essentially the same.[249] What

242. DSM-IV-TR, *supra* note 37, at 701.

243. *Id.* at 298.

244. There has been much written on whether mental health parity laws should be passed. Much of this issue hinges on whether mental illnesses are construed on par with physical diseases. *See generally* John K. Iglehart, *The Mental Health Maze and the Call for Transformation*, 350 NEW ENG. J. MED. 507 (2004).

245. This can be seen mostly prominently in how our culture (aided by science) views addiction and sexual paraphilias. See, e.g., Molly M. Warthan, Tatsuo Uchida, & Richard F. Wagner, *UV Light Tanning as a Type of Substance-Related Disorder*, 141 ARCHIVES DERMATOLOGY 963 (2005); Lynne Lamberg, *Researchers Seek Roots of Pedophilia*, 294 J. AM. MED. ASS'N 546, 547 (2005) (describing research examining similarities between heroin addiction and pedophilia).

246. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994) [hereinafter DSM-IV].

247. DSM-IV-TR, *supra* note 37.

248. Mayes & Horwitz, *supra* note 39, at 251.

249. *See* Compton, *supra* note 205, at 197-98.

has changed is the veritable explosion of disorders that have little connection with disease as traditionally understood or are not really biological in nature. In the present DSM there are a total of nine psychotic disorders. Psychosis includes mental illnesses whereby a person loses contact with reality and often experiences periods of hallucinations and delusions.[250] Schizophrenia is the most common psychotic disorder with a prevalence rate in the United States of about one percent of the general population.[251] Compare this with the seventeen listed sexual disorders,[252] which as discussed previously, have undergone a turbulent past. Included in this vast array of sexual disorders are: Exhibitionism, Pedophilia, Transvestic Fetishism, Gender Identity Disorder,[253] and Sexual Sadism among others. These disorders exist despite little to no empirical evidence of any underlying disease process that could account for their existence.[254] Pedophilia, an immoral act, is a mental disorder not because of some mental degeneration of the brain but because such behavior is socially construed to be a process of a sick mind.[255] Thus, it is a modern incantation of Pritchard's moral insanity without the presumption of lack of self-governance (or negation of *mens rea* I suppose).[256] One can surmise that in spite of biological psychiatry's force during the past twenty-five years, sex and mental capacity are forever entwined.

And what about the numerous personality disorders? The DSM-III created an entirely new section for personality disorders that had not been included in previous editions. Personality disorders are generally pervasive and insidious flaws of what has historically been conceived of as temperament, habit, or breeding. Thus, the current edition of DSM contains a diagnosis of "antisocial personality disorder"[257] that

250. *See* HAROLD I. KAPLAN & BENJAMIN J. SADOCK, KAPLAN AND SADOCK'S SYNOPSIS OF PSYCHIATRY: BEHAVIORAL SCIENCES, CLINICAL PSYCHIATRY 492 (1998).

251. *See* DSM-IV *supra* note 246.

252. Kaplan, *supra* note 250, at 539-82.

253. There is much scientific and political debate about the biological role of gender. Despite the paucity of definitive science on the matter, some view gender as a personal choice while the DSM says that it can be a mental disorder. *Compare* DSM-IV-TR, *supra* note 37, at 576 *with* Patricia L. Brown, *Supporting Boys or Girls When the Line Isn't Clear*, N. Y. TIMES, Dec. 2, 2006, at A1.

254. A cross-search in the PSYCHINFO database of the terms "pedophilia" and "biology" resulted in only four hits, none of which suggest a biological explanation; likewise, "neurobiology" and "paraphilias" produced seven with no biological explanations. American Psychological Association, APA PsycNET, http://psycnet.apa.org/ (last visited: Apr. 10, 2006).

255. *See generally* Richard Green, *Is Pedophilia a Mental Disorder?*, 31 ARCHIVES SEXUAL BEHAV. 467 (2002).

256. *See* PRICHARD, *supra* note 98.

257. DSM-IV-TR, *supra* note 37, at 701-06.

essentially defines a habitual rule-breaker as "mentally disordered" and presumably in need of psychiatric treatment (despite their being little, if any, successful treatment available).[258] While personality features were considered relevant to pre-DSM-III clinicians, their elevation as a separate category of illness represented a "medicalization" of behavior that was previously considered inseparable from personal identity.[259] This seemingly slight change has a profound premise and conclusion. If one's predilection for asocial behavior is a mental disorder rather than the outcome of personal choice, then questions surrounding legal and social culpability are prominently introduced into the mix, but in a manner that is foreign to traditional criminal law. The asocial behavior centers not on choice of the free agent who presumably could have been dissuaded by the deterrent effects of criminal sanctions. Rather, the behavior is indicative of a diseased mind that requires a plethora of mental health interventions. The agent, moreover, is presumed to lack robust responsiveness to traditional criminal sanctions including deterrence and retribution, leaving only incapacitation. While many scholars condemn retribution as an outmoded and harsh method of criminal justice, the de facto imprisonment of sex offenders under the numerous sexually violent predator statutes is accomplished under the incapacitation rubric. But calculated incapacitation is a sword that cuts both ways. Incapacitation removes the moral condemnation in place of a diseased model, and hence, the proportionality of punishment is also replaced by a public safety model. Of course, the question then becomes, would a sex offender ever be deemed safe enough for release into the community? In this way, the transformation of immoral conduct into diseased behavior becomes dangerous since the morality of just punishment is silently removed in favor of a purely risk assessment process. Yet as many scholars have demonstrated, humans are very poor at judging risk.[260]

This is not to suggest that those who habitually engage in one behavior over another cannot gain insight from psychotherapy or that undesirable behavior is incapable of being changed through mental

258. *See* William H. Reid & Carl Gacono, *Treatment of Antisocial Personality, Psychopathy, and other Characterological Antisocial Syndromes*, 18 BEHAV. SCI. & L. 647, 658 (2000) (concluding "[n]o traditional voluntary or inpatient milieu has been shown to be effective, and there is no individual or group psychotherapy that is routinely associated with success.").

259. *See generally* JOHN LOCKE, AN ESSAY CONCERNING HUMAN UNDERSTANDING (1689) (discussing personal identity and consciousness).

260. *See* W. KIP VISCUSI, SMOKE-FILLED ROOMS: A POSTMORTEM ON THE TOBACCO DEAL 136-75 (2002).

health programs.[261] Rather, it is the crossing of the important but nebulous line between medical illness and personal identity that is troublesome. By calling personality flaws illnesses, the role of personal choice and moral accountability are undermined. Furthermore, in areas where science has not shown there to be any disease process causing the behavior, questions of normality become entirely socially constructed, and hence, venerable to manipulation by the politically powerful. The term disorder is inherently meaningless since it has no scientific grounding. Thus, psychiatry is free to subsume more behaviors under this confutable classification scheme which engenders the profession more power in culture and law. The proliferation of mental disorders is an accretion of power with valence in every domain of life. Under the nosology of mental disorder, there is little that cannot be deemed a psychiatric condition.

Life is full of problems. This is a truism of all people from all generations. In dealing with emotional problems or brain diseases it is helpful to understand the problems that influence a person's suffering. However, the DSM interjects a number of disorders or descriptors that are neither illnesses nor sicknesses. Illicit drug abuse is a horrendous social and political problem that destroys many families, neighborhoods, and a good deal of many fine people. Taking drugs like cocaine undoubtedly changes the physiology of the brain,[262] yet there is no disease because there is no pathogen. The drug itself cannot be the pathogen because it is not a reproducing organism such as a virus or bacteria. An animal that voluntarily and knowing ingests a drug that will harm itself cannot be suffering from a disease unless we are willing to claim that ill-advised, intentional behavior is the product of disease. A brain disease is so because of a presumed pathogenic process harmonious with established laws of science.[263] Irrespective of whether such pathology is definitively identified, it leaves in its wake immutable signs of its presence, none of which includes a conscious undertaking by the host to induce more pathology.

Likewise, when the DSM identifies numerous medical conditions under its purview that only tangentially relate to the brain, the questions

261. Indeed, I believe as a psychologist myself that many of life's problems can be helped through psychotherapy. But it is one think to say that one's problems or penchants could benefit from therapy and quite another to say or imply that they are mental diseases.

262. *See generally* B. Jill Venton et. al., *Cocaine Increases Dopamine Release by Mobilization of Synapsin-Dependant Reverse Pool*, 26 THE J. NEUROSCIENCE 3206 (2006).

263. *See generally* Koch, *supra* note 227; Sally Satel & Scott Lilienfeld, *Medical Misnomer: Addiction Isn't A Brain Disease*, SLATE, July 25, 2007, http://www.slate.com/id/2171131/.

begs: what purpose does this serve? Thus, the "mental disorder" of "Breathing-Related Sleep Disorder"[264] (otherwise known as sleep apnea) or "Sexual Dysfunction Due to a Medical Condition"[265] are illegitimate to psychiatry not because they are inconsequential to the emotions or functioning of a person, but because they are neither brain diseases nor principally curative under psychiatric practice.[266] Similarly, "Hypoactive Sexual Desire Disorder"[267] is fraudulent because by failing to identify its medical origin, psychiatry inculcates a mental singularity when in fact it is apt to be entirely biological. Such methods serve only to confabulate sickness with mental phenomena by placing life's problems and aspects of medical diseases into a fictional mental domain that ostensibly is the exclusive authority of psychiatry.

B. A Road to Perdition

As is probably clear in this Article, Freud's influence in psychiatry and its classification of mental illnesses had many profound effects during the 1940s through the 1970s. As was discussed in Part I and Part II, what was curious and disturbing was that Freud's ideas were largely theoretical in a field that represented itself as science. As such, psychiatric thought was asserted instead of proven. Nonetheless, there is something to be said about a theoretical outlook on behavior. When the DSM-III was published, there was much outcry from the psychoanalysts who contested the deletion of "neurosis" from the diagnostic manual.[268] The DSM-II was essentially divided between psychotic illnesses and the neuroses.[269] Neurosis was conceived by Freud and psychoanalysts as an imbalance in the mind due to the conflict between the id and superego that the ego tried to resolve through various defense mechanisms, but wherein rational thought was preserved.[270] There are many problems with this notion of mind, the first of which is that who is to say that there is anything such as the id, ego, or superego? Notwithstanding, the benefit of this view in the DSM-II was a sense that not all mental

264. DSM-IV-TR, *supra* note 37, at 622.

265. DSM-IV-TR, *supra* note 37, at 558-61.

266. For instance, a pituitary adenoma could produce sexual dysfunction, but psychiatrists do not treat this illness, endocrinologists do. *See* EUGENE BRAUNWALD ET AL., HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 2033 (15th ed. 2001).

267. DSM-IV-TR, *supra* note 37, at 539.

268. *See* Ronald Bayer & Robert L. Spitzer, *Neurosis, Psychodynamics, and DSM-III. A History of Controversy*, 42 ARCHIVES GEN. PSYCHIATRY 187 (1985).

269. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS (2nd ed. 1968).

270. *See* SIGMUND FREUD, THE EGO AND THE ID 9 (1923).

problems were the same. That is, there were the psychoses which were thought of as severe breaks of the mind from reality and then there were the neuroses which were, in many ways, life's problems. Thus, it was a common view among the Freudians that all people encountered neurosis sometime in their lives and that part of life's work was to toil through them.[271] In departing from this idea, the DSM-III essentially transformed all behaviors in the diagnostic manual into illnesses. In so doing, they not only changed social perception of personality flaws from difficulties to illness, but also changed how institutions used these epistemological views.

It has often been said that what makes law different is the force of law.[272] Law is in a unique position to back up its assertions with sanctions. Thus, when the law borrows ideas from other disciplines, it has the capability to enforce those ideas throughout society. Moreover, law does not necessarily need to follow a pursuit of truth in the same manner that science does. In that vein, law has more to do with politics and seeking those ends than with conceptual validity. That is, justice is determined by what political actors decree it is, not by some lofty quest to resolve theory and practice. In terms of behavior, the expansion of "madness"[273] into the pantheon of the current DSM has epitomized this danger of the interplay between law and psychiatry.

As an illustrative example, take the antisocial personality disorder. In *Foucha v. Louisiana*,[274] the United States Supreme Court held that the state could not involuntarily hold a psychiatric patient adjudicated not guilty by reason of insanity (NGRI) who no longer is suffering from a mental illness. Mr. Foucha's retention was sought because although he was no longer psychotic, his future dangerousness was uncertain because of his antisocial traits. The Court held that such detention was unlawful because Foucha was no longer mentally ill and dangerous.[275] Citing its decision in *O'Connor v. Donaldson*,[276] the Court noted that mental illness is required for involuntary psychiatric commitment.[277] Since Foucha's antisocial traits were not an official diagnosis, his detention was predicated on possible future dangerousness.[278] In contrast, in *U.S.*

271. *See* OTTO FENICHEL, THE PSYCHOANALYTICAL THEORY OF NEUROSIS (1999).
272. *See* MAX WEBER, POLITICS AS A VOCATION (1919).
273. *See* Blackstone, *supra* note 22, and accompanying text.
274. Foucha v. Louisiana, 504 U.S. 71, 77 (1992).
275. *Id.*
276. O'Connor v. Donaldson, 422 U.S. 563 (1975).
277. *Foucha*, 504 U.S. at 77.
278. *Id.* at 78.

v. Jackson,[279] the Fifth Circuit held it permissible to continue the commitment of an NGRI whose schizophrenia was in remission because his *diagnosed* Antisocial Personality Disorder rendered him dangerous.[280] Likewise, in a North Carolina case, the Court of Appeals for Northern Carolina upheld the continued confinement of an NGRI patient with a history of a brief psychotic episode, substance abuse, and antisocial "traits."[281] Drawing upon the inclusion of personality disorders in the Diagnostic and Statistical Manual of Mental Disorders as well as expert testimony that such disorders are lifelong afflictions, the Court held that the defendant was mentally ill and dangerous within the ambit of the statute.[282] And there is, of course, the well-known *Kansas v. Hendricks*[283] case whereby the United States Supreme Court held that there was no violation of Hendricks's Constitutional rights when Kansas committed him for psychiatric treatment for pedophilia after his serving his criminal sentence. What can we deduce from these apparently incongruous results? Much has been written about the *Hendricks* case and I will not delve into the many legal controversies surrounding that case in this article. What I think is relevant, though, for this article is that while many mental health professionals have decried the *Hendricks* case, it was inevitable because the legacy of the DSM and psychiatry has been to subsume more and more behaviors under the broad rubric of "mental disorder." It is true that sexual psychopaths have routinely been civilly committed in the country,[284] but in an age of biological psychiatry the inclusion of pedophilia or the myriad of other "disorders" that have absolutely no foundation in a biologically-rooted, disease model discipline is a road that invites treachery. The law should not so blatantly abuse science to achieve politically desired, albeit understandable, results (in this case lifelong incapacitation). Likewise, psychiatry should not engage in such falsehoods as much of the DSM does.

279. U.S. v. Jackson, 19 F.3d 1003 (5th Cir. 1994).

280. *Id.* at 1007 (upholding the district court's finding of dangerousness "because the evidence shows that his current dangerousness stems from an antisocial personality rather than schizophrenia and that he can be held legally only if his violent behavior is 'due to a present mental disease or defect'.").

281. *In re* Hayes, 532 S.E.2d 553 (2000).

282. "[A]ssuming arguendo that Hayes is neither psychotic nor drug or alcohol dependent, he may still be found 'mentally ill' by virtue of having been diagnosed with a personality disorder." *Id.* at 558.

283. Kansas v. Hendricks, 521 U.S. 346, 372 (1997) (Kennedy, J., concurring).

284. *See* Edwin H. Sutherland, *The Sexual Psychopath Laws*, 40 J. CRIM. L. & CRIMINOLOGY 543 (1950).

IV. CONCLUSION: REFORM AND INSTITUTIONAL INERTIA

As I have presented, there is much to be concerned about the road that psychiatry is on. This is no mere intellectual debate for mental health professionals since how behavior is explained and excused has profound social and legal consequences. Herbert Fingarette's prescient conclusion in his Yale Law Journal article thirty years ago that legal conclusions regarding behavior are quite apart from social or humane ones was an astute observation.[285] The reform that the DSM needs must begin with an honest self-evaluation by psychiatry. If it is a science, then it must embrace the scientific principles and *diagnose* illnesses by virtue of their characteristics as disease. While it is an axiom that behavior and mental illness are different than say, cancer, insofar as it deals with the realm of the mind, Szasz and others are disingenuous when they suggest that mental illness is a myth because the mental and physical are patently different entities. Much folly can come of going down such a road – namely, who am I? A mind or brain that types these letters on this page? This is a solipsist fallacy that never ends. There are indeed many mental illnesses and while the science may leave us disappointed, the exercise of any scientific exploration is the gathering of evidence and deducing a conclusion. I think that for "madness" as Blackstone viewed it, the evidence is sufficient.

Science survives socially by its legitimacy, much like all social institutions. As such, if the aim of psychiatry is the benefice of people with mental illnesses, it behooves the discipline to wisely consider how history will account of it. Mental disorder is a myth because it is nescient – a term ripe for manipulation and diminutive of science. But since this term provides a tacit method of expanding its influence as the arbiters of behavior, I fear it will survive. In many ways, however, psychiatry cannot be blamed. In attempting to understand the metaphysical mind, psychiatry is not like physics, chemistry, or even law. That is, it cannot operate solely in the physical world, since the ultimate objective is an understanding of the human experience. Likewise, as a scientific endeavor, it operates in a political world that vigorously resists evidence that challenges the orthodoxy. Law is an orthodoxy that demands explanations which conform to its ontological view, and there are few institutions more powerful than law. Consequently, psychiatry is left with the dubious task of adapting its understanding of behavior to a culture and institution that demands

285. *See* Fingarette, *supra* note 197, at 443-44.

acceptance of its ideological framework. Humility, as the founder of psychiatry Benjamin Rush opined nearly 200 years ago, is the first and last step in understanding the astonishing operations of the mind.