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Bad Science Makes Bad Law: How the Deference Afforded to Psychiatry Undermines Civil Liberties

Samantha Godwin*

ABSTRACT

Courts and lawmakers trust psychiatric expertise when making judicial and public policy decisions concerning mental health, but is this trust well placed? This paper adopts a philosophy of science approach informed by medical research to evaluate the validity of psychiatric classification. This approach provides the basis for an interdisciplinary critical analysis of civil commitment law and use of psychiatric expert witnesses in light of legal evidence standards. This analysis demonstrates that involuntary civil commitment as it now stands is incompatible with broader due process and civil rights concerns and affords an unjustifiable evidentiary status to psychiatric diagnosis.

I. INTRODUCTION

This paper considers psychiatric diagnoses, the psychiatric profession, and the roles they play in the legal system. Judges and juries rely on psychiatric expert testimony to provide factual information when cases deal

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with mental health.[1] Legislators draft civil commitment statutes with the understanding that mental illness is a material phenomenon that actually exists in the world and not only in the beliefs of psychiatrists and the public.

In the first part of this article, I challenge the assumption that psychiatry provides reliable and scientific facts by demonstrating that the evidence available to psychiatrists is typically insufficient to support many of the claims they make about mental illness. In summary, psychiatry lacks reliability as a science because psychiatry's methodological approach to its own diagnostic criteria is not empirically meaningful; it categorizes mental illness in an arbitrary rather than scientifically valid way; and its theories are frequently unfalsifiable.

Having built a theoretical case against the scientific reliability of psychiatric diagnoses, in the second part of this paper, I critique courts' reliance on psychiatrists and psychiatry in establishing the facts of cases dealing with mental health. First, I demonstrate the jurisprudential inconsistency of granting psychiatric expert witnesses and diagnoses evidentiary status. Second, I critically evaluate the legal and philosophical bases for the involuntary civil commitment system through a close analysis of key case history in light of the problems with psychiatric evidence. In conclusion, I argue for radical reforms in mental health law that preserve constitutional guarantees of due process, rather than allow courts to be wowed by the pseudoscience of psychiatry.

II. PART ONE: PSYCHIATRY IS INSUFFICIENTLY SCIENTIFIC

> The confusion and barrenness of psychology is not to be explained by calling it a "young science"; its state is not comparable with that of physics, for instance, in its beginnings. . . . [I]n psychology, there are experimental methods and *conceptual confusion*. . . . The existence of the experimental method makes us think we have the

[1] For an example of the role of psychiatric expert testimony in civil commitment proceedings, see Debra T. Landis, Annotation, *Modern Status as to Standard of Proof Required in Civil Commitment*, 97 A.L.R.3d 780 (1980).

> means of solving the problems which trouble us; though the problem and method pass one another by.[2]

In any science, one of the fundamental questions of method is how scientists arrive at their theoretical conclusions from the observable data they have to work with. Such questions might include whether the conclusions are logically inferred from the data, whether the veracity of the theory depends only on the accuracy of the data, or whether the alternative hypotheses fit the data with equal logical plausibility.

When considering these questions as they apply to psychotherapy, it is necessary to consider the scope of the claims being made and the scope of the data being used. The data psychiatrists work with is very limited. Authoritative research has not conclusively demonstrated any specific biological causes for mental disorders. Furthermore, there are no biological markers for mental disorders, nor are there any laboratory tests to diagnoses mental illness.[3] Psychotherapeutic treatments, such as psychoanalysis and

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[2] LUDWIG WITTGENSTEIN, PHILOSOPHICAL INVESTIGATIONS 232 (G.E.M. Anscombe trans., Blackwell Publishers 2d ed. 1997).

[3] *See* U.S. CONG. OFF. OF TECH. ASSESSMENT, OTA-BA-538, THE BIOLOGY OF MENTAL DISORDERS 13–14 (1992), *available at* http://www.fas.org/ota/reports/9237.pdf [hereinafter OFF. OF TECH. ASSESSMENT] "Many questions remain about the biology of mental disorders. In fact, research has yet to identify specific biological causes for any of these disorders." *Id.* at 13–14. "Mental disorders are classified on the basis of symptoms because there are as yet no biological markers or laboratory tests for them. Such groupings, therefore, may not be completely valid—similar symptoms may result from a variety of causes." *Id.* at 46–47. Psychiatrist Allen Frances, chair of the APA DSM-IV Task Force and Professor Emeritus at Duke University, describes the issue as follows:

> Simply stated, descriptive psychiatric diagnosis does not now need and cannot support a paradigm shift. There can be no dramatic improvements in psychiatric diagnosis until we make a fundamental leap in our understanding of what causes mental disorders. The incredible recent advances in neuroscience, molecular biology, and brain imaging that have taught us so much about normal brain functioning *are still not relevant to the clinical practicalities of everyday psychiatric diagnosis.* The clearest evidence supporting this disappointing fact is that *not even 1 biological test is ready for inclusion in the criteria sets for DSM-V.* Fortunately, the NIMH is now embarked on a fascinating effort to effect the real paradigm shift of basing

psychopharmacological drugs, often appear to provide relief from disturbing psychological phenomena. However, the mechanism by which psychotherapeutic treatments result in symptom relief cannot be examined. That is, the relationship between the therapies and the symptom's underlying etiology is unobservable.[4]

The central issue is the extent to which the observable data of symptom relief provide verification for theories concerning the unobservable causes of those symptoms. To use an analogy, it is a little like the experience of smacking the side of a television to fix a fuzzy picture: if you know how to fix something, but you are not able to conclusively determine how you got it to work, then knowing how to fix it provides only a limited insight into why it broke.

There is an epistemological dilemma posed by the gap between the subject matter investigated by psychotherapists and observable psychological phenomena. Clinical psychologists and psychiatrists have developed elaborate theories to explain the behavior of individual patients and categories of patients, but their principal method of testing those theories experimentally is by way of psychiatrists' and psychotherapists'

> diagnosis on biological findings. Unfortunately, this is years (if not decades) from fruition.

Allen Frances, *A Warning Sign on the Road to DSM-V: Beware of its Unintended Consequences,* PSYCHIATRIC TIMES, Aug. 2009, at 1, 4 (emphasis added). Professor Frances went on to explain that psychiatric diagnosis is currently "stuck at [a] descriptive level" without a "fundamental and explanatory understanding of causality." *Id*.

[4] *E.g.,* ELLIOT S. VALENSTEIN, BLAMING THE BRAIN 96 (1996).

> The explanations of how psychotherapeutic drugs help to alleviate mental disorders rarely go beyond stating what chemical changes the drugs induce. The psychiatric literature rarely address how or why an excess or deficiency in serotonin or dopamine activity explains any particular mental disorder. There are few serious attempts to bridge the huge gap between neurochemistry and the psychological phenomena that must ultimately be explained.

Id.

abilities to alter the behavior or experience through treatment.[5] Although it is often claimed that the manner in which the symptoms respond to treatment, whether through drugs or psychoanalysis, is heuristically meaningful to the cause of the symptoms,[6] this can only be plausible if one accepts the initial premise that the treatment works in the way the psychologist or psychiatrist believes it works.

The types of tests that clinical psychological hypotheses rely on are methodologically circular because they require that data be interpreted according to assumptions that hold true only if the hypothesis is, in fact, correct.

Therefore, these hypotheses cannot be verified empirically, because the probative value of the evidence offered in their support depends on the truth of the hypotheses being tested. The scientific status of all hypotheses of this sort is questionable regardless of the volume of data collected to support them. While physicians confirmed to a very high degree of probability a hypothesis that syphilis can cause dementia[7] by confirming syphilis in blood samples and charting its progression through physical observation, psychiatrists do not employ similar methods. As will be discussed more fully in Part One, specific "mental illnesses," by contrast to known neurological diseases, cannot be confirmed with similar scientifically meaningful measurements. Although it is true that verification of medical hypotheses can only be certain to an unknown degree of probability, data

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[5] For a discussion of experimental testing of theories with regard to depression, see *e.g.,* Jeffrey R. Lacasse & Jonathan Leo, *Serotonin and Depression: A Disconnect between the Advertisement and the Scientific Literature*, 2 PLOS MED. 1211, 1211–15 (2005); Jonathan Leo & Jeffrey R. Lacasse, *The Media and the Chemical Imbalance Theory of Depression*, SOC'Y, Nov. 2008, at 35–45.

[6] *See* Lacasse & Leo, *supra* note 5, at 35.

[7] This example was suggested by Heathcote Wales, Professor of Law at Georgetown University Law Center, in comments made on an earlier draft of this paper. For a description of dementia as a symptom of syphilis, see *Neurosyphilis*, PUBMED HEALTH, http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001722/ (last reviewed Sept. 15, 2010).

mobilized in support of psychiatric hypotheses cannot even achieve this. Provided one controls for confounding variables, coincidence, and reverse causation, the greater the percentage of dementia patients whose blood samples test positive for syphilis compared to a control group, the more likely syphilis is to be a possible cause of dementia. There is no equivalent in psychiatry. No matter how large a sample of delusional patients one has, this will never provide evidence that schizophrenia causes delusions because the presence of schizophrenia cannot be confirmed except through reference to the delusions and other symptoms themselves. For example, there are no physically based diagnostic tests for schizophrenia, it is only inferred from characteristics psychiatrists assume to be its symptoms.[8] This will be explored more thoroughly in Part One.

A. General Epistemological Problems for Theories of Mental Illness

1. Adolf Grünbaum's Critique of Psychoanalytic Therapy

Adolf Grünbaum, a leading philosopher of science at the University of Pittsburg who studied psychoanalysis's epistemological liabilities, offered one of the major critiques of psychoanalysis to come out of the analytic philosophy of science. In this section, I expand upon his critique in order to demonstrate how it could apply equally to psychiatry. In this way, I propose that the epistemological liabilities of psychoanalysis are not unique to psychoanalysis but are also found, in a form, in psychiatry, and therefore psychiatry's claims to scientific validity must also be treated with great skepticism.

Grünbaum recognized a source of epistemological problems in psychoanalysis: the psychoanalysts' preferred means for verifying psychoanalytic hypotheses are found within the discipline and the theory

[8] Albana M. Dassori, Alexander L. Miller & Delia Saldana, *Schizophrenia Among Hispanics: Epidemiology, Phenomenology, Course, and Outcome*, 21 SCHIZOPHRENIA BULL. 303, 304 (1995) ("There was (and is) no test for schizophrenia that is independent of the phenomenological criteria.").

itself.[9] Grünbaum wrote that "we have been told that the validation or discreditation of psychoanalytic hypotheses is vouchsafed by the *investigatory value* of the particular clinical techniques employed in the psychoanalytic interview"[10] and cites Paul Meehl, former president of the American Psychological Association, as stating that "the best place to study [i.e., test] psychoanalysis is the psychoanalytic session itself."[11] Attempts to prove the validity of the psychoanalytic method by appeal to that method itself assumes the reliability of the method that one is trying to evaluate. This does not amount to a meaningful evaluation.

Freud tried to address this concern by offering what Grünbaum termed the "Necessary Condition Thesis."[12] Grünbaum summarized the thesis as: "Only psychoanalytic interpretations that 'tally with what is real' in the patient can mediate veridical insight, and such insight, in turn, is causally necessary for the successful alleviation of his neurosis."[13] This thesis can be seen to suffer from the same circularity that is found in Meehl's claim.

One of Grünbaum's most effective refutations of the Necessary Condition Thesis is that the therapeutic effect of psychoanalysis could just as plausibly be attributed to a placebo effect rather than showing any relation between the psychoanalysis and what is real in the patient.[14]

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[9] *See* Adolf Grünbaum, *Epistemological Liabilities of the Clinical Appraisal of Psychoanalytic Theory*, 14 NOÛS 307, 375 (1980) [hereinafter *Epistemological Liabilities*].
[10] *Id.* at 310.
[11] *Id*. at 375.
[12] *Id.* at 321.
[13] *Id*.
[14] *See generally id*. Of course, psychoanalysts are not the only people who try to improve the mental well being of others. Grünbaum drew a parallel with evangelical Christians who use suggestion to produce profound personality changes in people who are "born again" in their religious faith. *See id.* at 308. One might presume that evangelicals likely use their own version of the "Necessary Condition Thesis," believing that they could not have had those transformative religious experiences except as a result of a "personal relationship" with their God. *See id.* at 321. The positive transformation could therefore seem to verify the "truth" of their religion, but only for people who accept that this is in fact the mechanism responsible for the transformation. *See id.*

Analytically, there is no clear way to know which of the explanations, true insight or placebo, would be more correct.[15] Even if we could imagine a controlled experiment where the efficacy of a group of psychoanalysts was compared to the efficacy of a group of untrained people attempting talk therapy—if the psychoanalysts had superior results, this would not confirm that the superior results were a result of true insight and not some other difference in technique.[16]

While Grünbaum's target was specifically psychoanalysis, his thesis is indicative of a more general epistemological problem for theories informing psychotherapy and the treatments, classifications, and etiologies of mental disorders.

2. Could Theoretical Explanations for a Patient's Mental State Be Verified Externally?

It might be possible to consider a thought experiment to exclude placebo effects. Imagine that a psychoanalyst offers a patient two sets of explanations for the patient's psychological issues: a first "control" explanation that seems plausible but does not represent the genuine analysis and a second "test" explanation informed by the actual analysis of the origin of the patient's condition. Even if the patient was to respond more positively to the test explanation than to the control explanation, the experiment would only provide evidence against a *random* placebo effect, not evidence in favor of the psychoanalyst's test explanation. The patient may have reasons for wanting to believe the second explanation regardless of whether it is accurate. For example, simply providing a plausible narrative to frame a problem could provide relief. Or, a patient might find a therapist's explanation sympathetic, and the experience of sympathy could have a therapeutic effect. Because we cannot observe what mechanism in the patient's mind provided relief, and there are many plausible

[15] *See generally id.* (discussing the epistemological limitation of psychoanalysis).
[16] *See generally id.*

mechanisms, the external response cannot constitute positive evidence of any one of them.[17]

We could also assume that some hypotheses to explain a particular patient's behavior might be ruled out by evidence external to the patient, so that there might be at least, in theory, a way to show that some psychiatric theories are more plausible than others. The ability to rule out some explanations does not, in and of itself, justify believing explanations that have yet to be ruled out. For example, consider a therapist who theorizes that her patient's phobia is caused by either event A or event B. If, in reality, the patient did experience event A but not event B, then a theory contingent on event B can be ruled out. This does not mean, however, that the fact that event A occurred provides evidence that event A caused the patient's phobia. The only reason to believe that event A is the cause of phobia is the theory itself, so it is circular to say that the fact of event A supports the therapist's theory. Whether event A is viewed as necessary, contributory, or coincidental to phobia depends not on the presence or absence of event A, but whether one considers event A as meaningful to understanding the phobia. The fact that event A happened has only evidentiary value to the hypothesis that event A caused the phobia if the fact is interpreted with the assumption the hypothesis is true. So, while external facts about a patient may be sufficient to determine that some hypotheses are false, they are not sufficient to show that other hypotheses are likely true.

If there was a large enough sample of patients with the same phobia, and enough of them experienced event A, it might be possible to build a case that event A could probably contribute to that type of phobia using an experimental methodology to minimize confounding variables. This would still, however, be insufficient to determine whether event A was a cause for the phobia in any individual patient since individual patients' particular

[17] However, it might be possible to rule some out.

phobias could have causes: statistically demonstrating that a certain variable probably causes a certain effect (absent unknown confounding variables) does not demonstrate that other variables would not also cause this effect in any given case. It also could not confirm any theory of *how* event A is responsible for phobias. More significantly for psychiatry, however, attributing "mental illnesses" themselves as causes for patient symptoms could not be similarly evidenced by observation or historical records for the simple reason that "mental illnesses" are defined by the symptoms themselves.[18]

The disease or organic model of psychiatric mental illness might superficially appear to be more scientific than Freudian psychoanalytic claims, since psychiatry more uniformly positions itself as a medical discipline. However, this treatment model similarly posits theories of mental disturbances on an evidentiary basis dependent on assumptions contained within the hypothesis being tested: the treatment effects of psychiatric interventions on patient behavior only contribute evidence to support a proposed etiology if the relationship between cause and effect is in fact as it is according to the etiological theory. This is not a safe inference because the issue in question when diagnosing a patient is precisely what the cause or causes of the complaint or aberrant behavior are. When trying to determine a cause and effect relationship, an alleged effect only has evidentiary status in suggesting the presence of its alleged cause if the relationship between cause and effect accords with the theory. The theoretical framework itself, as will be described in greater detail in the following sections, lacks grounding in empirical observation, unlike other fields in science and medicine. As a result, the symptoms do not, in and of themselves, provide evidence to support the general etiological theory, so hypotheses concerning the causes of mental disturbances in psychiatry

[18] *See* OFF. OF TECH. ASSESSMENT, *supra* note 3, at 46–47.

suffer from similar problems of epistemological circularity as with psychoanalysis.

3. Reliable Inferences About the Cause of a Mental State Cannot Be Made by Altering the Mental State

Mental illnesses are popularly said to be caused by a "chemical imbalance in the brain," which can be corrected by psychoactive drugs.[19] The fact that the psychoactive drugs (sometimes) relieve undesirable symptoms is thought to provide evidence that these imbalances exist to be corrected.[20] Both psychiatrists and laypersons frequently believe that if someone appears to be suffering from some kind of malfunction of the brain and raising the level of a certain chemical in the brain appears to improve its function, this implies that the chemical levels raised were previously deficient, even absent any laboratory tests to determine pre-treatment deficiency.[21] To illustrate why inferences from altering a mental state do not help prove the cause of the original mental state, consider an example from Grünbaum:

> [P]henothiazenes [*sic*] turned out to be capable of inducing the negative side effect of parkinsonism, at least transiently (cf. Balkiston [8]: 1130). But the motor impairment manifested by parkinsonians is attributed to a deficiency of brain dopamine. Hence the unfavorable parkinsonian side effect of the phenothiazene [*sic*] drugs on schizophrenics amid the alleviation of psychotic symptoms produced by them turned out to have *heuristic* value as follows: Besides suggesting that these drugs block the dopamine receptors in the brain, it raised the possibility that an

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[19] The notion that chemical imbalances in the brain are the cause of mental illness is called the "monoaime hypothesis" in the literature. *See* STEPHEN M. STAHL, STAHL'S ESSENTIAL PSYCHOPHARMACOLOGY: NEUROSCIENTIFIC BASIS AND PRACTICAL APPLICATIONS 488–89, 521 (3d ed. 2008). There is no direct evidence of this, and attempts at direct verification of varieties of chemical imbalances in depression have failed and provided some evidence against the hypothesis in its basic form. *See id*.

[20] *See* Lacasse & Leo, *supra* note 5, at 1212.

[21] *See id*.

> excess of dopamine might be implicated in, the aetiology of schizophrenia. In this way, a *biochemical* malfunction of the brain was envisioned quite specifically as causally relevant to this psychosis (cf. Kolata [43a]). [22]

Even if it is assumed that (1) parkinsonism has a single etiology rather than being a symptom with multiple causes, (2) parkinsonism is always caused by dopamine deficiency, and (3) phenothiazine reduces dopamine production or activation, it still would not follow from these three assumptions that there is a logical imperative for believing that phenothiazine reduces psychosis by the same mechanism through which it induces parkinsonism.

Anti-psychotic drugs are known to have diverse side effect profiles.[23] In fact, different anti-psychotic drugs prescribed to treat the same symptoms often result in different side effects.[24] Since these drugs often have more than one neurological effect,[25] the reduction in psychotic symptoms could be attributable to an entirely different neurological mechanism besides dopamine reduction. If phenothiazines exhibit at least two mechanisms, one of which causes a reduction in psychotic symptoms and the other of which induces parkinsonism, then even correctly identifying the cause of the parkinsonism would not shed light on the cause of the reduced psychosis, let alone the cause of the original psychosis. Putting all of those problems aside and, for the sake of evaluating the logic of the claim, adopting the additional assumption that it is in fact a reduction in the effect of dopamine that leads to relief from psychotic symptoms in schizophrenic patients

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[22] Grünbaum, *supra* note 9, at 328.

[23] *See* ROBERT J. WALDINGER, PSYCHIATRY FOR MEDICAL STUDENTS 529 (3d ed. 1997) (arguing that "[a]ll antipsychotics have side effects" and exhibiting a list of side effects). *See also* L. Voruganti et al., *Comparative Evaluation of Conventional and Novel Antipsychotic Drugs with Reference to their Subjective Tolerability, Side-Effect Profile and Impact on Quality of Life*, 43 SCHIZOPHRENIA RES. 135–45 (2000) (comparing and discussing side effects).

[24] *See* Voruganti, *supra* note 23.

[25] *See id*.

treated with phenothiazine, this still would not provide compelling evidence for asserting that schizophrenia is caused by a malfunction of the brain leading to excess dopamine. To assert such a claim would require knowledge of the specifics of the state of a schizophrenic's brain prior to phenothiazine treatment. This is because the treatment only loosely suggests information about the brain in an altered post-phenothiazine administration state, and it is the prior state that is the subject of the theory.

Attempting to infer causation from correlation produces "third variable problems" throughout medicine and science.[26] In other scientific fields, there are strategies to increase the probability of a causal relation, such as randomizing "controlled" variables to prevent a systematic relation between the controlled variable and the independent variable being tested.[27] Psychiatric causal theories, however, would resist these approaches for a simple reason: it is only possible to reliably control for third variables when the variables are known.[28] When it comes to the question of how mental states are formed, the variables are largely unknown.[29] Not only do we not know all of the factors that might affect a person's mind, we cannot determine the range of variables that might influence it. Typically, when

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[26] *See* JOHN PHILLIPS, HOW TO THINK ABOUT STATISTICS 59–60 (1973). For a longer explanation of correlation and causation, see DAVID MOORE, STATISTICS CONCEPTS AND CONTROVERSIES 208–20 (1985).

[27] *See* PHILLIPS, *supra* note 26, at 141.

[28] There are, however, attempts to control for unknown variables through randomization. *See generally* Mark Nickerson, *The Control of Unknown Variables,* 97 CAN. MED. ASSOC. J. 118–22 (1967) (discussing attempts to control for unknown variables in clinical pharmacology. However, questions can remain as to how random the sample actually is, or whether symmetrical relationships with unknown variables persist, as long as those variables are themselves unknown).

[29] *See* John Horgan, *The Undiscovered Mind: How the Human Brain Defies Replication, Medication, and Explanation*, 10 AM. PSYCHOLOGICAL SCI. 470, 473 (1999); Howard Gardner, *Scientific Psychology: Should We Bury it or Praise it?*, 10 NEW IDEAS IN PSYCHOL. 179, 180 (1992); Peter Munz, *The Phenomenon of Consciousness from a Popperian Perspective, in* CONSCIOUSNESS TRANSITIONS: PHYLOGENETIC, ONTOGENETIC AND PHYSIOLOGICAL ASPECTS 307–26 (Hans Liljenström & Peter Århem eds., 2008).

associations between two variables reoccur in various circumstances (reducing the chance that the correlation is due to a confounding variable), a plausible theory explains how one variable causes the other and, if no equally plausible confounding variable could explain the correlation, it is reasonable to think that a causal relationship exists.[30] However, the existence of an organic mental illness cannot be directly observed in order to correlate it with any other variable;[31] rather, it is said to be implied by the symptoms themselves.[32] Given this, we cannot establish correlation between an organic disorder that exists apart from its symptoms and the symptoms themselves, except with regard to disorders that can be verified through non-psychiatric medical means.[33]

There are some basic flaws in trying to make inferences about the cause of an original state of mind from how that mind apparently changed after the introduction of a foreign substance such as a drug. To illustrate this, consider an analogous psychological thought experiment. If a patient presents with a mild case of "social phobia," and a psychiatrist attempts to "treat" the case by administering a dose of alcohol to the "patient," they would both likely find that relief from the symptoms would follow.[34] In reality, the psychiatrist would probably not infer that the social phobia is caused by a biochemical malfunction of the brain resulting in a sub-normal blood alcohol level. However if the psychiatrist were to make such an inference, that inference would be structurally the same as the example with phenothiazine, dopamine, and schizophrenics. The ability to alter a state by

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[30] *See* MOORE, *supra* note 26, at 219.
[31] *See* OFF. OF TECH. ASSESSMENT, *supra* note 3, at 46–47.
[32] *See id.*
[33] *See id.* The epistemic difficulties with psychiatric methodology may not apply to the methods of neurologists, but so far no definitive neurological markers have been found for any mental illnesses. If diagnostic laboratory tests were possible, however, these would not seem to constitute psychiatric tests but neurological tests, and this paper's subject is not the concept of mental illness but rather psychiatric expertise. *See id.*
[34] Of course, some "patients" would not react this way—just as psychotropic medication typically produces a variety of patient responses.

introducing specific chemicals does not logically suggest that that those chemicals are informative about the nature of the original condition any more than a psychoanalyst's ability to alter a patient's emotional state by describing what he believes to be the patient's unconscious motives is informative about what the genuine source of the patient's original emotional state was.

Moreover, because multiple mutually exclusive theories[35] on the etiology of schizophrenia would be consistent with the fact that phenothiazine reduces psychosis in schizophrenics, the data cannot be said to scientifically verify any theory. Instead, psychiatrists can at best make a speculative case as to why phenothiazine might have such an effect. But given that any such case cannot be structured into a testable hypothesis, it cannot be construed meaningfully as scientific.

The use of phenothiazines to treat schizophrenia offers a strong example of where the psychiatric profession was able to treat a condition with a drug in a way that seemed to confirm that they "got it right." Other pharmaceutical interventions cast a less favorable light on psychiatry. To use a prime example, anti-depressants work only marginally better than placebos.[36] Anti-depressants appear to work, but only because people tend to improve from depression whether they take real medication or sugar pills.[37] The marginal benefits may be attributed to a stronger placebo mechanism than that experienced by control groups. People who develop

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[35] *See generally* A. Furnham & P. Bower, *A Comparison of Academic and Lay Theories of Schizophrenia*, 161 BRIT. J. OF PSYCHIATRY 201–10 (1992) (discussing the numerous theories of schizophrenia's etiology).

[36] *See* Irving Kirsch & Guy Sapirstein, *Listening to Prozac but Hearing Placebo: A Meta-Analysis of Antidepressant Medication,* PREVENTION & TREATMENT, June 1998, at 2a.

[37] *See id*; Joanna Moncrieff, *The Antidepressant Debate*, 180 BRIT. J. OF PSYCHIATRY 193–94 (2002); Sharon Begley, *The Depressing News About Antidepressants,* THE DAILY BEAST (Jan. 28, 2010, 7:00 PM), http://www.thedailybeast.com/newsweek/2010/01/28/the-depressing-news-about-antidepressants.html.

side effects tend to experience stronger placebo effects because the side effects confirm that they received the real drug rather than the placebo, causing an enhanced super-placebo effect.[38]

B. Are Psychiatric Diagnoses Equivalent to Medical Diagnoses?

Many would argue that even if psychiatry is not able to fully explain scientifically the etiologies of mental disorders, it remains scientifically valuable because it can identify coherent syndromes, describe diagnostic criteria for those syndromes, and make predictions about individuals' prognoses and responses to treatment by studying the population experiencing these symptoms. This section challenges the widely-held belief that psychiatric diagnoses correspond to any scientifically ascertainable syndromes. While each new edition of the *Diagnostic and Statistical Manual* (DSM) has increasingly shied away from describing most disorders explicitly in terms of hypothesized etiology,[39] psychiatrists have continued to categorize clinical features according to unverifiable theoretical classifications rather than classifying patients according to the empirical data.

1. Could Psychiatric Diagnoses Have a Physical Reality?

Psychiatrists assert that particular symptoms are caused by, and are evidence of, specific mental illnesses, which can be diagnosed by evaluating a patient's behavior and professed ideas. There is no doubt that psychiatric patients can exhibit unusual behavior, or that they report experiencing unusual thoughts, ideas, and sensations—and we might often reasonably infer that there must be something "wrong" with them. The question I wish to pose here is not whether diseases of the brain can occur the same way as diseases of the body, but whether psychiatrists offer scientifically testable reasons for thinking that the behavior and ideas

[38] *See* Moncrieff, *supra* note 37, at 193 (using the term "amplified placebo effect").
[39] *See* OFF. OF TECH. ASSESSMENT, *supra* note 3, at 46.

patients present are truly symptomatic of the specific illnesses that psychiatrists diagnose. The epistemological problem with psychiatric diagnoses is that the specific mental illnesses tends to be defined not by any scientifically testable underlying pathology or etiology, but by the symptoms themselves.[40] This amounts to a basically circular definition, and a more detailed elaboration will be provided below. The question then becomes whether the diagnostic criteria actually provide evidence for specific mental illnesses or if the diagnostic criteria for mental illnesses are essentially invented categories artificially imposed on the data. Patient behavior, ideas, and experiences may be both real and organic in origin. This may be true without any indication that the specific psychiatric illnesses of which they are said to be symptoms have a somatic reality.

To use an example, patients can be diagnosed as schizophrenic if they exhibit *any* two or more of a long list of varied and potentially unrelated symptoms (provided that they do so with sufficient duration, have sufficient social dysfunction, and do not meet certain exclusion criteria):

> (1) delusions
> (2) hallucinations
> (3) disorganized speech (e.g., frequent derailment or incoherence)
> (4) grossly disorganized or catatonic behavior
> (5) negative symptoms, i.e., affective flattening, alogia, or avolition
> [Only one of the above] symptom[s] is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.[41]

Imagine two groups: patients in group A have disorganized speech and an affective flattening but normal perceptions and ideas, and patients in group B have a bizarre delusion but typical speech and affect. Both A and B have

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[40] *See id.* at 47.
[41] AM. PSYCHOL. ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 312 (4th ed., text rev., 2000) [hereinafter DSM-IV-TR].

social or occupational dysfunction and have had their symptoms for at least one month. Additionally, nothing developmental, medical, or substance-related explains the symptoms. According to the DSM classification, both A and B should be said to suffer from schizophrenia. Yet A and B have no symptoms in common and have totally different and seemingly unrelated presentations. In what way does it make sense to say that both groups suffer from the same mental illness?

This is not a case where patients with the same clinical presentation are inferred to have the same syndrome due to their similarities. Instead, these patients would be thought to have a common illness despite their complete lack of similarities. The decision to classify A and B as suffering from the same mental disorder could not be explained by the observable phenomena of their clinical presentation but only by a theory about how those symptoms relate to an underlying cause. As described in the previous section, these theories cannot be empirically validated because the probative value of their data depends on the veracity of their theoretical conclusions.

To extend this critique, imagine group C shares a belief that "a stranger has removed [their] internal organs and has replaced them with someone else's organs without leaving any wounds or scars,"[42] and, as a result of this belief, all members of group C have quit their jobs. Group D also shares this delusion, believing that a strangers have removed their internal organs and replaced them with someone else's. However, while members of group D find this strange and disturbing, the delusion has not stopped them from showing up to work or socializing with their friends (and thus they do not meet Criteria B, an additional criteria, where to be diagnosed as schizophrenic a patient must both have symptoms as described above and substantial social dysfunction). Using the DSM IV-TR definition of schizophrenia, group C suffers from the same mental disorder as groups A and B—with whom it shares no common symptoms or experience—but

[42] *Id.* at 299.

group D is excluded from the same diagnostic category. This exclusion is sanctioned despite the fact that C and D have precisely the same symptoms and presentation, and they differ only in how well or how poorly they cope with their afflictions (or, perhaps, differ only in random chance, in how well they like their job and/or friends, or in how socially acceptable their symptom is to people around them). At this point it becomes clear that the description of schizophrenia as a label could not have emerged organically merely from analyzing patient presentation and grouping a set of similarly presenting patients together; rather, the way the psychiatric profession groups patients together depends on the significance attributed to often disparate symptoms.

In physical medicine, it is possible to suppose that two different modalities of presentation might be attributable to the same underlying condition, where some gold standard diagnostic test is positive in both presentations.[43] However, because no such physical test exists[44] or, for that matter, does any single unifying symptom or indicator demonstrate schizophrenia,[45] no such inference can be drawn. Instead, schizophrenia's diagnostic criteria seem to be an essentially arbitrary cluster of symptoms that would characterize totally disparate clinical presentations under the same label, while excluding from that label extremely similar presentations.[46] Another feature of the DSM definition of schizophrenia that points to shoehorning symptoms into a preconceived invented category rather than inferring a category from symptoms. Namely, that symptoms vary according to demographics: schizophrenia supposedly occurs in one

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[43] *Cf.* M. Carrington Reid et al., *Use of Methodological Standards in Diagnostic Test Research,* 274 J. AM. MED. ASS'N 645, 646–49 (1995).

[44] *See generally* DSM-IV-TR, *supra* note 41, at 299 ("No laboratory findings are diagnostic of Schizophrenia . . . .").

[45] *See id.* at 305 ("No single symptom is pathognomonic of Schizophrenia . . . .").

[46] *Cf. id*. at 303 (discussing a wide range of "sub-types"); *id.* at 310–11 (discussing distinctions made between schizophrenia and similar mental illnesses, some of which are simply made "by definition").

pattern in men while presenting in a completely different pattern in women, with differing symptoms beginning at different age ranges.[47]

Further, the supposed correlations between schizophrenia and the tendency to have larger or smaller neuroanatomical structures than a control group[48] is of no help in establishing schizophrenia as a coherent, discrete disorder that exists independently of the DSM-IV-TR. This is because the sample of schizophrenia patients would have been selected according to the DSM-IV-TR diagnostic criteria, and the correlations could have been made stronger or weaker had a different diagnostic criteria set with a different constellation of symptoms been adopted. This, therefore, provides no reason to think that the set criteria actually used corresponds to any discrete condition existing in the world.[49]

There is no reason to doubt that some people in reality fit the presentations of A, B, and C. In this sense, "schizophrenia" might be "real" in that there are people who would fit the description. But there is also no reason to think that A, B, and C have anything naturally, medically, or psychologically to do with each other, except insofar as the American Psychiatric Association (APA) has arbitrarily decided to label them together. Schizophrenia, like all so-called mental illnesses, has never had a laboratory test, brain tissue abnormality, or other physical marker that can

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[47] *See* DSM-IV-TR, *supra* note 41, at 307–08.

[48] *See generally* Martha E. Shenton et al., *A Review of MRI Findings in Schizophrenia,* 49 SCHIZOPHRENIA RES. 1–52 (2001) (reviewing the literature of MRI findings).

[49] The APA hints at acknowledging this limitation in the DSM-IV-TR:

> The DSM-IV is a categorical classification that divides mental disorders into types based on criteria sets with defining features. . . . [T]here is no assumption that each category of mental disorder is a complete discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. . . . The clinician using DSM-IV should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion.

See DSM-IV-TR, *supra* note 41, at xxxi.

identify it[50] because it cannot be tested for or examined, and there is no way to confirm that the symptoms are symptomatic of a specific, discrete, underlying disorder. In this sense, no reason exists to believe that schizophrenia as a discrete and coherently conceptualized condition exists in the world in any meaningful way independent of the APA's narrative about the symptoms that might trigger the classification. This is similarly true of any psychiatric diagnosis in that, while the symptoms may be empirically observable, there is no empirically-based reason to describe a list of symptoms as being one disorder or another disorder.[51] There is therefore no scientific basis for bridging the gap between a set of clinical symptoms and a diagnosis: the diagnosis is simply imposed on the symptoms.[52]

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[50] *See* U.S. PUB. HEALTH SERV., *Overview of Mental Illness*, *in* MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2.html (last visited Feb. 20, 2012). "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." *Id.* "The development of morbid anatomy and histology in the nineteenth century . . . showed that many diseases defined as syndromes were in fact associated with identifiable lesions. This led to the view that the demonstration of such an identifiable lesion was the defining characteristic of disease . . . There are many problems with this clear-cut and initially appealing view, especially perhaps as far as much of psychiatry is concerned.…however, in psychiatry no physical basis has been defined for most of the major syndromes." EVE C. JOHNSTONE, ET. AL. SCHIZOPHRENIA, CONCEPTS AND CLINICAL MANAGEMENT, 3 (Cambridge Univ. Press 1999).

[51] *Cf.* OFF. OF TECH. ASSESSMENT, *supra* note 3, at 46–47. *See generally*, Peter Zachar, *Psychiatric Disorders are not Natural Kinds*, 7 PHIL., PSYCHIATRY, & PSYCHOL. 167–82 (2000); Tim Thorton, *Reliability and Validity, in Psychiatric Classification: Values and neo-Humeanism*, 9 PHIL., PSYCHIATRY, & PSYCHOL. 229, 229–35 (2002).

[52] "Categorical labels imply the presence of natural boundaries between major syndromes, even though there is no empirical evidence for such boundaries. . . . Despite the pervasive assumption that mental disorders are categorical, there is little or no evidence that there are natural boundaries separating putative categories. . . . No one has ever found a set of symptoms, signs, or tests that separate mental disorders fully into non-overlapping categories. C. Robert Cloninger, *A New Conceptual Paradigm from Genetics and Psychobiology for the Science of Mental Health*, 33 AUST. & N.Z. J. PSYCHIATRY 174, 175–76 (1999). *But see,* Robert Kendell & Assen Jablensky, *Distinguishing Between the Validity and Utility of Psychiatric Diagnoses*, 160 AM. J. PSYCHIATRY 4, 7 (2003)

There is no logically necessary reason to believe that a patient with both "odd beliefs" and "distorted perceptions," but with perfect social manner, presentation, and speech categorically suffers from the same mental illness as a patient who presents with reduced speech output, a flattened affect, lack of volition, and disorganized speech, but who also neither hallucinates nor possesses any delusions.[53] The only reason to hold such a belief is if one already assumes the accuracy of the hypothesis that these are two presentations of the same illness. When the principal evidence for an organic basis for schizophrenia consists of the effects of drug therapies on schizophrenic patients, as in the anti-psychotic drug example discussed earlier, it does not help to show the diagnosis itself is an empirically valid category and not an artificially assembled collection of symptoms. Just as a single symptom can be symptomatic of multiple illnesses, a single drug may prove effective treatment for multiple illnesses.[54] This is even more relevant in practice because prescription psychoactive drugs have mixed therapeutic success,[55] making the epistemological status of diagnostic categories as they are applied in practice even more dubious than they are in theory.

Some MRI studies have shown certain brain-imaging scans to have a correlation with schizophrenia.[56] However, in all of these studies, most subjects with brain scans showing patterns positively correlating with schizophrenia do not develop schizophrenia, and a portion of those subjects with brain scans showing patterns negatively correlating with schizophrenia go on to develop schizophrenia anyway.[57] Because these MRI results are

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(discussing the numerous commentators in the field who dispute the empirical validity of psychiatric diagnostic categories).

[53] To borrow from the DSM-IV-TR's diagnostic criteria, see DSM-IV-TR, *supra* note 41, at 312.

[54] Consider, for example, how many different conditions and diseases might be ameliorated by aspirin or penicillin.

[55] For example, with regard to anti-depressants, see Moncrieff, *supra* note 37, at 193–94.

[56] *See* Shenton et al., *supra* note 48, at 1.

[57] *See id*. For an excellent example of one study showing an unusually high degree of correlation, see Dominic E. Job et al., *Grey Matter Changes Can Improve the Prediction*

neither necessary nor sufficient for identifying schizophrenia,[58] they in no way validate the somatic existence of schizophrenia as a syndrome described in the DSM. The MRI results may simply correlate, directly or indirectly, to one of the diagnostic criteria for schizophrenia without correlating to the others, therefore providing little support for framing the category of schizophrenia in the way psychiatrists have chosen to do so.[59] If a certain individual's MRI results correlate strongly with flattened affect,[60] the individual's results would likely also correlate with schizophrenia regardless of the actual predictive value of MRI results for schizophrenia's other symptoms. This is because anyone with flattened affect, already meeting one criterion for schizophrenia, would have to meet fewer other criteria than those without flattened affect. Given this, the MRI results would merely delineate a population that partially meets one criterion for schizophrenia, so even if individuals in that population were no more likely than others to possess any of the other symptoms ascribed to schizophrenia, they would still be more likely than average to fulfill the diagnostic criteria as a whole.[61]

In this way, MRI studies provide only a false appearance of biological grounding for schizophrenia.[62] In reality, the use of MRI data does nothing

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of Schizophrenia in Subjects at High Risk, BMC MEDICINE, Dec. 2006, at 29. Note, however, that even in Job's study, which took a population of "high risk" patients and a low risk control group, most of those with an MRI pattern best predicting schizophrenia never developed schizophrenia, and many of those without it did. *See id.*

[58] *See* DSM-IV-TR, *supra* note 41, at 299, 305. *But see* Dassori, Miller & Saldana, *supra* note 8, at 304.

[59] *Cf.* Thornton, *supra* note 51, at 229–35.

[60] Flattened affect (also termed "blunted affect") is a term for a lack of emotional expression and expressive gestures. *See* GEORGE STEIN & GREG WILKINSON, SEMINARS IN GENERAL ADULT PSYCHIATRY 174 (2d ed. 2007).

[61] This group would need only one other Criterion A symptom whereas the rest of the population would need two, so it would appear to be more likely to have "schizophrenia" than the general population.

[62] One of the most promising bits of MRI data was a finding that groups of schizophrenics on average had less gray matter volume than control groups. *See* Beng-Choon Ho et al., *Long-term Antipsychotic Treatment and Brain Volumes*: *A Longitudinal*

more than adding another inconclusive psychiatric symptom to the list would. Unusual MRI scans are indicative of some biological state or condition, but this is not in and of itself the syndrome described by the DSM-IV-TR criteria for schizophrenia for the simple reason that no MRI result includes or excludes the full population diagnosed as schizophrenic.[63] Even if the available neuroscientific evidence is insufficient to validate psychiatric classifications, presenting any sort of neuroscientific data or claims (whether it is adequate evidence or not) as backing those classifications will often convince people that they are valid.[64]

Even if all of the potential combinations of symptoms were to respond favorably to the same treatments, plenty of medical illnesses with clearly different and unrelated etiologies and presentations are treatable in the same manner.[65] While it is true that varied symptomatic presentation alone does

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Study of First-Episode Schizophrenia, 68 ARCHIVES GEN. PSYCHIATRY 128 (2011). More recent studies however have found that gray matter loss actually correlates with *the use of antipsychotic medication* where the greater the amount of antipsychotics one takes, the more gray matter one loses. *See id*. at 134.

[63] *See* Job et al., *supra* note 57, at 29.

[64] "Explanations of psychological phenomena seem to generate more public interest when they contain neuroscientific information. Even irrelevant neuroscience information in an explanation of a psychological phenomenon may interfere with people's abilities to critically consider the underlying logic of this explanation. We tested this hypothesis by giving naïve adults, students in a neuroscience course, and neuroscience experts brief descriptions of psychological phenomena followed by one of four types of explanation, according to a 2 (good explanation vs. bad explanation) x 2 (without neuroscience vs. with neuroscience) design. Crucially, the neuroscience information was irrelevant to the logic of the explanation, as confirmed by the expert subjects. Subjects in all three groups judged good explanations as more satisfying than bad ones. But subjects in the two nonexpert groups additionally judged that explanations with logically irrelevant neuroscience information were more satisfying than explanations without. The neuroscience information had a particularly striking effect on nonexperts' judgments of bad explanations, masking otherwise salient problems in these explanations." Deena Skolnick Weisberg et al., *The Seductive Allure of Neuroscience Explanations*, 20 J. COGNITIVE NEUROSCIENCE 470, 470 (2008).

[65] For example, many different types of infectious agents present similar symptoms like fever, and respond favorably to the same antibiotics. *C.f.* RICHARD A. HARVEY, PAMELA C. CHAMPE, & BRUCE D. FISHER, LIPPINCOTT'S ILLUSTRATED REVIEWS: MICROBIOLOGY (332-357) (describing numerous infectious agents and their symptoms

not mean that a diagnosis is an artificially established category, in medical diagnoses that can present with multiple symptoms, the illness is only classified specifically and definitively if there is a physically observable differential diagnostic criterion that can be applied regardless of the way the symptoms present.[66] Here again, the issue is whether the symptoms would in fact provide evidence for the theory if the theoretical explanations for the theory were not already assumed. A collection of symptoms can provide evidence for the existence of a particular mental disorder only if the diagnostic criteria are already presumed to correspond to features of some real phenomenon.[67] To cite another example, while Ritalin improves the study habits and exam scores of children with ADHD, it improves the study habits and exam scores of *most people who take it*, to the point of generating its own black market economy in schools.[68] Ritalin's effects, therefore, tell us very little about ADHD, just as looking at anti-psychotic drugs tell us very little about schizophrenia. Thus, looking at symptoms or effective treatments tells us very little about the root cause.

2. Is Psychiatry Different from Other Medical Fields in this Regard?

Many medical fields diagnose patients according to tests that lead physicians to infer the existence of underlying tissue pathology without observing it directly.[69] We have every reason to believe that our mental experiences depend in part on the physical state of our brains, and we have every reason to believe that atypical brain states can produce atypical

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and treatments, some of which have similar symptoms and respond to the same antibiotics).

[66] *See generally* Stephen Walter, *Gold Standard Test, in* ENCYCLOPEDIA OF BIOSTATISTICS (2005).

[67] *See* David L. Sacket et al., *Evidence Based Medicine: What it Is and What it Isn't*, 312 BRIT. MED. J. 71, 71 (1996).

[68] Jeremy Laurance, *Ritalin Abuse Hits Students Looking for an Exam Kick*, THE INDEPENDENT (Aug. 26, 2003), http://www.nootropics.com/methylphenidate/index.html.

[69] *See generally* Walter, *supra* note 66.

mental states.[70] It therefore seems very reasonable to assume that profoundly abnormal mental experiences, such as daytime hallucinations, are or may be caused by organic brain abnormalities.

A question arises: are psychiatric diagnoses un-testable, or simply difficult to test? One of the most famous criticisms of the scientific status of psychiatry is found in psychologist David Rosenhan's "pseudo-patient" experiment where he found that his assistants could gain admittance into reputable hospitals and be diagnosed with schizophrenia simply by claiming to have had auditory hallucinations; no amount of subsequent observation was perceived as invalidating the original diagnosis[71] Rosenhan's conclusion, that this implied psychiatric diagnosis was fundamentally unscientific, has been rightly criticized by retired professor of psychiatry Robert Spitzer,[72] among others, for only demonstrating that diagnostic reliability is difficult—and made more so when patients feign symptoms of known disorders.[73] American neuroscientist Seymour Kety[74] pointed out that if he was to drink a quart of blood and arrive at a hospital vomiting blood, the staff would consistently diagnose him with a bleeding peptic ulcer, but this misdiagnosis would not imply that medicine was incapable of

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[70] The effects of drugs and alcohol on the mind are reason enough to think this.

[71] *See* D. L. Rosenhan, *On Being Sane in Insane Places*, 179 SCI. 250, 250 (1973).

[72] Robert Spitzer, an extremely influential psychiatrist, is best known for leading the development of the DSM-III as the chair of the American Psychiatric Association's Task Force on Nomenclature and Statistics. Spitzer also chaired the APA Work Group to Revise the DSM-III, which produced the DSM-III-R and was a special advisor to the APA Task Force on the DSM-IV. *See* DSM-IV-TR CASE BOOK VOL. 2. : EXPERTS TELL HOW THEY TREATED THEIR PATIENTS xiii (Robert Spitzer et. al. eds., American Psychiatric Publ'g, Inc. 2006).

[73] *See* Robert L. Spitzer, *More on Pseudoscience in Science and the Case for Psychiatric Diagnosis: A Critique of D. L. Rosenhan's "On Being Sane in Insane Places" and "The Contextual Nature of the Psychiatric Diagnosis,"* 33 ARCHIVES GEN. PSYCHIATRY 459 (1976).

[74] Seymour Kety was a very influential neuroscientist who developed the first method for measuring cerebral blood flow, researched genetic predisposition for schizophrenia, and served as the scientific director of the National Institute of Mental Health. *See* Phillip S. Holzman, *Seymour S. Kety, M.D., 1915–2000*, 157 AM. J. PSYCHIATRY 1057, 1057 (2000).

correctly diagnosing the condition.[75] This analogy would be an apt one, except for the fact that it ignores the epistemologically relevant difference between the type of claim being made when someone attributes vomiting to an ulcer and when someone attributes hallucinations to schizophrenia.

The difference is that while a physician would not be able to assess during an initial examination whether someone was vomiting blood because the patient had an ulcer or because the patient drank a quart of blood, the etiological theory that the patient had an ulcer is in principle confirmable through visual inspection via endoscopy. However, no analogous possibility exists with mental disorders. In non-speculative physical medicine, although patient self-reports might lead to a diagnosis, the diagnoses are based on an etiological theory derived from physical observation of the biological mechanisms that could produce such symptoms.[76] To return to an earlier analogy, successfully applying "percussive maintenance" to a television with a fuzzy picture might provide evidence that the TV suffered from a problem in the vacuum tube's power supply, but this is only because people have opened up other malfunctioning televisions to examine their wiring. There is no meaningful way to physically observe the cause of most human behavior, including hallucinations and other bizarre mental phenomena that seem necessarily organic in origin. Even neural imaging fails to demonstrate causality because neuroanatomy and the degree of blood flow to relevant parts of a brain are affected by external stimuli as well.[77] Behaviors can be both plausibly explained as caused by or causing their neurological correlates.

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[75] *See* Seymour S. Kety, *From Rationalization to Reason*, 131 AM. J. PSYCHIATRY 957, 959 (1974).

[76] *See* Sackett et al., *supra* note 67, at 72.

[77] For example, talk therapy demonstrates distinct brain changes in patients suffering from depression. *See* Kelly Connelly, *Therapy Show a Distinct Pattern of Brain Changes (Patients Recovering From Depression)*, MED. NEWS TODAY (Jan. 6, 2004), http://www.medicalnewstoday.com/articles/5181.php.

We can also imagine instances where direct observation of the relationship between a symptom and an underlying cause is in fact available. If a patient suddenly has the subjective mental experience of being unable to see, and CT scans of other patients with this subjective mental experience have revealed tumors pressing against the optic nerve, then the patient's mental experience could provide empirically meaningful evidence to suggest the possible presence of a brain tumor, even without a CT scan. Of course, blindness would not provide irrefutable evidence of a brain tumor, but it rather provides some evidence in proportion to the likelihood of a brain tumor explaining the mental phenomenon. This likelihood is itself scientifically determinable by analyzing the frequency that brain tumors can be confirmed by CT scans in patients with such mental experiences.

Where scientifically verifiable means of relating a symptom to an underlying cause are available, however, the diagnosis is based not on the methods of psychiatry but on the methods of clinical neurology.[78] Neurologists in these instances provide only epistemologically satisfying evidence. Symptom interpretation here depends on the extent to which doctors can directly observe tissue pathology in a patient's brain and relate those observations to behaviors and experiences. The psychiatric methods of diagnosis add nothing in these instances and have no clear intersection with neurology's methods.[79]

3. Could Psychiatry Be Scientific in the Way Other Highly Theoretical Fields Can Be Scientific?

Psychiatry is not the only field that both holds itself out as scientific and advances claims about subjects that seem to have a physical basis but

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[78] *See* John Horgan, *The Undiscovered Mind: How the Human Brain Defies Replication, Medication, and Explanation,* 10 PSYCHOL. SCI. 470, 473 (1999). However, "[n]euroscience has had virtually no payoff in terms of diagnosing and treating mental illness." *Id.*

[79] *Cf. id.*

cannot be observed directly. Theoretical physicists also study presumably physical subjects beyond possible human observation. However, there is a critical difference. When the subject of a physicist's inquiry is an unobservable phenomenon, a physicist will extrapolate the existence of an unobservable phenomenon through the application of knowledge of the laws of physics determined from direct observation. Thus, the underpinning of a physicist's theory of unobservable phenomenon remains grounded in and derivable from what he or she can observe.

For example, while a black hole or an electron might be unobservable, their existence is scientifically verifiable because the mechanisms by which observable objects interact with each other form systematically discernible "laws of physics," which can be scientifically verified (or at least confirmed to a high level of probability).[80] These laws, when coupled with observable data, can provide empirically meaningful support for hypotheses about the unobservable phenomena they imply. If a physicist, observing a star wobbling in a particular way, hypothesizes that this is due to the presence of an unobserved massive celestial object in its vicinity, the hypothesis is scientifically grounded to the extent that physicists have observed other stars wobbling in the presence of observable massive celestial objects.[81] Even without directly "seeing" a black hole, a physicist can hypothesize its presence scientifically by comparing the behavior of a star in the black hole's vicinity with the way other stars are affected by the gravity of large observable celestial bodies. The unobservable phenomenon is thereby inferred from observable, empirically accessible data.

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[80] *See generally* Jean Schneider, *New Worlds Outside the Solar System*, 10 EUR. REV. 185, 188-190 (2002) (describing the "stellar-wobble" technique of exosolar planet detection, where stars are observed for a "wobble" characteristic of a planet's gravitational field effecting the star's path. In this way, while the planet itself cannot be directly viewed, the laws of gravity suggest that a star 'wobbling' in such a manner does so because of another large but smaller mass, thus the existence of a planet is inferred from the empirical data, but not observed directly.)

[81] *See id* at 188-190.

Starting from the presumption that subjective mental experience has a physical basis in the brain, we have every reason to think that if a patient suffers from hallucinations, he or she may have something physically atypical about his or her brain. However, this is where psychiatric methodology diverges from the methodology of theoretical physics. Not only is any interaction between a particular abnormal behavior and the purportedly physical mental illness unobservable, but psychiatric methods offer no way to observe *analogous* interactions. In other words, there are no fully observable systems in psychiatry to form an equivalent empirical basis for their inferences.

C. Conclusion to Part One

It has been suggested that the need to place psychiatry within the realm of medicine as a science is socially motivated: a way of raising the prestige of mental health professions and reducing the stigma of their patients.[82] However, Part One of this article has shown that psychiatry and clinical psychology cannot meet the standards of medicine, and thus awarding psychiatry the social status of medicine is unjustified. In his paper, "On Being Sane in Insane Places," Rosenhan raised the issue of whether observed patient symptoms produced consistent psychiatric diagnoses, or whether, instead, once labeled with a diagnosis, all data from a patient could be, and in fact was, interpreted as consistent with the diagnosis.[83] When Freud's patients responded positively to his psychoanalytic interpretations, he felt that the data confirmed his descriptions because they must have corresponded with what was real in the patient. But when Freud's patients did not respond favorably, Freud attributed this to the strength and

[82] *See* Sander L. Gilman, *The Struggle of Psychiatry with Psychoanalysis: Who Won*?, 13 CRITICAL INQUIRY 293, 295–96 (1987).
[83] *See* Rosenhan, *supra* note 71, at 250.

resistance of the neurosis he described, so these data also confirmed his description.[84]

When the APA voted to remove homosexuality from its list of mental disorders in the DSM-II, Rosenhan remarked that the fact a professional organization could vote on whether or not a particular human experience should be perceived as a "disorder" according to shifts in social perception underscored the difference between psychiatric disorders and medical ones.[85] Even now, the APA is planning to delete dozens of "mental disorders" currently listed in the DSM-IV-TR from the new DSM-V (expected in May 2013) while it simultaneously classifies new sets of behaviors that people have long engaged in as criteria for mental disorders.[86] Some might protest that physicists also "vote" on the validity of proposed laws of nature in that they collectively deem some theories sufficiently supported and others not. The truth-value in physics, however, does not ultimately depend on the *opinions* of physicists; some proofs work mathematically and others do not. While Galileo's heliocentric theory of the solar system was rejected by the church-based intellectual establishment of his day, he had reason to think he was nonetheless correct because his theory was confirmable by observing the sky, rather than "confirmed" only through the consensus of other physicists.

Psychotherapeutic theories, whether in the form of psychiatric diagnoses or psychoanalytic descriptions, seem to be independent of and imposed on data, rather than being dependent on and derived from data. Although these psychiatric and psychotherapeutic practices could be extremely useful to and improve the quality of life for some people, this usefulness does not

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[84] *See Epistemological Liabilities*, *supra* note 9, at 322.

[85] *See* LAURA SLATER, OPENING SKINNER'S BOX: GREAT PSYCHOLOGICAL EXPERIMENTS OF THE TWENTIETH CENTURY 80 (2004).

[86] *See* AM. PSYCHIATRIC ASS'N, *Proposed Draft Revisions to DSM Disorders and Criteria*, DSM-5 DEV., http://www.dsm5.org/ProposedRevisions/Pages/Default.aspx (last visited Feb. 21, 2012).

provide the scientific status common to most modern medicine.[87] To make this distinction, psychoanalysis and psychiatry must be evaluated not only in terms of the efficacy of their clinical practice, but also as academic disciplines claiming to present evidence about the facts of the world. In this regard, psychotherapeutic theories might be better conceptualized not as scientific hypotheses, but as narrative descriptions[88] While not scientifically verifiable in the same manner as neurology or other medical disciplines, psychotherapeutic theories may nonetheless be useful narratives, helpful in developing a sympathetic understanding of individuals' circumstances and experiences. Even though psychotropic drugs tell us little about who has a mental illness—and many are ineffective for treatment purposes—some people still find them useful in dealing with the problems they face daily. The ability to name the source of one's problems can potentially feel empowering or provide relief, even if there is no substance behind the name apart from the institutional conventions of psychiatrists. Scientific verification might then be unnecessary for the successful application of psychiatry in a voluntary treatment setting. The same, however, may be equally true of other unscientific treatments that some people nonetheless find useful, like acupuncture. The fact that a treatment works does not mean that it works for the reasons the practitioner says it works. Thus, successful treatment does not necessarily justify regarding the practitioner as an expert on the maladies he or she seeks to treat.

III. PART TWO: PSYCHIATRIC DIAGNOSES AS LEGAL EVIDENCE

The inherent epistemological liabilities of psychiatry have the potential to cause profound problems in civil cases and the criminal justice system. In a voluntary treatment setting, the epistemological questions are less important since no one is in conflict. In an adversarial setting, where the question is

[87] *See* Kendell & Jablensky, *supra* note 52, at 7.
[88] *Cf.* Gardner, *supra* note 29, at 186–90 (arguing for an increasingly comprehensive approach to psychology).

not simply what treatment could be effective but what version of the truth is accurate, the epistemological questions matter profoundly because courts must resolve a dispute between two parties, both advancing claims of fact to support their desired outcomes. When providing evidence to establish the legal elements for involuntary commitment, to use an insanity defense in criminal trials, or to decide which patients are able to access potentially helpful medication and which are restricted to non-medical treatments and so on, description of the patient's alleged mental illness will privilege one party's interests against another's. Epistemological problems in psychiatry may be unimportant to the voluntary patient who finds his or her treatment a worthwhile experience, but these problems defeat the entire purpose of permitting psychiatric expert testimony in a court of law when attempting to determine the facts of a case.

In the following section, I argue that the unjustifiable reliance on psychiatric expertise has the potential to produce substantively and procedurally unjust results.

A. Psychiatric Testimony Does Not Contribute Meaningful Information

Psychiatrists are often called to testify as to whether or not an undesirable behavior is caused by a mental illness. For example, in order to successfully argue an insanity defense, one must generally demonstrate that a mental illness affected the defendant's reasoning about a crime and the defendant's ability to "distinguish between right and wrong."[89] If a person is mentally ill, he or she is said to have diminished legal responsibility.[90] Psychiatrists have no means of observing the interaction between the supposed "cause," the mental illness, and the "effect" of the undesirable behavior. Instead, the only data available for diagnosing mental illness is the undesirable behavior itself. Rather than providing independent evidence of an illness, and

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[89] *See* 22 C.J.S. *Criminal Law* § 134 (outlining the requisite conditions to be considered as having a mental disease or defect).
[90] *See id*.

evidence for how and why it causes an undesirable behavior, the psychiatrist does the opposite: he or she uses the undesirable behavior as evidence for the mental illness.

In other words, while the psychiatrist has added his or her own *completely unverifiable* hypothesis for why a person acts the way he or she does, the psychiatrist has contributed absolutely no new evidence. Psychiatrists do not even help a court understand the evidence before it because, as described earlier, their methodology assumes the truth of unverifiable relationships between the data and psychiatric hypotheses. To describe a set of behaviors as symptoms of mental illness does nothing to bridge the explanatory gap as to the cause of the behaviors. Instead, it impresses the court with a sense of false necessity where judges and jurors are likely to feel compelled to defer to "expert" opinions of psychiatrists, often to a court's detriment.[91]

A United States Supreme Court case from 1983, *Barefoot v. Estelle*,[92] established that clinical opinions of psychiatrists could be employed to answer hypothetical questions about a defendant's potential dangerousness, a practice employed extensively in Texas death penalty cases.[93] In Texas, juries in capital cases actually used to vote on whether a defendant would receive the death penalty.[94] Psychiatrist James Grigson was frequently permitted to testify during death penalty sentencing that there was a "one hundred percent and absolute"[95] chance that the accused would commit

[91] *See* Weisberg et al., *supra* note 64, at 470 (explaining how explanations that use scientific jargon are often more persuasive to people, whether or not they are scientifically sound).
[92] Barefoot v. Estelle, 463 U.S. 880 (1983), *overruled on other grounds by* Morris v. Woodford, 229 F.3d 775 (2000).
[93] *See* Ron Rosenbaum, *Travels With Dr. Death*, VANITY FAIR, May 1990, at 141, *reprinted in* SAMUEL BRAKEL & ALEXANDER BROOKS, LAW AND PSYCHIATRY IN THE CRIMINAL JUSTICE SYSTEM 252 (2001).
[94] *See id*.
[95] *Barefoot*, 463 U.S. at 919.

violent acts in the future[96] without even examining the defendant.[97] At the time, a person could only be sentenced to death in Texas if "there [wa]s a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society."[98] Grigson claimed that his predictions constituted "medical opinion[s] . . . particular to the field of psychiatr[y] and not to the average layman."[99] Justice Blackmun, remarking on the poor "present state of psychiatric knowledge," dissented in *Barefoot v. Estelle*. Regarding Grigson, Blackmun wrote that "[i]n a capital case, the specious testimony of a psychiatrist, colored in the eyes of an impressionable jury by the inevitable untouchability of a medical specialist's words, equates with death itself."[100] While this example is unusually dramatic, the "inevitable untouchability of a medical specialist's words"[101] can prove decisive with judges and juries in more mundane civil commitment cases. In another case where serious doubt still exists as to defendant's guilt, Grigon's testimony may have contributed to the controversial execution of Cameron Todd Willingham.[102]

In the landmark civil commitment case *Addington v. Texas*,[103] the appellant argued that since due process requires proof beyond a reasonable doubt for criminal trials, due process must similarly require proof beyond a reasonable doubt before the state can deprive someone of their liberty through involuntary civil commitment.[104] The US Supreme Court rejected this argument and found that, unlike in criminal trials, involuntary civil

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[96] *See* Rosenbaum, *supra* note 93, at 252–53.
[97] *See Barefoot*, 463 U.S. at 923 n.6.
[98] *Id*. at 884.
[99] *Id*. at 918.
[100] *Id*. at 916.
[101] *Id*.
[102] For discussion of the controversy surrounding the facts of this case and Grigson's role in it, see David Grann, *Trial By Fire: Did Texas Execute an Innocent Man?*, THE NEW YORKER, Sept. 7, 2009, http://www.newyorker.com/reporting/2009/09/07/090907fa_fact_grann?currentPage=all.
[103] Addington v. Texas, 441 U.S. 418 (1979).
[104] *Id.* at 418.

commitment proceedings could effectively incarcerate people under a mere "clear and convincing" evidence standard.[105] The outcome is that those merely *alleged* to be mentally ill are left with a second, lower due process entitlement and lesser state-recognized liberty interests.[106] This result was only possible because of an unjustifiable deference to psychiatric expertise and a gross overestimation of the reliability of psychiatric evaluations and theories.

Chief Justice Burger, writing for the *Addington* Court, explained that:

> Whether the individual is mentally ill and dangerous to either himself or others and is in need of confined therapy turns on the *meaning* of the facts which must be interpreted by expert psychiatrists and psychologists. 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.[107]

The Court concluded that the standard of proof should be lowered to accommodate this "fallibility" and "lack of certainty."[108] A more reasonable conclusion, however, would have been to recognize that psychiatrists and psychologists are not in a privileged position to interpret the facts of a case, and the spin they put on the facts should not be relied upon to tell a court what the facts mean for legal purposes.

Federal Rule of Evidence (ER) 702 on expert witnesses superseded the older "general acceptance" test for whether expert scientific testimony is admissible.[109] The rule states:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill,

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[105] *See id*.
[106] *See id*.
[107] *Id.* at 429 (emphasis in the original).
[108] *Id.*
[109] Daubert v. Merrell Dow Pharms, Inc. 509 U.S. 579, 579 (1993).

> experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.[110]

By these criteria, a psychiatrist should not be able to qualify as an expert witness on questions of either the "mental illness" or "danger to oneself or others" criteria for civil commitment. Psychiatric explanations of mental illness are not the product of reliable principles and methods, and psychiatric evaluations of dangerousness are not particularly reliable.[111] In *Daubert v. Merrell Dow Pharmaceuticals Inc.*, the US Supreme Court held that when faced with "expert scientific testimony . . . the trial judge, pursuant to Rule 104(a), must make a preliminary assessment of whether the testimony's underlying reasoning or methodology is scientifically valid and properly can be applied to the facts at issue."[112] While psychiatrists might argue that they enjoy "general acceptance" in the scientific community despite their methodological flaws, this should not permit them to testify as experts under the *Daubert* standard, which explicitly rejects the older "general acceptance" standard as a basis for evaluating expert witnesses.[113] The *Daubert* Court further stated that "many considerations will bear on the inquiry, including whether the theory or technique in question can be (and has been) tested."[114] Because psychiatric theories of mental illness cannot be meaningfully tested, a trial court in a jurisdiction

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[110] FED. R. EVID. 702.
[111] A great deal of empirical research undermines the claim that psychiatrists are able to predict dangerousness effectively. For reviews of this literature that conclude that psychiatric dangerousness predictions are ineffective, see Joseph J. Cocozza & Henry Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084, 1084–86 (1976); Bernard L Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439, 439–40 (1974).
[112] *Daubert*, 509 U.S. at 580.
[113] *See id*. at 579–80.
[114] *Id*. at 580.

following the *Daubert* standard should exclude psychiatrists as expert witnesses under ER 702.

A possible objection to this line of argument may be that while psychiatrists do not have scientifically testable theories, they at least have extensive experience dealing with people who are "insane" or "mentally ill" in the lay sense of these terms. In *Kumho Tire Co. v. Carmichael*, the US Supreme Court found that *Daubert's* judicial "gatekeeping" requirements and standards apply not only to "scientific" testimony but to any expert testimony (in the case, Carmichael sued Kumho Tire Company after a tire blew out in an automobile, resulting in an accident that killed a passenger and injured several others—a purported expert testified to defects in the tire).[115] In *Kumho Tire Co.*, the Court upheld the exclusion of the testimony of a "tire failure analyst" when a lower court found his methodology did not satisfy the *Daubert* interpretation of ER 702,[116] even though the analyst relied on "skill" and "experience" in his "observations."[117] Given the *Kumho Tire Co.* Court's clarification of the *Daubert* standard, even if psychiatrists can claim to have skill and experience in dealing with people who are "crazy" in the lay sense of the word, that skill and experience would not be sufficient by itself to make their testimony admissible if the methodology they use cannot be shown to be reliable.

B. Civil Commitment

When people are deemed to be mentally ill, they may be legally deprived of their liberty in circumstances where non-mentally ill persons cannot be.[118] Because the manner in which psychiatrists assign the status of mental illness is unscientific and epistemologically suspect, regardless of any legitimate governmental or social interests that might motivate civil

[115] *See* Kumho Tire Co., Ltd. v. Carmichael, 526 U.S. 137, 147 (1999).
[116] *See id*. at 139.
[117] *Id*. at 147.
[118] Paul S. Appelbaum, *The Right to Refuse Treatment with Antipsychotic Medications: Retrospect and Prospect,* 145 AM. J. PSYCHIATRY 413, 417 (1988).

commitment laws, such laws will be necessarily unreliable in their application. There is then a profound danger of arbitrarily and unnecessarily incarcerating people who have committed no crime. This danger is amplified by the lack of due process afforded to people facing civil commitment and the unjustifiable deference given to psychiatric testimony.

1. Why Civil Commitment?

Before critiquing civil commitment, it is necessary to consider three possible reasons why allegedly mentally ill people are treated differently from others with regard to involuntary confinement. One reason, provided by Paul Applebaum, one of the leading defenders of civil commitment, is that the only justification for confining mentally ill people in circumstances where non-mentally ill people would not be confined is the potential for treatment.[119] The entire purpose of commitment for Appelbaum, then, is compulsory treatment.[120]

There are some immediate problems with this view. Were compulsory treatment the necessary and sufficient reason for civil commitment, then the only two elements for civil commitment that would make sense would be the presence of a mental illness and a refusal to accept treatment (or perhaps the presence of a *severe* mental illness, though it would be hard to imagine what non-arbitrary criteria could be devised to determine this outside of posing a danger to oneself or others). Instead, the overwhelming majority of mental commitment statutes also require potentially committed persons to be dangerous to themselves or others.[121] The dangerousness criteria does not reasonably relate to compulsory treatment, since many people are mentally ill and refuse supposedly beneficial treatments, but are not committable because they are not dangerous. If the public interest in civil commitment is compulsory treatment, and not the protection of the public

[119] *See id.*
[120] *See id.*
[121] *See* 56 C.J.S. *Mental Health* § 54 (2010).

or the "mentally ill" individual, then why should the state exempt people who would equally "benefit" from compulsory treatment but who pose no danger?

There is a constitutionally protected right, derived from an individual's liberty interests, to refuse medical treatment.[122] The argument that mentally ill people would benefit from needed medical treatment, and that this benefit outweighs their right to refuse and therefore justifies commitment, would apply equally to *anyone* who refuses needed medical treatment. Yet, far from using the threat of commitment to coerce non-mentally ill people into needed treatment, the state instead applies the coercive power of the criminal and civil justice systems against doctors who attempt to override patient refusal by regarding nonconsensual medical treatment of "competent" patients as a battery.[123]

A second explanation for civil commitment is found in the inclusion of the dangerousness criterion, which might imply that the state's interest actually lies in its police power to protect society from dangerous individuals and protect individuals from themselves.[124] However, if this is the state's legitimate motive, why should it limit civil commitment to those who are both dangerous and mentally ill? Why not commit dangerous non-mentally-ill people as well? It is not the case that only mentally ill people pose dangers to themselves. When non-mentally ill people refuse critical medical treatment, they could certainly be seen as a danger to themselves, and yet the refusal of medical treatment is a legally protected right.[125] The

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[122] *See* 77 C.J.S. *Right to Die* § 2 (2011). That right goes so far as to permit a right to refuse life-sustaining treatment. *See id*. *But see* 22A AM. JUR. 2D *Death* § 470 (2012) (explaining that one exception to the right to die is when dying would constitute child abandonment).

[123] *See* Rodriguez v. Pino, 634 So. 2d 681, 685 (Fla. Dist. Ct. App. 1994) ("[A] physician who treats a patient despite such a refusal is civilly (and criminally) liable for assault and battery.").

[124] *See* Addington v. Texas, 441 U.S. 418, 426 (1979).

[125] *See* PAUL APPELBAUM, ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE 121-23 (1994). In fact, the right to refuse medical treatment exists

state also allows people to participate in many high-risk recreational activities such as cave diving, BASE jumping, or high-stakes gambling, and actually facilitates students acquiring six-figure non-dischargeable debt in an economy with uncertain job prospects. It would seem that, in general, any state interest in protecting people from themselves is rarely compelling enough to override personal liberty interests.[126]

The state interest in preventing grave disability implied by the "gravely disabled"[127] criterion that is used in some states' commitment statutes[128] does little to resolve this problem. For example, California law allows the confinement of a person who, "as a result of a mental disorder, is a danger to others, or to himself or herself, or gravely disabled."[129] However, the same law also expressly prohibits confinement of people who are gravely disabled but not mentally ill.[130] This seems to imply that the state then normally claims no sufficiently compelling interest in either preventing someone from becoming gravely disabled or compelling someone to recover from, treat, or ameliorate a grave disability. A gravely disabled person whose disability is caused by anything but mental illness is free to

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even *after* involuntary commitment and requires subsequent judicial procedures to override. *See id*.

[126] There are notable exceptions, like seatbelt and helmet laws, but these are neither equivalent intrusions into personal liberty, nor are they enforced with incarceration or civil commitment for those who would ignore them.

[127] "Gravely disabled" is a term used in some states' involuntary commitment statutes that may refer to "individuals who are incapable of providing for their basic survival needs," or alternatively to individuals "unable to provide specific needs such as essential medical care, shelter, or safety, leading to serious physical debilitation or serious physical disease, or making the individual incapable of surviving safely in freedom." 53 AM. JUR. 2D *Mentally Impaired Persons* § 19 (2011).

[128] *See* Randy K. Otto, *On the Ability of Mental Health Professionals to "Predict Dangerousness": A Commentary on Interpretations of the "Dangerousness" Literature*, 18 LAW & PSYCHOL. REV. 43, 44–45 (1994).

[129] Cal. Welf. & Inst. Code § 5150 (West 2012). In California, the maximum term of involuntary detention for gravely disabled people is capped at 47 days; in cases where continued treatment is deemed necessary conservator is appointed prior to the end of the 47 days. Cal. Welf. & Inst. Code § 5270.55 (c).

[130] *See id.*

refuse a cochlear implant, artificial limb, or even a wheel chair; he or she may, to borrow Appelbaum's expression, "rot with their rights on."[131] Why would the state have a greater interest in addressing the grave disability of mentally ill people than addressing the grave disability of non-mentally ill people? Surely the state's interest in a person's "ability" is in no way enhanced just because that person is mentally ill.

A third possible justification is that mentally ill people are involuntarily committed because they are irrational, and mental illness implies irrationality.[132] There are a number of problems with this justification. The first is that while people often accuse each other of being "irrational," there is no generally agreed upon definition for rationality, nor is there any clear way to evaluate whether or not someone meets that standard.[133] Some would try to define rationality as "acting with self[-]interest,"[134] but this fails to resolve the problem because "self-interest" is similarly controversial and problematic to define.[135] How does someone determine what is in their self-interest, or in another's self-interest? People frequently recognize that each individual is best positioned to decide what is in his or her self-interest, though in some cases people with the power to do so paternalistically assert that socially less powerful people[136] do not correctly assess what is in their own best interests. This form of paternalism, however, is not generally driven by any underlying, clarifying theory of

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[131] Appelbaum uses this rather derisive expression in a number of places. *See, e.g.,* APPELBAUM, *supra* note 125, at 137.
[132] *Cf.* Addington v. Texas, 441 U.S. 418, 429 (1979).
[133] *See* RANDALL COLLINS, SOCIOLOGICAL INSIGHT: AN INTRODUCTION TO NON-OBVIOUS SOCIOLOGY 4 (2d ed. 1992); Samantha Godwin, *Children's Oppression, Rights and Liberation*, 4 NW. INTERDISC. L. REV. 247, 275–79 (2011).
[134] *See* William Guth & Ian Macmillan, *Strategy Implementation Versus Middle Management Self-Interest*, 7 STRATEGIC MGMT. J. 313, 313 (1986) (discussing the presumption).
[135] *See id*.
[136] Historical examples include women, slaves, and indigenous populations. Today, children are treated this way. *See* Godwin, *supra* note 133, at 275–79.

rationality or best interest; it is simply the assertion of a value judgment.[137] Value judgments of this type might be more or less persuasive, but they are not uncontroversial, nor do they rest on logical necessity. More importantly, there is no reason to think that psychiatrists are especially well-equipped to make these value judgments, so deferring to psychiatrists on questions of what is "irrational" and how much "irrationality" is sufficient for commitment makes little sense.

The notion that mentally ill people can be confined because they are irrational is also unpersuasive. Irrationality and dangerousness, without mental illness, has not been regarded as sufficient for commitment (as reflected by the fact that mental illness is a required element or component of involuntary commitment statutes). For example, Christian Scientists and Jehovah's Witnesses are motivated by beliefs they agree are not grounded in rationality, but instead dictated by faith. And yet, when these beliefs cause them to refuse lifesaving treatment,[138] the state is generally not permitted to intervene against their will.[139] Several cases have found that irrationality is no obstacle for legal competence to make one's own medical decisions, and a patient's right to refuse medical treatment cannot be

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[137] *See id*.

[138] Christian Scientists reject all physical medical treatment; Jehovah's Witnesses will accept some medical treatments, but not blood transfusions. *See* B.A. Robinson, *Two Christian Groups that Oppose Medical Care*, RELIGIOUSTOLERANCE.ORG, http://www.religioustolerance.org/medical2.htm (last updated Aug. 1, 2010).

[139] *See* 22A AM. JUR. 2D *Death* § 463. There are some instances where courts have found that the state's interests override an individual's liberty or privacy interests; however, courts are often extremely deferential to patient's right to refuse treatment. For instance, in *In re Brown*, an Illinois appeals court found that the trial court erred in allowing a pregnant Jehovah's Witness to be transfused against her wishes according to the state's interests in preserving her life and that of her viable fetus, finding instead that her right to refuse medical treatment was more compelling. *See* In re Brown, 689 N.E.2d. 397, 400 (1997). The Pennsylvania Superior Court found that even where a Jehovah's Witness (who did in fact die) had two children, "there is no evidence to suggest that any state interest in this case was compelling enough to override [the Jehovah's Witness's] refusal of blood. . . . There is no evidence that the state's interest in protecting third parties is implicated here." In re Duran, 769 A.2d 497, 505 (2001).

overridden simply because he or she is irrational.[140] In *Rodriguez v. Pino*, the Florida District Court of Appeals rejected two doctors' arguments that Pino's inability to "make a rational decision" rendered her incompetent to refuse medical treatment.[141] Instead, the court stated that "[o]bviously, a patient may not be deemed incompetent simply because his decision is not a medically appropriate one."[142] In *Lane v. Candura*, the Massachusetts Court of Appeals reversed a lower court's decision to appoint a temporary guardian for a patient who refused a leg amputation, supposedly irrationally. The Massachusetts Court of Appeals found that "the irrationality of her decision does not justify a conclusion that Mrs. Candura is incompetent in the legal sense. The law protects her right to make her own decision."[143] If a patient could be considered incompetent to refuse medical treatment because doing so was not medically appropriate in a physician's view, this would obviously make the right to refuse treatment meaningless.

These cases imply that the state recognizes that it does not have a compelling interest in forced medical treatment, preventing dangerousness, or in confining "irrational" people, but that it does in confining only people who are both dangerous and mentally ill.[144] Because the state does not confine people who are merely mentally ill and refusing treatment, it is not consistent to claim that the compelling interest is found in the state's *parens patriae* interest to provide for citizens who cannot provide for themselves. Instead, one might infer that mentally ill people are assumed to be uniquely

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[140] Shine v. Vega, 709 N.E.2d 58 (Mass. 1999); Matter of Conroy, 486 A.2d 1209, 1225 (N.J. 1985) (offering support for this view in addition to the two cases previously discussed).
[141] Rodriguez v. Pino, 634 So. 2d 681, 686 (Fla. Dist. Ct. App. 1994).
[142] *Id.* at 685.
[143] Lane v. Candura, 376 N.E.2d 1231, 1235 (Mass. App. Ct. 1978).
[144] For example, "Under the Texas Mental Health Code, however, the State has no interest in confining individuals involuntarily if they are not mentally ill or if they do not pose some danger to themselves or others." Addington v. Texas, 441 U.S. 418, 426 (1979).

dangerous, threatening, or uncontrollable, or that psychiatrists are best equipped to predict dangerousness. Both assumptions are completely unfounded, as discussed in the next section.

2. Mental Illness as an Element for Civil Commitment

Involuntary civil commitment is a state law issue,[145] and commitment statutes vary from state to state. However, the overwhelming majority of states require that in order to be involuntarily committed, a person must be both dangerous to him or herself, or others, and mentally ill—a mere finding of dangerousness is insufficient.[146] The reliance on "expert psychiatrists and psychologists"[147] described by the *Addington* Court cannot be justified given the lack of scientific grounding in psychiatric theory. This unreliability is grounded by the reality that psychiatrists are not competent in reliably predicting future dangerousness,[148] and diagnoses of major mental illnesses are not meaningfully associated with future violence.[149]

The MacArthur Research Network on Mental Health and the Law[150] conducted a study where 1,136 people admitted to acute civil inpatient facilities in Worcester, Kansas City, and Pittsburgh were interviewed over a period of twenty weeks from when they were discharged.[151] The study found that a diagnosis of major mental disorders was actually associated with a lower rate of violence than disorders not typically subject to involuntary commitment, such as personality and adjustment disorders.[152] A diagnosis of schizophrenia was particularly associated with lower rates of

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[145] *See* 53 AM. JUR. 2D *Mentally Impaired Persons* § 4 (2011).
[146] *See* 56 C.J.S. *Mental Health* § 54 (2010).
[147] *Addington*, 441 U.S. at 429.
[148] *See* Cocozza & Steadman, *supra* note 111, at 1084–86; Diamond, *supra* note 111, at 439–40.
[149] *See* Paul S. Appelbaum et al., *Violence and Delusions: Data from the MacArthur Violence Risk Assessment Study,* 157 AM. J. PSYCHIATRY 566, 566 (2000).
[150] *See id.*
[151] *See id.*
[152] *See id.*

violence, and there was no association with violence and delusions or hallucinations.[153] The study found that predictive risk factors were largely demographic and that, unaided by actuarial data, psychiatrists are poor at predicting future violence.[154]

The same group of researchers conducted an earlier study with five hundred people in Pittsburgh.[155] The study compared a patient population to a general non-patient population where interviews with collaterals and police record checks were made to determine the prevalence of violence over a ten-week period.[156] The study found that "[t]he prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence of violence among other people living in their communities who do not have symptoms of substance abuse."[157] Of those who commit acts of violence, the types of violence committed by people who had been released from a mental institution and those who were in the community in the same period of time were similar in terms of type, target, and location.[158]

Some judges have also expressed doubt that psychiatrists are able to predict future dangerousness. The Blackmun dissent in *Barefoot v. Estelle*, for example, cites numerous reports that question the ability of psychiatrists

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[153] *See id*.
[154] *See* MACARTHUR RES. NETWORK ON MENTAL HEALTH & L. http://www.macarthur.virginia.edu/mentalhome.html (last updated May 2004).
[155] *See* Henry J. Steadman, et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 393 (1998). *See also The MacArthur Commuinty Violence Study*, MACARTHUR RES. NETWORK ON MENTAL HEALTH & L., http://www.macarthur.virginia.edu/violence.html (last visited Feb. 22, 2012) (discussing the Steadman, et al., study).
[156] *See* Steadman, et al., *supra* note 155, at 393.
[157] *Id.* Those patients who had substance abuse issues or were victims of crimes were more violent than substance abusers and victims of crimes who did not also have major mental illnesses. *See id.* The point remains, though, that major mental illness alone was not an indication of dangerousness, but it could be when combined with one of these three other factors.
[158] *See id.*

to predict dangerousness.[159] The APA's *amicus* brief in *Estelle* stated that "[t]he unreliability of psychiatric predictions of long-term future dangerousness is by now an established fact within the profession."[160] The *Estelle* dissent also cites the APA's "Draft Report of the Task Force on the Role of Psychiatry in the Sentencing Process" as claiming that "[c]onsiderable evidence has been accumulated by now to demonstrate that long-term prediction by psychiatrists of future violence is an extremely inaccurate process."[161] Another commentator said that "[i]n general, mental health professionals . . . are more likely to be wrong than right when they predict legally relevant behavior. When predicting violence, dangerousness, and suicide, they are far more likely to be wrong than right."[162] Although *Estelle* dealt with death penalty sentencing testimony, the unreliability of psychiatric opinions on future dangerousness should equally call into question psychiatric testimony in civil commitment cases, where future dangerousness is also typically among the criteria the state must prove.

3. Deprived of Liberty without Due Process of Law[163]

Before a criminal court can deprive an accused person of his or her liberty, the state must have demonstrated proof of guilt beyond a reasonable doubt.[164] The US Supreme Court ruled in *Addington v. Texas* that due process for civil commitment does not require the same "proof beyond a reasonable doubt standard"—rather, it merely requires a "clear and convincing standard" of proof.[165] The *Addington* Court's reasoned that:

> [T]he state [should not] be required to employ a standard of proof that may completely undercut its efforts to further the legitimate

[159] *See* Barefoot v. Estelle, 463 U.S. 880, 920–22 (1983) (Blackmun, J., dissenting).
[160] *Id.* at 920.
[161] *Id*.
[162] *Id.*
[163] The Fifth Amendment to the US Constitution guarantees that "[n]o person shall . . . be deprived of life, liberty, or property, without due process of law." U.S. CONST. amend. V.
[164] Addington v. Texas, 441 U.S. 418, 421–422 (1979).
[165] *Id.* at 425.

> interests of both the state and the patient that are served by civil commitments."[166] …
>
> We have concluded that the reasonable-doubt standard is inappropriate in civil commitment proceedings because, *given the uncertainties of psychiatric diagnosis, it may impose a burden the state cannot meet* and thereby erect an unreasonable barrier to needed medical treatment.[167]

This reasoning is extremely flawed for numerous reasons. The fact that the "uncertainties of psychiatric diagnoses" are such that they cannot meet the "proof beyond a reasonable doubt" standard required for criminal cases is not a reason to arbitrarily lower the level of proof constitutionally required for due process. Instead, if psychiatric diagnoses cannot meet the burden of proof required by criminal due process to deprive someone of their liberty, psychiatric diagnoses should not be relied on when basic liberty is at stake.

A significant reason why a "proof beyond a reasonable doubt" standard is applied to criminal cases is because the public has a justifiable suspicion of the veracity of the state's case. The mere fact that a police officer or a district attorney says that a person is a criminal who has committed a felony is grossly insufficient to persuade a court that the accused should be sent to prison. Instead, the state must prove its case beyond a reasonable doubt because the state's position alone is insufficient to justify a conviction. Psychiatric theories of mental illness lack a reliable basis in evidence. The fact that the state's psychiatric witnesses receive greater deference than the state's law enforcement officers or attorneys is entirely unjustifiable: at least a prosecutor is required to have some sort of material evidence, whether physical evidence or eyewitness testimony, to bring charges rather than relying on mere suspicion or opinion. A psychiatrist, however, is able to present no material evidence whatsoever.

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[166] *Id* at 430 (emphasis added).
[167] *Id* at 432 (emphasis added).

The argument that "[t]he state [should not] be required to employ a standard of proof that may completely undercut its efforts to further the legitimate interests of both the state and the patient that are served by civil commitments"[168] entirely misses the purpose of constitutionally protected due process. Due process does not protect the "legitimate interests of the state," but the liberty interests of the accused. Many crimes are extremely difficult to prove beyond a reasonable doubt. For many of these difficult-to prove-crimes, the state has an arguably greater interest in criminal prosecution than any typical state interest in civil commitment.[169] The difficulty posed in the prosecution of these crimes does not justify lower due processes standards, and with good reason: the state has no legitimate interests in convicting people who *are not proven guilty*, and the standard of proof used to determine guilt is beyond a reasonable doubt.

A legal finding of guilt is a status that can only be assessed in relation to a standard of proof—a person is guilty for legal purposes *because* he or she has been proven guilty according to a legal process that satisfies the state's burden of proof. If the state arbitrarily lowered the standard of proof in criminal cases so that only clear and convincing evidence was sufficient to find guilt, then the state would be equally able to claim an interest in punishing that new and enlarged set of "guilty" people. When the state has demonstrated guilt to a clear and convincing standard, but not beyond a reasonable doubt, the beyond a reasonable doubt standard undercuts the state's interest in punishing people whose guilt is demonstrated clearly and convincingly. But the state has no legitimate interest in treating those people as *guilty* because the standard is not clear and convincing evidence of guilt, but evidence beyond a reasonable doubt.

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[168] *Id*. at 430.

[169] Perhaps the most widely discussed example is the difficulty of proving rape to such a standard where no physical evidence exists, coupled with the vital social importance of prosecuting rapists. For discussion, *see generally* Shelia Weller, *Why is Date Rape so Hard to Prove?* 6 (4) HEALTH (TIME INC. HEALTH) 62 (Jul. 1992) (discussing these issues).

The same reasoning applies with regard to civil commitment. The state can only claim a legitimate interest in committing people who are mentally ill and dangerous to a clear and convincing (but not beyond a reasonable doubt) standard if it is *presupposed* that the legal threshold for mental illness and dangerousness is clear and convincing evidence and not the beyond reasonable doubt standard. The *Addington* Court's logic, then, is entirely circular. It implicitly posits a legally relevant standard of proof for mental illness and dangerousness of less than beyond a reasonable doubt standard as a justification for insisting that the standard is too burdensome.

Reasoning similar to the *Addington* Court's logic is offered in *Tippett v. Maryland*:

> It must be recognized, however, that as to the ultimate issue of the inmate's dangerousness, the beyond a reasonable doubt standard may in practical operation be too onerous. After all, the ultimate issue is not as in a criminal case whether an alleged act was committed or event occurred, but the much more subjective issue of the individual's mental and emotional character. Such a subjective judgment cannot ordinarily attain the same "state of certitude" demanded in criminal cases.[170]

It is, of course, often true that a finding of dangerousness cannot "attain the same 'state of certitude'" as "demanded in criminal cases."[171] But this again fails to provide a credible justification for lowering the standard, making it is easier to lock people up whose dangerousness is less certain. Whether the deprivation of liberty is to be justified by the fact of an action that actually occurred, or a *Minority Report*-style[172] future prediction of

[170] Tippett v. Maryland, 436 F.2d 1153, 1165 (4th Cir.1971).
[171] *See id*. at 1165.
[172] *See generally* PHILIP K. DICK, THE MINORITY REPORT (2002). "The Minority Report," a famous science fiction short story by Philip K. Dick, involves individuals in law enforcement with the ability to predict future crimes and imprison people accordingly. This story was supposed to be dystopian, but it is essentially the same theory that civil commitment operates under. However, "precrime" predictions in "The Minority Report" were said to be highly accurate, whereas our courts acknowledge the fallibility of

dangerousness, the loss of liberty is the same. It is completely unreasonable to argue that the standard of proof for confining someone for the *possibility* that they *might* commit a crime should be *lower* than the standard of proof required for confining someone for *actually* having committed a crime. In the former instance, the harm to society posed by the accused is purely theoretical; in the latter case, it is actual. The standard of proof used in a trial "serves to allocate the risk of error between the litigants,"[173] and where the interest of the individual greatly outweighs the interest of the state, the standard of proof should allocate the risk overwhelmingly to the state.[174] Whether in a criminal trial or civil commitment proceeding, individuals stand to be deprived of the same liberty interest, and since it is unreasonable to think that the state has a greater interest in preventing *theoretical* harm than in deterring *actual* harm, it follows that the risk of error should be distributed even more extensively onto the state in civil commitment hearings than in criminal trials.

It is possible that the interest in punishing people for crimes they have already committed is different and less than the state's interest in preventing future harm.[175] To punish someone for a crime that is already in the past may do little to remedy the damage, whereas detaining someone so that they cannot commit an act of violence might actually prevent a crime from taking place.[176] To tease out the different interests at work in these two

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psychiatric diagnoses, but nonetheless allow psychiatrists to exercise similar power. For example, see Addington v. Texas, 441 U.S. 432 (1979) as earlier discussed.

[173] Addington v. Texas, 441 U.S. 418, 423 (1979).

[174] *Id.* at 427 ("The individual should not be asked to share equally with society the risk of error when the possible injury to the individual is significantly greater than any possible harm to the state. We conclude that the individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence.").

[175] This point was brought to my attention by Heathcote Wales in comments on an early draft of this paper.

[176] *Id.*

scenarios, consider three principle justifications for criminal punishment.[177] First, punishing criminals might serve to deter others from committing the same crime in the future, thus preventing future harm.[178] Second, physically imprisoning people incapacitates them from harming society while imprisoned.[179] Third, punishment fulfills a retributive role of justice that sets moral standards of acceptable behavior for society by meting out "just deserts."[180]

The police power aspect of civil commitment is, for the most part, justified by only the second state interest: it protects society through incapacitating the committed person. Most criminal prison sentences are justified on all three grounds because they deter, incapacitate, and exact retribution. If civil commitment is justified only in terms of incapacitation, but criminal punishment is justified by incapacitation, deterrence, and retribution, then the state would seem to have greater interests in punishing criminals than involuntarily committing patients.

There are cases, however, where criminal punishment cannot be justified by deterrence or incapacitation. For example, consider a single individual convicted of voluntary manslaughter committed "in the heat of passion" under circumstances extremely unlikely to be repeated. If the crime of voluntary manslaughter due to a "reasonable" emotional rage always went unpunished, then there would be less to deter people from committing the crime in the future. However, a robust deterrent effect could be sustained even if a small number of individuals went unprosecuted (perhaps the ones

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[177] Of course, there are many other justifications for punishment, and this is a necessarily simplified presentation. S*ee Legal Punishment*, STAN. ENCYCLOPEDIA PHIL., http://plato.stanford.edu/entries/legal-punishment/ (last visited Feb. 22, 2012).

[178] *See e.g.,* Kevin Carlsmith, John Darley & Paul Robinson, *Why Do We Punish? Deterrence and Just Deserts as Motives for Punishment,* 83 J. PERSONALITY & SOC. PSYCHOL. 284, 284–99 (2002); JOAN PETERSILIA, WHEN PRISONERS COME HOME: PAROLE AND PRISONER REENTRY 229 (2003).

[179] *See Legal Punishment*, *supra* note 177.

[180] For discussion, see John Braithwaite & Philip Pettit, NOT JUST DESERTS: A REPUBLICAN THEORY OF CRIMINAL JUSTICE 6 (Oxford: Claredon Press 1990).

least likely to recommit). Moreover, the effect of deterrence on true crimes of passion is debatable. Such crimes are surely less likely to be deterred by punishment than premeditated and rationally self-interested crimes.

Incapacitation would also be an insufficient reason to lock people up in this situation since they would pose no danger to others, and because the circumstances in which they killed would not likely arise again. The only justification left for punishing these crimes of passion at all would be retribution and social condemnation. These interests may very well be less compelling than the state's interest in preventing future violence, a supposed purpose for civil commitment. However, the proof beyond a reasonable doubt standard is not reserved only for crimes in which the state has a singular, potentially lesser, interest. The proof beyond a reasonable doubt standard is instead applied to all crimes, including those where deterrence and incapacitation are the most prominent interests served through punishment. When considering the rationale for different standards of proof between criminal punishment and civil commitment, it is necessary to consider the public interests implicated by the entire range of crimes that require a proof beyond a reasonable doubt standard, rather than only the crimes where the state may plausibly have diminished interests in prosecution.

The *Addington* Court again applies circular reasoning by beginning from the implicit premise that an individual subject to civil commitment proceedings is, in fact, mentally ill:

> The heavy standard applied in criminal cases manifests our concern that the risk of error to the individual must be minimized even at the risk that some who are guilty might go free. The full force of that idea does not apply to a civil commitment. It may be true that an erroneous commitment is sometimes as undesirable as an erroneous conviction. . . . Moreover, it is not true that the release of a genuinely mentally ill person is no worse for the individual than the failure to convict the guilty. One who is suffering from a debilitating mental illness and in need of

> treatment is neither wholly at liberty nor free of stigma. It cannot be said, therefore, that it is much better for a mentally ill person to "go free" than for a mentally normal person to be committed.[181]

By arguing that a mentally ill person is not "wholly at liberty" and implying that it is, therefore, worse "for the individual" to allow a "genuinely mentally ill person" to "go free" than it would be to allow a guilty person to go free,[182] the *Addington* Court presupposes that the individual in question is, in fact, "genuinely mentally ill." Obviously, releasing a person who is *not* actually mentally ill has the same consequences as releasing a person who is *not* actually guilty: namely, preserving their freedom rather than wrongfully depriving them of it. The *Addington* Court itself recognizes this issue, stating "[t]his Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."[183]

The *Addington* Court's claim that mentally ill people are not totally free from stigma when not confined[184] has identical problems. Accepting the highly questionable claim that the "mentally ill" are not "free from stigma" whether they are committed or not, courts cannot simply presume that anyone alleged to be mentally ill is in fact mentally ill. Civil commitment also has obviously stigmatizing effects.[185] The *Addington* decision states that:

> [I]t is indisputable that involuntary commitment to a mental hospital after a finding of probable dangerousness to self or others can engender adverse social consequences to the individual. Whether we label this phenomena "stigma," or choose to call it something else, is less important than that we recognize that it can

[181] Addington v. Texas, 441 U.S. 418, 428–29 (1979) (internal citations omitted).
[182] *Id*.
[183] *Id.* at 425.
[184] *See id.* at 429.
[185] *See* Bruce Link & Jo Phelan, *Labeling and Stigma, in* A HANDBOOK FOR THE STUDY OF MENTAL HEALTH: SOCIAL CONTEXTS, THEORIES, AND SYSTEMS 571, 573 (Teresa Scheid & Tony Brown eds., 2d ed. 2010) [hereinafter *Labeling and Stigma*].

> occur and that it can have a very significant impact on the individual.[186]

There is no meaningful way to compare the consequences of false negatives across categories for policy purposes without knowing the ratio of false negatives to true negatives. This problem reaches the point of absurdity when it is recognized that the category of legal guilt exists only as a product of judicial process—one is legally innocent until proven legally guilty by a court of law. While the acts that evidence guilt in a crime have a separate ontological existence from a finding of guilt, there is no test for guilt independent of the judicial system that would produce the potential false negatives and false positives.[187] Similarly, while the behaviors and ideas taken to be "symptoms" of mental illness may have an ontological existence on their own, mental illness itself exists only insofar as psychiatrists label a set of attributes or persons as mentally ill. The comparison between the consequences of a mentally ill person being released to the consequences of a guilty person being released is entirely inappropriate and meaningless for policy purposes.

The conclusion is also extremely strange because it implies that, consequences to the individual aside, it is worse for a mentally ill person to go free than a guilty person to go free. For example, it is hard to imagine any persuasive policy or legal argument that a murderer or mafia boss is better off on the streets than a potentially suicidal person.

Another line of argument adopted in numerous decisions is that a civilly committed person need not be afforded the same protections as a suspect in a criminal case because the intent is not punitive.[188] The Court in *Addington* writes, "there are significant reasons why different standards of proof are called for in civil commitment proceedings as opposed to criminal

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[186] *Addington*, 441 U.S. at 425–26.

[187] Of course, while someone found innocent cannot later be found guilty for the same crime, one found guilty may later be legally exonerated—so this is a case where false negatives are a null set, but false positives are not.

[188] *See* 53 AM. JUR. 2D. *Mentally Impaired Persons* § 5.

prosecutions. In a civil commitment state power is not exercised in a punitive sense."[189] The Court cites *State v. Turner*[190] for the proposition that "the State of Texas confines only for the purpose of providing care designed to treat the individual."[191] This reasoning was described more elaborately in *Schall v. Martin*, where the Court held that juveniles detained pending trial were not being punished, because the purpose of the detention was not expressly punitive, but to prevent them from committing crimes for which they otherwise may not have been detained.[192] The parallels with civil commitment for the mentally ill should be obvious: detention is supposedly justified not to punish someone for an action they have committed, but to prevent them from carrying out some act of violence.

In the more recently decided *Gilford v. People*, the Colorado Supreme Court argued that "since commitment proceedings are not designed to address criminal conduct, but rather are concerned only with the present and future mental health and well-being of the mentally ill individual, it necessarily follows that 'no penal or punitive considerations underlie the state's interest in . . . commitment.'"[193] This reasoning misses the crux of the issue: while the state has no interest in punishing people for being mentally ill, a person has an interest in *not being punished*.

A defender of the *Addington* decision might contend that not only is the state's *intent* non-punitive,[194] but that a civilly committed person, though confined and deprived of liberty, does not in fact *experience* punishment in the same way as a convict because civil commitment is not similarly

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[189] *Addington*, 441 U.S. at 428.
[190] State v. Turner, 556 S.W.2d 563, 666 (Tex. 1977). Turner challenged a judgment confining him indefinitely to a state mental hospital in Texas; the Turner court held that only a preponderance of the evidence was necessary for this indefinite commitment. *Id.* at 563.
[191] *Addington*, 441 U.S. at 428, n.4.
[192] Schall v. Martin, 467 U.S. 253, 253 (1984).
[193] Gilford v. People, 2 P.3d 120, 125 (Colo. 2000) (omission in original) (quoting People v. Chavez, 629 P.2d 1040, 1048 (Colo. 1981)).
[194] *See Gilford*, 2 P.3d at 125. *See also Addington*, 441 U.S. at 423.

stigmatizing. Criminal convictions stigmatize by design because they serve to blame and denounce the convict for behavior that society deems intolerable—civil commitment, however, carries no such blame. Thus, the *Addington* Court might seem justified in thinking that the lack of punitive intent on the part of the state would be relevant—without punitive intent, there is perhaps less stigma. In this way, there might be less interest in avoiding civil commitment because commitment would not bring the social condemnation of a criminal conviction.

This logic relies on a false understanding of the practical social consequences that result from being labeled mentally ill and confined to a mental institution as a danger to oneself or others. Labeling theory and, more relevantly, "modified" labeling theory, as developed in the 1980s by Bruce Link and Jo Phelan of Columbia University's School of Public Health, explain how stigma and subtle discrimination resulting from a mental illness label could have a tremendously negative impact on a person's life.[195]

Early in life, people in society develop a "lay theory about what it means to have a mental illness,"[196] which shapes their expectations about whether people will reject others with "mental illness."[197] Because people who are labeled as having "mental illness" are also socialized in this manner, they may "act less confidently and more defensively, or they may simply avoid a potentially threatening contact altogether." [198] This may result in uncomfortable social interactions, reduced self-esteem, and a diminished quality of life.[199] Link and his colleagues found that people labeled with "mental illness" who recognize that others devalue and discriminate against

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[195] *See Labeling and Stigma*, *supra* note 185, at 573.
[196] Bruce Link & Jo Phelan, *Conceptualizing Stigma*, *in* DEVIANT BEHAVIOR: A TEXT-READER IN THE SOCIOLOGY OF DEVIANCE 264, 274 (Delos H. Kelly & Edward Clarke eds., 7th ed. 2008).
[197] *See id.* at 275.
[198] *Id*.
[199] *See id*.

the mentally ill respond to this recognition with secrecy, withdrawal, and attempts to educate about mental illness.[200] Those who withdraw end up having a limited social network composed primarily of household members.[201] Amy Kroska and Sarah Harkness tested a hypothesis that a cultural perception of mental illness as devalued and discriminated against negatively affects labeled persons, but not unlabeled ones, by comparing community residents to psychiatric patients according to their perceptions of "mentally ill persons," "myself as I really am," and "myself as others see me."[202] The stigmatizing associations between ratings for perceptions of "mentally ill persons," "myself as I really am," and "myself as others see me" was stronger in the labeled group than in the unlabeled group.[203]

Additionally, the potential benefits of treatment do not prevent or reverse the negative effects of stigma. In a longitudinal study, Link found that reported experiences of discrimination continued to negatively impact former patients' lives long after they were "far less symptomatic and largely drug and alcohol free."[204] A follow up study in 1997 by Link found that while "symptoms" improved after treatment, the effects of stigma on self-esteem endured.[205]

It is also generally questionable whether a criminal conviction carries more stigma than involuntary commitment for mental illness and dangerousness. Some crimes, especially violent crimes and sex crimes, are highly stigmatizing. Many non-violent crimes (such as marijuana possession, certain white collar offenses, etc.) seem to have minimal stigma attached in many communities. Prison sentences are generally seen as

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[200] *See* Bruce Link et al., *A Modified Labeling Theory Approach to Mental Disorders: An Empirical Assessment*, 54 AMERICAN SOC. REV. 400, 403 (1989).
[201] *See id*.
[202] Amy Kroska & Sarah K. Harkness, *Exploring the Role of Diagnosis in the Modified Labeling Theory of Mental Illness*, 71 SOC. PSYCHOL. Q. 193, 193 (2008).
[203] *See id.*
[204] *See Labeling and Stigma*, *supra* note 185, at 361, 371.
[205] *See id.*

highly stigmatizing,[206] but they may be less so in communities that have a large population that have been in prison.[207] More robust due process rights are afforded to defendants in many cases that do not even attach to a prison term. By comparison, mental illness might be a stigma of rather mythic proportions: it is common to declare the most despicable public enemies as "insane." For example, Hitler is popularly described as "insane,"[208] as are Kim Jong Il,[209] Saddam Hussein[210], and comic book super villains.[211]

When considering a jurisprudentially consistent due process standard for depriving someone of liberty, the relevant interests to consider are not the state's interests, but the interests of the person whose liberty hangs in the balance. To an individual who expresses no interest in mental health treatment but a profound interest in his or her freedom, the state's purpose is essentially irrelevant. This logic was applied in *Specht v. Patterson*, where the court held that "the punishment under the second Act is criminal

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[206] *See* PETERSILIA, *supra* note 178, at 106–07, 120, 133.
[207] *See id.* at 229.
[208] *See* Erica Goode, *Insane or Just Evil? A Psychiatrist Takes a New Look at Hitler*, N.Y. TIMES, Nov. 17, 1998, http://www.nytimes.com/1998/11/17/science/insane-or-just-evil-a-psychiatrist-takes-a-new-look-at-hitler.html.
[209] *See* Gordon Cucullu, *The Manipulative Mind of Kim Jong Il*, FRONT PAGE MAGAZINE, Dec. 7, 2005, http://archive.frontpagemag.com/readArticle.aspx?ARTID=6357.
[210] CIA profiler Jerrold Post tried to discourage people from thinking that Saddam Hussein was actually "insane" or "crazy," alleging instead that Saddam Hussein's mental illness was "the most dangerous political personality type, what's called malignant narcissism" stating that "he is so consumed by compensatory self-adoration, messianic ambitions, grandiose self concept…that he has no capacity for caring for his own people. No capacity for the pain, the suffering of others." *Profiler: Saddam's Not Insane* ABC NEWS, Feb. 25, 2003, http://abcnews.go.com/Nightline/story?id=128495&page=1#.T6jTYlHEpFI . This type of remote psudo-diagnoses of more precisely described and psychologized mental illness is probably better propaganda than simply declaring a political enemy insane, because it comes across as more precise and legitimate.
[211] *See Institutional Care*, GROPING THE ELEPHANT, http://gropingtheelephant.wordpress.com/2009/08/30/institutional-care/ (last visited Feb. 22, 2012).

punishment even though it is designed not so much as retribution as it is to keep individuals from inflicting future harm."[212]

The assertion that the state's supposed interest ought to be the deciding factor in how much due process someone is afforded invites the possibility that the state could reduce its burden and imprison more people simply by relabeling socially undesirable groups subject to civil, rather than criminal, sanctions. This possibility was hinted at in *Powell v. Texas*, a case in which a person convicted of public drunkenness attempted to rely on the excuse that he was "mentally ill" with "alcoholism."[213] The *Powell* Court stated:

> [T]he medical profession cannot, and does not, tell us with any assurance that, even if the buildings, equipment and trained personnel were made available, it could provide anything more than slightly higher-class jails for our indigent habitual inebriates. Thus we run the grave risk that nothing will be accomplished beyond the hanging of a new sign—reading "hospital"—over one wing of the jailhouse. One virtue of the criminal process is, at least, that the duration of penal incarceration typically has some outside statutory limit; this is universally true in the case of petty offenses, such as public drunkenness, where jail terms are quite short on the whole. "Therapeutic civil commitment" lacks this feature; one is typically committed until one is "cured." Thus, to do otherwise than affirm might subject indigent alcoholics to the risk that they may be locked up for an indefinite period of time under the same conditions as before, with no more hope than before of receiving effective treatment and no prospect of periodic "freedom."[214]

Far from reducing the need for due process protections, supposedly non-punitive civil commitment can result in a longer and more severe loss of freedom. As the *Powell* Court described, renaming a jailhouse wing to "hospital" hardly alleviates the harms of confinement.[215] It is also certainly

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[212] Specht v. Patterson, 386 U.S. 605, 608–09 (1967).
[213] Powell v. Texas, 392 U.S. 514, 521, 532 (1968).
[214] *Id.* at 529.
[215] *See id.*

not clear that confinement in a mental institution is a lesser loss of liberty than confinement in a prison. Involuntary commitment in a mental institution, like a prison, locks people away against their will, depriving them of their freedom of movement and ability to participate in society at large. While most patients in the majority of mental hospitals may have better conditions than those in super-max prisons, defendants serving time in comparatively comfortable minimum security prisons and federal prison camps still enjoy a right to be tried by a beyond a reasonable doubt standard. Patients may be subjected to pressure and leveraging to compel them to take psychotropic medication against their will; they can be mechanically restrained and injected with mind-altering drugs; many are put in conditions essentially comparable to solitary confinement (euphemized as "seclusion").[216] In these ways, it is easy to imagine that involuntary commitment can sometimes represent a more extreme and total loss of liberty than many prison terms.

IV. CONCLUSION

Having explained why psychiatry is not, and cannot be, a legitimate science capable of informing the meaning of facts to a court and how the specter of mental illness is used as an unjustifiable means of circumventing due process, I conclude with some brief but substantial recommendations for mental health law reform.

First, psychiatric diagnoses should not form part of the criteria for determining who is civilly committable. As described in Part One, theories of mental illness are unverifiable and the concept of specific and discrete diagnoses is incoherent. As described in Part Two, the presence of a diagnosis of major mental illness, or of hallucinations or delusions, is not by itself predictive of future violence. Psychiatrists are extremely poor at

[216] *See generally* Laura Stokowski, *Alternatives to Restraint and Seclusion in Mental Health Settings: Questions and Answers from Psychiatric Nurse Experts*, MEDSCAPE TODAY, May 3, 2007, http://www.medscape.com/viewarticle/555686.

predicting "dangerousness," rendering them useless for the purposes relied on for civil commitment. Retaining psychiatrically described "mental illness" as a criterion for involuntary commitment arbitrarily privileges the collective and individual guesses of a profession that is incapable of fulfilling the trust courts place in it.

Second, while the state has a legitimate interest in preventing highly probable acts of violence, lowering the burden of proof in order to "prove" dangerousness is inconsistent with the notions of justice and fairness on which liberal democratic legal systems are based. Because the liberty interest implicated in civil commitment is the same as in criminal incarceration, for the state to legitimately confine someone on a theory of future dangerousness, due process should be understood to demand the same level of proof beyond a reasonable doubt that is normally required to confine someone for extended lengths of time. Since, as the *Addington* Court argued, this higher burden of proof is unlikely to be met on a question of future harm rather than on a question of actual harm, commitment for dangerousness should also be abolished or used very sparingly when there truly is proof beyond a reasonable doubt. People who *prove* themselves dangerous by way of a conviction for an actual crime should instead be able to voluntarily seek psychiatric treatment within the criminal justice system (possibly in hospital facilities segregated from other prisoners). Such a scheme would retain any possible benefits of civil commitment, including the availability of treatments that may be helpful even if the diagnoses associated with it are not scientifically valid. It would do so, however, without violating people's civil rights through preventative detention with dubious rationale and insufficient due process.