

# SOUNDING THE MIND: ON THE DISCRIMINATORY ADMINISTRATION OF PSYCHOTROPICS AGAINST THE WILL OF THE INSTITUTIONALIZED

KEVIN NEWMAN\*

## I. INTRODUCTION

Even outspoken critics of the involuntarily administration of psychotropic medication acknowledge that pharmaceutical intervention is often the best hope for many with mental illness to assimilate safely back into their communities and live robust, productive lives.<sup>1</sup> But while individuals generally have a nearly limitless right to choose what may enter their bodies, however ill-advised or insalubrious that choice, it remains legally unclear whether consumers of mental health services, particularly the involuntarily committed, possess a right to turn away drugs that trained caregivers believe to be appropriate and salutary, both to their charges and to the society at large.

The right to refuse turns on two inquiries: whether an individual is competent to decide what is in his or her best interest and, if so, whether

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\* Class of 2013, University of Southern California Gould School of Law; B.A. Plan II Honors Program 1999, University of Texas at Austin; M.F.A. Creative Writing 2004, Columbia University. I want to give special thanks to my Note advisor, Professor Elyn Saks, who asked me to be a part of the Institute that bears her name, and tirelessly guided me throughout my research. I also owe a debt of gratitude to the members of the RLSJ Board and Staff for the tremendous part they played in helping me realize this Note.

<sup>1</sup> See, e.g., ELYN SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL 84 (1999) (acknowledging that although she has strong criticisms against forced administration of psychotropic medication, “drugs have enabled many of the afflicted to live happy, functional lives in the community”).

the state has a legitimate reason to deny that decision.<sup>2</sup> The preliminary task of establishing the incompetency of the civilly committed is not as straightforward as it might first seem—one's institutionalization alone will not do.<sup>3</sup> In fact, while legal scholars have sought to hew a competency standard out of reason, common sense, and even personal experience, no clear criteria have emerged from the bench that would dispose of the issue.<sup>4</sup> Nonetheless, even those patients deemed competent may be stripped of their right to refuse medication if they fail the second inquiry: whether the state's interest outweighs the individual's.<sup>5</sup> But what are these competing interests and by what process can they fairly be weighed? Two decades ago, in *Mills v. Rogers*, the Supreme Court declined to answer these questions, leaving lower courts, in lieu of a crystalline rule, to invoke and follow related precedent in the markedly different context of criminal institutionalization.<sup>6</sup> The procedure widely used at psychiatric institutions is to convene non-judicial panels to balance individual liberty against government exigency.<sup>7</sup> This hearing process, while incidentally educating mental health consumers as to why they are being medicated, is largely a perfunctory formal requirement that in practice serves as a mere rubber stamp.<sup>8</sup> Although troubling, the decision to force mind-altering chemicals into an individual's bloodstream—to say nothing of the Kafkaesque principle conferring on extra-judicial panels the power at once to recommend medication and to silence objections—is eclipsed by the problematic and empirical reality that psychiatric diagnoses for the institutionalized have long been tainted by invidious and insidious racial and gender biases.<sup>9</sup>

It is a contention of this Note that courts cannot continue to pawn off their responsibility to adjudicate in light of diagnoses which result not

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<sup>2</sup> See *In re Qawi*, 81 P.3d 224, 232–33 (Cal. 2004).

<sup>3</sup> See, e.g., *Rogers v. Comm'r of the Dep't of Mental Health*, 458 N.E.2d 308, 313–14 (Mass. 1983) (“a person diagnosed as mentally ill and committed to a mental institution is still considered to be competent enough to manage his personal affairs”).

<sup>4</sup> See, e.g., Elyn Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 945 (1991) (“neither statutes nor case law clearly articulate or apply a competency standard”).

<sup>5</sup> *In re Qawi*, 81 P.3d at 232–33.

<sup>6</sup> *Mills v. Rogers*, 457 U.S. 291, 304–05 (1982) (refusing “to weigh or even to identify relevant liberty interests that might be derived directly from the Constitution, independently of state law”).

<sup>7</sup> *Washington v. Harper*, 494 U.S. 210, 231–32 (1990).

<sup>8</sup> Bruce Winick, *Forcible Medication*, in *ENCYCLOPEDIA OF PSYCHOLOGY AND LAW* 326, 326–29 (2007).

<sup>9</sup> See *infra* Part IV.

wholly from biological differences between men and women, or between Whites and Blacks, but from impermissible and often unconscious racist and sexist forces yet to be eradicated in the practice of psychiatry.<sup>10</sup> This is an especially great danger given the manner in which certain psychiatric diagnoses pathologize the distinctive, often contrarian perspectives of these groups, undermining the credibility—the very sanity—of their voices.<sup>11</sup> With these perspectives and hard data incorporated in the analysis, something counterintuitive suddenly becomes sensible: psychiatrists, and the medical personnel working with them, no matter how well-meaning, are precisely the wrong professionals to turn to for an unbiased decision regarding treatment that infringes on a person's right to cognitive liberty, which is to say, the right to think for oneself.

Relying on historical, sociological, and psychological sources, this Note endeavors to enlarge and reconfigure the question of an institutionalized person's right to refuse medication. It argues that a persistent, documented inequality in decisions to medicate exposes the folly of blind adherence to medical judgment and imposes on the judiciary a legal and ethical duty to engage these questions collaboratively with experts and caregivers. Part II surveys Supreme Court precedent that interprets and informs current state practices. Part III explores the freedoms implicated by forced medication: the freedom to decline the administration of medication and thereby its adverse effects, as well as the freedom of cognitive thought demanded by a materialistic approach to the mind. Part IV introduces the philosophical bases for pathologizing statistically deviant behavior and suggests that psychiatry and its traditional prescriptions be met with strong skepticism. Part V further explores this idea by examining the effects of these presumptions through the disproportionate diagnoses of schizophrenia in African-Americans and borderline personality disorder in women. Finally, the Note puts forth legislative and judicial solutions to these problems, and offers guidance to advocates looking to protect the right of mental health consumers who would refuse, if they only had the right, medications that alter how they think.

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<sup>10</sup> *Id.*

<sup>11</sup> See *infra* Part III.

## II. WHEREFORE *ROMEO*?: THE TENUOUS LEGAL BASIS OF FORCIBLE MEDICATION AND ITS UNLIKELY PROGENITOR

How did it come to pass that fundamental liberties like the right to privacy<sup>12</sup> and freedom of thought,<sup>13</sup> on which the right of competent individuals to refuse medication is predicated,<sup>14</sup> can be practically extinguished on the strength of purely non-judicial determinations?<sup>15</sup> The process can likely be traced to a holding in the 1982 case of *Youngberg v. Romeo*, a dispute which arose out of a related but separate issue.<sup>16</sup>

Nicholas Romeo was a thirty-three-year-old man with the mind of a toddler.<sup>17</sup> While a resident of Pennhurst State School and Hospital, he was prone to fits of violence, inflicting and sustaining injuries by the dozen.<sup>18</sup> After breaking his arm in one such incident, he was brought to the hospital ward whereupon officials shackled him while he healed and indefinitely beyond.<sup>19</sup> His mother brought suit, arguing that the state's use of physical restraints violated his Eighth Amendment protection against cruel and unusual punishment.<sup>20</sup> Although the Court found a substantive liberty interest in free movement, the Court's deference to medical-professional judgment weakened the protection of this interest in cases of restraint.<sup>21</sup> A legacy of *Youngberg*, the consequences of which reverberate into realms quite distant from those then at issue, was the creation of a presumption that professional judgment is valid with respect to care for the institutionalized, trumping a patient's desire for alternative courses of treatment or simply to be left alone.<sup>22</sup>

Less than a decade after *Youngberg*, the Supreme Court was

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<sup>12</sup> See, e.g., *Miller v. Rumsfeld*, 647 F.2d 80 (9th Cir. 1981) (referencing "the fundamental right of privacy" that emerged out of the line of cases beginning with *Griswold v. Connecticut*, 381 U.S. 479 (1965)).

<sup>13</sup> See, e.g., *Schneiderman v. U.S.*, 320 U.S. 118 (1943) ("If any provisions of the Constitution can be singled out as requiring unqualified attachment, they are the guaranties of the Bill of Rights and especially that of freedom of thought contained in the First Amendment.").

<sup>14</sup> See *In re Qawi*, 81 P.3d 224, 232–33 (Cal. 2004).

<sup>15</sup> See *Youngberg v. Romeo*, 457 U.S. 307 (1982).

<sup>16</sup> See *id.*

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* at 310.

<sup>19</sup> *Id.* at 310–11.

<sup>20</sup> *Id.*

<sup>21</sup> *Id.* at 322–23.

<sup>22</sup> *Id.* at 323.

presented with the question of what minimal procedural rights were guaranteed for an institutionalized person who objected to the administration of prescribed medication.<sup>23</sup> The state policy at issue in *Washington v. Harper* gave doctors power to administer unwanted medication to inmates who were found to be gravely disabled or thought to be a danger to themselves or others so long as the medication was believed to be in their best interest.<sup>24</sup> But *whose* finding would suffice? The Court held that the right of a panel within the institution to conduct an administrative review comported with due process, thereby dispensing with the need for a full judicial hearing.<sup>25</sup> The *Harper* decision has been lauded by many in the mental health community as a clear affirmation of an individual's liberty to refuse medication, insuperable by anything short of a clear government showing that rigorous standards and procedures have been met for the administration of such medication.<sup>26</sup> But insofar as *Harper* expressly deprives institutionalized inmates their day in court in the name of "institutional convenience,"<sup>27</sup> leaving them at the mercy of committees drawn from the ranks of the selfsame institutions with whose decisions they vigorously disagree, it must be asked just how "rigorous" such a process can be.

In the years following *Harper*, the Court has twice brought its right-to-refuse analysis to bear on the question of an individual's competency to stand trial and in both cases reformulated its approach to consider less intrusive alternatives.<sup>28</sup> In *Riggins v. Nevada*, the Court decried the Nevada state policy requiring no inquiry into "reasonable alternatives," finding that a state's right to forcibly medicate a prisoner awaiting trial on murder and robbery charges came with a corresponding obligation to establish the need of the chosen treatment.<sup>29</sup> In the context of non-violent offenses, the Court went further still, holding in *United States v. Sell* that the government may not medicate forcibly if "alternative, less intrusive

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<sup>23</sup> *Washington v. Harper*, 494 U.S. 210, 222–23 (1990).

<sup>24</sup> *Id.* at 222.

<sup>25</sup> *Id.* at 231–32.

<sup>26</sup> *Id.* See also Chuck Weller, *Forced Administration of Antipsychotic Drugs to Civilly Committed Mental Patients in Nevada: A Remedy Without a Clear Statutory Authorization*, 11 NEV. L.J. 759, 764 (2011) (citing, and concurring with a position statement of Mental Health America endorsing the opinion found in *Harper*).

<sup>27</sup> See *Harper*, 494 U.S. at 249–50 (Stevens, J., dissenting).

<sup>28</sup> See *Riggins v. Nevada*, 504 U.S. 127, 136 (1992); see also *United States v. Sell*, 539 U.S. 166, 180–81 (2003).

<sup>29</sup> *Riggins*, 504 U.S. at 136.

treatments” exist that could serve a substantially similar end.<sup>30</sup> This inquiry into the availability of alternative treatments marks an important departure from *Youngberg*, which found it “not appropriate for courts to decide” among viable alternatives,<sup>31</sup> as well as from *Harper*, which ruled out any alternative that came at more than a “*de minimis* cost to valid penological interests.”<sup>32</sup> After decades of nugatory doctrinal movement on the question of forced medication, *Sell* gives reason for guarded optimism, inviting policy makers and advocates to establish the substantial similarity between alternative treatments and psychotropic medications that can provide the legal basis for refusal.<sup>33</sup>

### III. OWNING THE SELF: THE RIGHT TO CONTROL THE BODY AND THE MIND

While the majority in *Harper* affirmed the Washington State policy of providing a three-person board to assess an inmate’s mental health, his own interests, and the interests of those with whom he would come into contact,<sup>34</sup> Justice Stevens’ powerful dissenting opinion found intractable the majority’s notion that a person could have a “significant liberty interest” in refusing unwanted medication while so brusquely ignoring the “several dimensions of that liberty.”<sup>35</sup> Of those liberties, Stevens said:

They are both physical and intellectual. Every violation of a person’s bodily integrity is an invasion of his or her liberty . . . . And when the purpose or effect of forced drugging is to alter the will and the mind of the subject, it constitutes a deprivation of liberty in the most literal and fundamental sense.<sup>36</sup>

That the intellect, like the body, is altered by medication might strike few as an especially novel proposition.<sup>37</sup> But, by drawing attention to cognitive liberty claims, Stevens was actually joining an increasingly urgent debate as to what psychotropic medication in fact does to one’s mental processes.<sup>38</sup> However, before turning to that debate, we will

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<sup>30</sup> *Sell*, 539 U.S. at 180–81.

<sup>31</sup> *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982).

<sup>32</sup> *Harper*, 494 U.S. at 211 (majority opinion).

<sup>33</sup> *See Sell*, 539 U.S. at 181.

<sup>34</sup> *Harper*, 494 U.S. at 236 (Stevens, J., dissenting).

<sup>35</sup> *Id.* at 211 (majority opinion).

<sup>36</sup> *Id.* at 237–38 (Stevens, J., dissenting).

<sup>37</sup> *Id.*

<sup>38</sup> *Id.* at 237.

address the more obvious deprivation worked on those subjected to medication against their will: the interest in bodily integrity.

#### A. INTERESTS OF THE BODY

Implicit in the common law tort of battery is the right to bodily integrity, which recognizes the “[t]he inviolability of the person”<sup>39</sup> and the “thorough-going self determination” that animates much of Anglo-American law.<sup>40</sup> The right to bodily integrity protects individuals not merely from malign invasions but also from those calculated to produce a healthful effect.<sup>41</sup> Mental health consumers wishing to turn away medication, however, will find the right largely eviscerated by the decisions in *Youngberg* and *Harper*, both of which authorize courts to yield to state statutes impinging on that liberty so long as the statutes promote any legitimate purpose.<sup>42</sup>

But the strongest arguments now offered as evidence of a state’s legitimate interest in forcibly medicating may be more tenuous than previously believed. Elyn Saks, Professor of Law at the University of Southern California, identifies and disposes of what she avers are the three strongest arguments for medicating the unwilling, and suggests workable alternatives to each.<sup>43</sup> She asks only whether each alternative is consistent with one criterion: it must offer equal treatment, hence equal respect and dignity, to persons irrespective of their mental health. The first argument a state could make is that it has a legitimate interest in expeditiously rehabilitating the mentally ill to free up limited space and resources in its institutions of civil commitment. Saks counters by insisting that budgetary concerns are “never a sufficient justification to abridge so important a right.”<sup>44</sup> The state might reply that it needs, in any event, to protect patients who are threatened by another within the institutional setting.<sup>45</sup>

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<sup>39</sup> *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 252 (1891).

<sup>40</sup> *Natanson v. Kline*, 350 P.2d 1093, 1104 (1960).

<sup>41</sup> The right to refuse psychotropic medication should not be confused with the right to refuse life-saving medication, which is often governed by the doctrine of informed consent that only a competent person can supply, and which touches on unique state interests. Among these state interests are: “the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession.” See *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 271 (1990).

<sup>42</sup> See *Youngberg v. Romeo*, 457 U.S. 307, 320–21 (1982); *Harper*, 494 U.S. at 225 (1990).

<sup>43</sup> *SAKS*, *supra* note 1, at 85–86.

<sup>44</sup> *Id.* at 85.

<sup>45</sup> *Id.*

Here, Saks, who has written extensively on the dangers and abuses associated with mechanical restraints,<sup>46</sup> offers restraints and seclusion as potentially viable alternatives.<sup>47</sup> While she may at first seem to be ceding ground, Saks emphasizes that these techniques are permissible only in extreme circumstances because they could also be permissibly applied to people without mental illness. Lastly, the state might put forward its *parens patriae* interest in protecting its citizens by alleviating their pain and suffering.<sup>48</sup> Though there is virtue in the reduction of suffering, because the state still cannot force people *without* mental illnesses to treat pain they prefer to leave untreated,<sup>49</sup> Saks' criterion of choice is not met and the practice cannot be justified.

But more than ancillary to the right to be free from unwanted medication is an individual's interest in being free from the varied, often quite serious, and sometimes lethal adverse effects of psychotropic medication.<sup>50</sup> The *Harper* court, while paying some mind to the findings of an amicus brief prepared by the American Psychological Association, ultimately dismissed these concerns.<sup>51</sup> In a lengthy passage from the majority opinion rejecting each of the side effects commonly associated with antipsychotics, the Court callously brushed off the severity of the effects they describe and the non-negligible percentages of users affected.<sup>52</sup> Of dystonia, "a severe involuntary spasm of the upper body, tongue, throat, or eyes," the Court deferred to a ruling at the trial level that yet another drug, Cogentin, could be administered to treat and reverse the illness.<sup>53</sup> Notably missing in this suggestion is any effort to track down known side effects associated with Cogentin, readily available had the Court bothered to seek them out, viz. tachycardia, anorexia, and toxic psychosis.<sup>54</sup> Of neuroleptic malignant syndrome, the Court was willing to accept the possible consequence of "death from cardiac dysfunction" since

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<sup>46</sup> See, e.g., Elyn R. Saks, *The Use of Mechanical Restraints in Psychiatric Hospitals*, 95 YALE L.J. 1836 (1986) (arguing that "[b]ecause the treatment benefits of restraints are highly speculative, a practice so restrictive and degrading as mechanical restraints is justified only in the face of imminent and serious danger").

<sup>47</sup> *Id.* at 1851–52.

<sup>48</sup> SAKS, *supra* note 1, at 85.

<sup>49</sup> *Id.* at 88.

<sup>50</sup> *Id.* at 84.

<sup>51</sup> *Washington v. Harper*, 494 U.S. 210, 230–31 (1990).

<sup>52</sup> *Id.*

<sup>53</sup> *Id.* at 229–30.

<sup>54</sup> *Cogentin Side Effects*, DRUGS.COM Online, available at <http://www.drugs.com/sfx/cogentin-side-effects.html> (last visited Apr. 13, 2013).



it is “relatively rare.”<sup>55</sup> With respect to the particularly troubling side effect tardive dyskinesia, “a neurological disorder, irreversible in some cases, that is characterized by involuntary, uncontrollable movements of various muscles, especially around the face,” the Court considered the divergent opinions of the State and of the amici before deciding that a “fair reading” suggests that about ten to twenty-five percent will experience tardive dyskinesia and that ten percent of those cases will be severe, a figure with which the majority is obviously perfectly comfortable.<sup>56</sup>

Although even a modest shift in the ideological balance of the Court could be enough to overturn this line of reasoning, *stare decisis* notwithstanding, consider that not only are some living with mental illness forced to cope with the physical changes worked by psychotropics, they are left at the mercy of the prevailing state of the medical art. When new medications, presumably more effective or targeted than their predecessors, are introduced into the market, those who would be forcibly medicated will have no opportunity to argue that the side effects of these new medications are not meaningfully more severe than those the *Harper* Court was willing to tolerate. The Court’s standard for tolerating side effects was based on a “fair reading” of information supplied by litigants of a given time, dealing with drugs on the market at that given time, and corresponding to a given state of pharmacological understanding.<sup>57</sup> To this end, the standard is no standard at all; it is at best a mere historical description.

Additionally, to justify a second look at the hardline stance taken with respect to side effects, lawyers could call upon the principle, which they failed to do in *Harper*, that a patient may not be forced to take psychotropic medication unless it is in his or her best interest, with full consideration of the known and unknown dangers of medications. An analysis of a patient’s best interests is woefully incomplete without fully weighing the therapeutic good with the iatrogenic bad. All courts, including even the current Supreme Court, could thus use the occasion of litigation involving drugs unknown in 1990, the year *Harper* was decided, to rethink the cold, gruff reasoning that the state may compel individuals to subject their bodies to extraordinary, untold risks.

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<sup>55</sup> *Washington v. Harper*, 494 U.S. 210, 229–30 (1990).

<sup>56</sup> *Id.* at 230–31.

<sup>57</sup> *Id.* at 230–31.

## B. INTERESTS OF THE MIND

In his famous paean to the "liberty of the mind," Justice Cardozo listed freedom of thought as first among the fundamental rights to be incorporated into the Fourteenth Amendment.<sup>58</sup> This freedom, he wrote, represents "the indispensable condition, of nearly every other form of freedom."<sup>59</sup> Justice Jackson viewed the freedom of mind as a bulwark against the kind of "officially disciplined uniformity for which history indicates a disappointing and disastrous end."<sup>60</sup>

If medication can alter thought, forcing medication on the unwilling subject comes at great cost to his freedom "to select how [he] will think" and fails to appreciate that "the right to control thinking processes is the right of each individual person."<sup>61</sup> Cognitive liberty, understood as a right to *choose* what to think, to forge *personal* meaning, is a species of—perhaps even reduces to—freedom of thought. But implicit in the low-level scrutiny with which the court in *Harper* analyzed the state policy of providing administrative panels in place of judicial hearings is a rejection of the view that the alteration of thought caused by psychotropic medication amounts to an encroachment on a fundamental right.<sup>62</sup> The ability to produce one's own ideas, which psychotropic medication jeopardizes, is necessary to have a meaningful First Amendment right to communicate those ideas, one "as important as the right protected in *Roe v. Wade*."<sup>63</sup> Forcible medication frequently and drastically curtails this fundamental right of cognitive liberty.

It was not until the 1950s that the first antipsychotic medications were developed and marketed in the United States, offering willing

<sup>58</sup> *Palko v. Connecticut*, 302 U.S. 319, 327 (1937) (holding that only provisions of the Bill of Rights necessary to the existence of liberty or justice, such as freedom of thought, apply to the states through the Fourteenth Amendment), *overruled by* *Benton v. Maryland*, 395 U.S. 784 (1969) (adding the double jeopardy prohibition of the Fifth Amendment as a right applying to the states through the Fourteenth Amendment).

<sup>59</sup> *Id.*

<sup>60</sup> *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 637 (1943).

<sup>61</sup> Thomas B. Roberts, *Academic and Religious Freedom in the Study of the Mind*, in *ENTHEOGENS AND THE FUTURE OF RELIGION* 137, 141 (Robert Forte ed. 1997).

<sup>62</sup> *Washington v. Harper*, 494 U.S. 210, 226 (1990) (finding the Washington State policy a "rational means of furthering the State's legitimate objectives").

<sup>63</sup> Thomas Gutheil & Paul Applebaum, "Mind Control," *Synthetic Sanity*, "Artificial Competence," and *Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 *HOFSTRA L. REV.* 77, 82 (1983) (quoting *Rogers v. Okin*, 478 F. Supp. 1342, 1367 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom.*, *Mills v. Rogers*, 457 U.S. 291 (1982)).

individuals relief from unwanted, often destructive thoughts.<sup>64</sup> For the greater part of the country's history, however, it was taken for granted that thought processes were unsusceptible to control and thus inherently free. Only recently have pharmacological breakthroughs made it possible to alter thought processes through the intervention of medication that changes the brain's neurochemistry.<sup>65</sup> In praising the virtues of cognitive enhancement, law professor Marc Blitz argues:

The power to reshape our thinking processes biologically should be recognized as merely one form of a more general power that our freedom of mind is intended to place firmly in our own hands, not in the hands of government officials: namely, the power to make autonomous choices about the shape of the self that perceives, learns, archives, and re-imagines the world.<sup>66</sup>

Blitz has in mind a freedom to seek medication that would alter one's thought processes for the "better," but his argument also implicitly countenances the autonomy interest in refusing any medication capable of altering the "the shape of the self."<sup>67</sup>

That thoughts are inseparable from the neurochemistry that produces them is an idea of relatively contemporary provenance. While three-and-a-half centuries ago René Descartes, in his *Meditations on First Philosophy*, first described body and mind as separate substances—a physical structure causally interacting with an ethereal spirit—few scientists today, now equipped with a superior understanding of brain mechanisms and functions, take seriously any idea but that the body and mind are one and the same.<sup>68</sup> Still, modern and thoroughly scientific materialism, the view "of the mind as a biological manifestation within the brain," is neither widely accepted nor intuitive.<sup>69</sup> But Cartesian dualism, a conception of the mind as the incorporeal locus of reason and the brain as the physical structure of computation, runs deep.<sup>70</sup> It is this understanding about the

<sup>64</sup> Cini Abraham & Nancy N. Cain, *Psychotropic Medications*, in *ENCYCLOPEDIA OF APPLIED DEVELOPMENTAL SCIENCE* 891, 891 (2004).

<sup>65</sup> Marc Jonathan Blitz, *Freedom of Thought for the Extended Mind: Cognitive Enhancement and the Constitution*, 2010 WIS. L. REV. 1049, 1053 (2010).

<sup>66</sup> *Id.* at 1054.

<sup>67</sup> *Id.*

<sup>68</sup> Howard Robinson, *Dualism*, in *THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY* (Edward N. Zalta ed. 2003), <http://plato.stanford.edu/archives/fall2003/entries/dualism>.

<sup>69</sup> Andrew Lelling, *Eliminative Materialism, Neuroscience, and the Criminal Law*, 141 U. PA. L. REV. 1471, 1476 (1993).

<sup>70</sup> Adam Benforado, *The Body of the Mind: Embodied Cognition, Law, and Justice*, 54 ST. LOUIS U. L.J. 1185, 1190 (2010) (describing dualism as "the language of the law and the core of

world, a product of our “moral intuitions,” that has shaped the law, and only a steady acceptance of the implications of modern neuroscience is likely to alter those intuitions and ultimately the law itself.<sup>71</sup>

That neurochemical processes and thoughts themselves are distinct is a critical conceptual leap. After all, if medication can be said to target merely a defective process, then a person cannot claim as strong a possessory interest in the thoughts arising by virtue of that process. Research into the nascent field of embodied cognition gives experimental credence to materialism, revealing how “[o]ur perceptions, attitudes, feelings, memories, and judgments are influenced—indeed, constructed—by bodily states and experiences.”<sup>72</sup> Thoughts are not independent from brain chemistry but grounded in it.<sup>73</sup>

It is perhaps a lingering attachment to dualism that has made it easier for courts to view medications as affecting the chemical pathways of thought processes, seen as physical, somehow more “brain-like,” rather than as affecting thoughts, seen as transitory and elusive, somehow more “mind-like.” While judicial opinions have addressed the role of psychotropics in altering a patient's cognitive processes,<sup>74</sup> the Ninth Circuit has indicated it might be responsive to the materialist line of reasoning.<sup>75</sup> In *Mackney v. Procunier*, the court did not distinguish the mental from the material aspects of cognition when it found that the administration of a drug in preparation for electroshock therapy for alleged experimental purposes constituted “impermissible tinkering with mental processes.”<sup>76</sup> Helping betray the notion that thought and thought processes are inseparable categories, the court cited such landmark fundamental

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our culture”).

<sup>71</sup> Joshua Greene & Joshua Cohen, *For the Law, Neuroscience Changes Nothing and Everything*, 359 PHIL. TRANSACTIONS ROYAL SOC'Y B: BIOLOGICAL SCI. 1775, 1779 (2004).

<sup>72</sup> Benforado, *supra* note 70, at 1190.

<sup>73</sup> *Id.*

<sup>74</sup> See, e.g., *Washington v. Harper*, 494 U.S. 210, 229 (1990) (“The purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes.”); *Cochran v. Dysart*, 965 F.2d 649, 650 (8th Cir. 1992) (“The purpose of psychotropics is to change a patient's cognitive processes by altering the chemical balance in the brain.”).

<sup>75</sup> *Eisenstadt v. Baird*, 405 U.S. 438, 452 (1972) (establishing that unmarried people have the same “right to privacy” as married couples to possess contraception); *Stanley v. Georgia*, 394 U.S. 557, 564 (1968) (establishing an implied “right to privacy” that prohibited making the private possession of obscene material a crime); *Roe v. Wade*, 410 U.S. 113, 149–54 (1973) (establishing that the “right to privacy” extended to a woman's decision to have an abortion).

<sup>76</sup> *Mackey v. Procunier*, 477 F.2d 877, 878 (1973).

rights cases as *Eisenstadt v. Baird*, *Stanley v. Georgia*, and *Roe v. Wade*.<sup>77</sup>

Strong arguments suggesting that thoughts result from physical processes of the brain, and not from the province of the mind, would serve the legal end of equating forced medication with forced thought. Dov Fox demonstrates what these arguments, which address the “conceptual schism of mind and body,”<sup>78</sup> might look like:

Recent research into the human nervous system has uncovered the existence of discernible correlates in our brain chemistry for what were once thought of as the purely philosophical and psychological, including thoughts, emotions, and behaviors like decision-making, free will, moral judgment, personality, consciousness, and the self. Among these neuroscientific insights is the discovery that even the most sophisticated operations of mind are deeply integrated with the mechanical operations of biological organisms.<sup>79</sup>

Once it can be shown that psychotropic medication deprives freedom of thought by altering brain chemistry, it is more likely that state regulations that allow the administration of medication in the absence of consent will be subject to the strict scrutiny standard.

### III. LISTENING TO GOD: THE PSYCHIATRIC CONCEPTION OF THE RIGHT MIND

That psychotropic medication can be effective in treating a host of mental health conditions is not in serious dispute.<sup>80</sup> Pharmaceutical innovations have helped combat the scourge of serious mental illness and will surely continue to do so.<sup>81</sup> Critics of psychiatry do not, however, level their attacks at clinical efficacy; their critique is foundational and systemic.<sup>82</sup> They do not ask whether psychiatry can help normalize behavior; they ask whether normalization is a worthy goal in the first

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<sup>77</sup> *Id.* at n.3 (citing *Eisenstadt*, 405 U.S. at 452; *Stanley*, 394 U.S. at 564; *Roe*, 410 U.S. at 149–54).

<sup>78</sup> Dov Fox, *The Right to Silence as Protecting Mental Control*, 42 AKRON L. REV. 763, 794 (2009).

<sup>79</sup> *Id.* at 794–95.

<sup>80</sup> For example, second-generation, “atypical” antipsychotic drugs like Clozapine, used to treat schizophrenia, have improved on earlier “typical” drugs while greatly reducing risk of tardive dyskinesia (though increasing the risk of agranulocytosis). Robert Freedman, *Drug Therapy: Schizophrenia*, 349 NEW ENG. J. OF MED. 1738 (2003).

<sup>81</sup> *Id.*

<sup>82</sup> ZBIGNIEW KOTOWICZ, R.D. LAING AND THE PATHS OF ANTI-PSYCHIATRY 4–5 (1997).

place.<sup>83</sup>

In the 1950s and 1960s, critics of psychiatric approaches to mental health gained traction and a considerable following.<sup>84</sup> The rubric under which these critics are often grouped—anti-psychiatry—is perhaps misleading. A number of the most prominent among them were themselves trained in psychiatry and remained faithful to the discipline in spite of their fundamental disagreement over characterizing aberrant behavior as inherently flawed and suspect.<sup>85</sup> What unifies them is a belief that “psychiatric diagnosis is scientifically meaningless,” representing little more than an effort to identify and label that which falls outside a culture’s notions of what constitutes “normal” behavior.<sup>86</sup>

These critics believe that at the root of psychiatry is a philosophical conceit, ushered through the centuries from Socrates to the present day, that we may come to know human nature and in the process discover what is fundamental to it. With this faith, it is sensible and even just to delimit the space within which acceptable behavior, an outgrowth of that human nature, exists. Against this intellectual current emerged a relativist critique, championed most famously by the French historian and social critic Michel Foucault, who argued that there could be no understanding of human nature outside the bounds of history and society.<sup>87</sup> Foucault argued that normative accounts of the mind—what constitutes “normal” as opposed to “deviant” behavior—are meaningless in the absence of the cultural context of time and place.<sup>88</sup> As he once remarked in what might be described as a foundational creed of the anti-psychiatry movement, “madness only exists in society.”<sup>89</sup>

But Foucault went further. He argued that our scientific knowledge, itself contingent and unstable, is built upon a yet shakier foundation: the unconscious.<sup>90</sup> This notion of unconscious knowledge is critical because it helps answer the claim that, in disciplines such as psychiatry, pure

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<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> Thomas Szasz of the United States and R.D. Laing of Scotland, both practicing psychiatrists, were among the most vocal critics of their respective fields.

<sup>86</sup> KOTOWICZ, *supra* note 82, at 4–5.

<sup>87</sup> MICHEL FOUCAULT, *THE FOUCAULT READER* 4 (Paul Rabinow ed., 1984).

<sup>88</sup> *Cf.* RICHARD J. McNALLY, *WHAT IS MENTAL ILLNESS?* (2010) (arguing against social constructivists by citing such mental conditions as mania and melancholia, which are believed to have existed in all cultures and times).

<sup>89</sup> FOUCAULT LIVE: *COLLECTED INTERVIEWS 1961–1984* 8 (Sylvère Lotringer ed., 1996).

<sup>90</sup> MICHEL FOUCAULT, *THE ORDER OF THINGS* 325 (Routledge Classics 1989).

objective rationality, untainted by personal animus, is chimerical. In other words, psychiatric diagnoses that may seem merely to reflect the good intentions and best understanding of the medical establishment are embedded with the unconscious drive of society to purify or expel patterns and modes of thought that do not comport with the larger goals of the society.

Another anti-psychiatric critique contends that misattribution of mental illness and internal inconsistency in diagnoses plague the psychiatric practice. To illustrate, consider the fates of two women who could be characterized as melancholic. The first has lost her husband. In the months that follow, she has trouble getting out of bed, cannot shake regrets over how they spent their last days together, and despairs of a future without him. The second woman has lost no one, but she is despondent as well, her sadness rooted in myriad inarticulable causes but reflecting in her mind a distressing pattern over which she has grown to feel anxious, even helpless. While the grieving widow is unlikely, within boundaries, to merit a diagnosis of clinical depression even though she is depressed, the second woman appears to be “irrationally” troubled: her symptoms are amorphous, difficult to readily locate or understand by recourse to pure reason.<sup>91</sup> In such situations, the psychiatrist is placed in the uncertain role of “judging whether emotions are appropriate/healthy, with reference to the norm of ‘rationality.’”<sup>92</sup> It is not difficult to imagine a culture in which an absence of strong emotional responses, such as these fits of extreme sadness, would be viewed as a bizarre deviation and unhealthy repression for which medication is advised. So long as the ascendant culture is white, Western, and male, and so long as psychiatry fixates on deviations from cultural norms, individuals who are emotionally healthy, but whose behaviors rub against the dominant paradigm, will be susceptible to pathologization, and subjected to unnecessary, often dangerous medication.

It should be emphasized, though, that the subjectivity of mental illness alone is a poor justification for discrediting attempts to identify and understand mental disorders. Many somatic illnesses—chronic fatigue syndrome, Epstein Barr virus, soft tissue damage, among others—are far

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<sup>91</sup> In fact, the American Psychiatry Association, perhaps in an effort to answer this charge, has proposed the inclusion of bereavement over a loved one in a diagnosis of depression in the fifth edition of its *Diagnostic & Statistical Manual*, to be published in 2013. See Benedict Carey, *Grief Could Join List of Disorders*, N.Y. TIMES, Jan. 24, 2012, at A1.

<sup>92</sup> Clare Shaw & Gillian Proctor, *Women at the Margins: A Critique of the Diagnosis of Borderline Personality Disorder*, 15 FEMINISM & PSYCHOL. 483, 485 (2005).

more difficult to diagnosis with certainty than others, and this is not a denial that such conditions are real, with real consequences to the individuals living with them.<sup>93</sup> Moreover, certain psychological disorders can contribute to somatic dysfunction, as witness the links between borderline personality disorder and diabetes.<sup>94</sup> Not even hard-shelled skeptics of psychiatry are committed to the belief that mental illness is illusory. What they contend is that mental illness is simply a term attached to ways of perceiving and responding to the world that are “beyond the pale.”<sup>95</sup> Thomas Szasz, a leading exponent of anti-psychiatry, memorably described the phenomenon: “If you talk to God, you are praying; If God talks to you, you have schizophrenia.”<sup>96</sup>

Schizophrenia, in particular, has been nearly impossible to pin down. Even a basic framework to account for the disorder has yet to emerge. Theories have spanned the “genetic, neurochemical, virological, neuropsychological, psychoanalytic, cognitive, sociological, political, and ecological,” leaving the disorder practically void for “intractable vagueness.”<sup>97</sup> That such diagnoses cannot be made with great certainty, and that these diagnoses may lead to institutionalization and forced medication, is troubling, as it leaves the door open for conscious and unconscious stereotyping to fill the gaps left by our tentative understanding of the disorder.

Perhaps most illustrative of the perverse logic of modern psychiatry is that the salient feature of mental illness—deviation from the norm—is a defining feature of a large swath of the most important contributors of cultural, artistic, and technological output. Those exhibiting genius and those manifesting certain forms of mental illness have been found to have certain genetic commonalities. In 2010, Swedish researchers discovered that creative and schizophrenic individuals share similar lowered dopamine D2 receptor densities, which may account for both groups’ ability to make “unusual associations” unseen by others.<sup>98</sup> While

<sup>93</sup> Elyn R. Saks & Stephen H. Behnke, *Competency to Decide on Treatment and Research: MacArthur and Beyond*, 10 J. CONTEMP. LEGAL ISSUES 103, 120 (1999).

<sup>94</sup> Stephen Leichter, *Making Outpatient Care of Diabetes More Efficient: Analyzing Noncompliance*, 23 CLINICAL DIABETES 187, 188 (2005).

<sup>95</sup> KOTOWICZ, *supra* note 82, at 67.

<sup>96</sup> THOMAS SZASZ, *THE SECOND SIN* 101 (1973).

<sup>97</sup> Geoffrey Hunt, *Schizophrenia and Indeterminacy: The Problem of Validity*, 11 THEORETICAL MED. & BIOETHICS 61, 62 (1990).

<sup>98</sup> Orjan de Manzano et al., *Thinking Outside a Less Intact Box: Thalamic Dopamine D2 Receptor Densities are Negatively Related to Psychometric Creativity in Healthy Individuals*, 5 PLOS ONE 3 (May, 2010).



researchers like Frederick Goodwin and Kay Jamison have shown that disorders like bipolar disorder may cause a drop in cognitive ability as measured by IQ tests,<sup>99</sup> it is the novel associations and perceptions attached to a number of mental disorders, aberrant and at times even troubling to the medical professional, which provide the very source of singular insight. Forced medication that returns patients to a neurochemically “normal” state jeopardizes the potential contributions of those whose irregular or eccentric thought patterns are the source of the perspicacity needed to see beyond conventional frameworks.

And indeed there is reason to believe that many will fail to realize vast potential as a result of the unwanted administration of psychotropic medication. Artists experience depression ten times more often than the population at large,<sup>100</sup> which may go some way to answering Edgar Allen Poe’s “unsettled question” of whether madness was in fact the “loftiest intelligence.”<sup>101</sup> Many of the great scientists and mathematicians of the twentieth century were hampered by the label “mentally ill.”<sup>102</sup> The life and career of John Nash, brought to international attention with the publication of the book, *A Beautiful Mind*, and the eponymous award-winning film on which it was based, provides a useful illustration of the stunting effects of institutionalization.<sup>103</sup> Nash wrote his Ph.D. dissertation at Princeton at the age of twenty-one, laying the foundations for what is now known as the Nash equilibria.<sup>104</sup> Over four decades later, he would go on to win the Nobel Prize in Economic Sciences for his “pioneering analysis of equilibria in the theory of non-cooperative games.”<sup>105</sup> Yet in 1959, a mere nine years after he wrote his dissertation, Nash was diagnosed with paranoid schizophrenia and placed in McLean Hospital in

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<sup>99</sup> See FREDERICK GOODWIN & KAY JAMISON, MANIC-DEPRESSIVE ILLNESS: BIPOLAR DISORDERS AND RECURRENT DEPRESSION 276 (2007).

<sup>100</sup> Hara Estroff Marano, *Genius and Madness*, PSYCH. TODAY, May 7, 2007, available at <http://www.psychologytoday.com/articles/200705/genius-and-madness>.

<sup>101</sup> Edgar Allen Poe, *Eleanora*, in 1 TALES AND SKETCHES 635, 638 (Thomas Olive Mabbott ed., 1978).

<sup>102</sup> Beyond the individuals already discussed, others include Georg Cantor, the Swiss mathematician who helped revolutionize the concept of infinite, and Kurt Gödel, the German logician who battled obsessive-compulsive disorder late in life.

<sup>103</sup> See generally SYLVIA NASAR, *A BEAUTIFUL MIND: THE LIFE OF MATHEMATICAL GENIUS AND NOBEL LAUREATE JOHN NASH* 253–331 (1998) (discussing Nash’s experiences in and out of psychiatric clinics).

<sup>104</sup> *Id.* at 14, 98.

<sup>105</sup> *The Sveriges Riksbank Prize in Economic Sciences in Memory of Alfred Nobel 1994*, NOBELPRIZE.ORG, [http://www.nobelprize.org/nobel\\_prizes/economics/laureates/1994/](http://www.nobelprize.org/nobel_prizes/economics/laureates/1994/) (last visited Apr. 13, 2013).

Virginia.<sup>106</sup> The experience at McLean was so disturbing that upon release, he fled immediately to Europe.<sup>107</sup> Following deportation back to the United States, Nash again found himself in and out of different hospitals for the next nine years.<sup>108</sup> He was only able to resume his work after his release in 1970, when he refused further antipsychotic medication.<sup>109</sup> By that time, however, he was likely past his intellectual prime.<sup>110</sup>

Psychiatric views of wellness are also unstable, shifting to conform to changes in cultural attitudes. This is hardly surprising since behavior, however marginalized it may have been at any single historical moment, can no longer be said to veer into the realm of the abnormal or deviant once harmonized with contemporary community standards. Until 1973, for example, homosexuality was defined as a mental disorder by the *Diagnostic & Statistical Manual*, the definitive guide to psychiatric disorders.<sup>111</sup> So long as behavior is pathologized, new methods of treatment will emerge as well as skepticism about the worthiness of those manifesting the “condition” in seemingly unrelated areas of life. The Briton Alan Turing, yet another scholar whose fame, like Nash’s, rested in part on his skill as a mathematician and cryptanalyst, offers a case in point.<sup>112</sup> Crucially involved in the development of the code-breaking Enigma machine, Turing was brought into the deepest levels of British

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<sup>106</sup> NASAR, *supra* note 103, at 253–61.

<sup>107</sup> *Id.* at 264–66.

<sup>108</sup> *Id.* at 288–339.

<sup>109</sup> *See id.* at 323–55.

<sup>110</sup> *See* Charles Choi, *The Stroke of Genius Strikes Later in Modern Life*, LIVESCIENCE.COM (Nov. 7, 2011, 3:01 PM), <http://www.livescience.com/16911-scientific-breakthroughs-genius-aging.html> (“By 2000, great work before age 30 almost never happened in any of the three fields. In physics, great achievements by age 40 occurred in only 19 percent of case by the year 2000, and in chemistry, it almost never occurred.”).

<sup>111</sup> Robert L. Spitzer, *The Diagnostic Status of Homosexuality in DSM III: A Reformulation of Issues*, 138 AM. J. PSYCHIATRY 210, 210 (1981). *See also* Summary of Text Changes to DSM-IV to DSM-IV-TR, AMERICAN PSYCHIATRIC ASSOCIATION, <http://www.psychiatry.org/practice/dsm/summary-of-text-changes-from-dsm-iv-to-dsm-iv-tr> (last visited Apr. 13, 2013) (To date, the DSM-IV still lists criteria for nine paraphilias and recently added “sexuality and gender-identity disorder,” suggesting something of a retrenchment to notions of homosexuality as pathological); Merriam Webster, MERRIAM-WEBSTER.COM, <http://www.merriam-webster.com/dictionary/paraphilias> (defining paraphilias as “a pattern of recurring sexually arousing mental imagery or behavior that involves unusual and especially socially unacceptable sexual practices . . .”).

<sup>112</sup> *See* ANDREW HODGES, *ALAN TURING: THE ENIGMA* (2000) (discussing Turing as an embarrassment to his colleagues as well his decision to take a new “organo-therapy” designed to “reduce sexual urge”).

national security.<sup>113</sup> After being convicted of the then-crime of gross indecency for confessing to committing homosexual acts, Turing opted for hormonal treatment designed to “cure” his homosexuality rather than submit to incarceration.<sup>114</sup> Not long after, he was relieved of his responsibilities in Government Communications Headquarters, a British Intelligence Agency, for fear that his “condition” left him vulnerable to entrapment by Soviet operatives.<sup>115</sup> He was found dead of an apparent suicide at the age of forty-two.<sup>116</sup>

The legal significance of these criticisms of psychiatry is not at first as obvious as their moral and ethical pull. To the extent that current doctrine regarding forced medication places full faith in the hands of medical professionals, who may be beholden to their medical educations or unwilling to account for unconscious forces shaping their field, it is imperative to have a figure outside of this closed loop who can look upon any determinative, quasi-judicial proceeding with relative impartiality. Ironically, considerations of institutional competence, which have played such a strong role in judicial deference to the medical community, do more to discredit reliance on psychiatrists. In fact, psychiatrists on the whole are tendentious with respect to psychiatric orthodoxy and unlikely to question data compiled over decades for suggestions of sexist, racist, or politically-expedient diagnoses. Impartial arbiters, not beholden to or blinded by the study of psychiatry, in tandem with medical personnel who are intimately aware of a given person’s condition, could help safeguard the rights of those whose unconventional notions and manners represent a threat not to themselves or the community, but to the status quo of the political order.

#### IV. LIVING DOWN STEREOTYPES: RACIAL AND GENDER BIAS IN THE DIAGNOSIS OF PSYCHIATRIC CONDITIONS

It is unnecessary to charge the psychiatric field with institutional sexism and racism to illustrate the dangers to individual liberty posed by validating medical professionals’ continued willingness to forcibly medicate patients. In fact, insisting that psychiatry is tainted by prejudice is likely to shift the debate away from the concerns of patient rights to the

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<sup>113</sup> See *id.* at 146–242.

<sup>114</sup> *Id.* at 456–73.

<sup>115</sup> See *id.* at 497–97, 502–27.

<sup>116</sup> *Id.* at 5, 487–88.

integrity of the psychiatric profession itself.<sup>117</sup> It is enough to consider unconscious cultural forces and examine them in light of the empirical data suggesting that, at the very least, women and African-Americans are disproportionately diagnosed with conditions that often make them susceptible to institutionalization and unwanted medication.<sup>118</sup>

What is the nature of these forces that may unconsciously insinuate themselves into an institution? Consider the case of Samuel Cartwright, the nineteenth-century American psychologist who first theorized a new form of impulsive disorder: the desire of a slave to escape his or her bondage.<sup>119</sup> Cartwright's approach required what would seem an extraordinary leap: the belief that it is not normal to wish for one's freedom. Cartwright managed to escape accusations that his new psychiatric label, drapetomania—literally, a runaway slave's madness—was nothing more than an attempt to serve the American South's appetite for free labor. He did so by invoking the outside authority of God, citing the Scriptures as a basis for believing that slavery was not an evil institution propped up by inhumanity and greed, but rather one “ordained both by the Bible and the brute facts of ‘nature.’”<sup>120</sup> Cartwright's use of “nature” is telling. If one accepts Cartwright's premise that the slave attempting to escape was not merely defying a legal obligation but also the natural order, then his theory has a certain perverse pull: after all, the unnatural is the essential province of psychiatry.

The story of drapetomania's invention and deployment represents more than a mere historical curiosity. It serves as a striking reminder of the ways in which the seemingly distinct spheres of the personal and political can be blurred, and of “the role of prevailing sociocultural norms in the construction of psychiatric diagnoses.”<sup>121</sup> Take the recent work of University of Sheffield psychologist Dr. Sean Spence, who argues that

<sup>117</sup> See Swaran Singh & Tom Burns, *Race and Mental Health: There is More to Race than Racism*, 333 BRIT. MED. J. 648, 649 (2006). The authors take exception to accusations of racism in the field, remarking on the “striking similarity” in diagnoses across cultures. Still, they suggest commonalities among those migrants diagnosed with psychosis based on “shared experiences of discrimination, social exclusion, and urbanicity,” differences they suggest are environmental rather than genetic. *Id.*

<sup>118</sup> Walter R. Gove, *Mental Illness and Psychiatric Treatment Among Women*, 4 PSYCHOL. WOMEN Q. 345, 345–47 (2010); JONATHAN METZL, *THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE* x–xi (2009).

<sup>119</sup> Bill Bynum, *Discarded Diagnoses: Drapetomania*, 356 THE LANCET 1615, 1615 (2000).

<sup>120</sup> *Id.*

<sup>121</sup> Carlota Ocampo, *Drapetomania*, in THE ENCYCLOPEDIA OF MULTICULTURAL PSYCHOLOGY 158, 159 (Yolanda Jackson ed., 2006).

jazz, the rich musical genre that emerged in African-American communities of the Southern United States, had its roots in mental illness.<sup>122</sup> Locating the emergence of jazz from ragtime music in the improvisatory genius of cornetist Buddy Bolden, later diagnosed as schizophrenic, Spence argues that Bolden was able to create a new musical genre out of ragtime because his cognitive impairments forced him to forge a different musical path.<sup>123</sup> While Spence's argument is meant to be apolitical and made in good faith, his line of reasoning is problematic because it is predicated on a surely hyperbolic assumption about jazz's evolution from ragtime. Implicit is the suggestion that the musical breakthrough—creating a new musical genre by defying the strictures of another—was not otherwise inevitable. While Spence may be forgiven for wading out of his depth into this kind of historiography, his attempt reflects the alarming ease with which psychiatric explanations are proffered to account for behavior that could as easily be the product of innate creative genius. It is yet more troubling, given the history of disproportionate psychiatric diagnoses along racial lines, that Spence goes so far as to locate the very etiology of jazz in the creative leap of an African-American diagnosed as schizophrenic. In so doing, Spence expropriates credit for the invention of the quintessentially American musical genre; jazz, by his logic, sprang not from the mind of Buddy Bolden, but from the illness from which he suffered.

Perhaps the most widely studied disparity in psychiatric diagnoses along racial lines is schizophrenia in black men. Despite having been shown to exist equally among all ethnicities, schizophrenia is four times more likely to be diagnosed in Blacks than in Whites.<sup>124</sup> Grappling with this long-observed imbalance, Jonathan Metzl, in his book *Protest Psychosis: How Schizophrenia Became a Black Disease*, suggests a radically different explanation.<sup>125</sup> Through a careful study of "White" and "Negro" case files from the Ionia State Hospital for the Criminally Insane, Metzl proposes that institutional racism continues to prevail in the field of psychiatry not as a static phenomenon but one that "waxes and wanes, becoming more powerful in the context of specific moments when racial

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<sup>122</sup> R. Ballie, *The Melody Behind the Illness*, 32 MONITOR ON PSYCHOL. 17, 17 (2001).

<sup>123</sup> *Id.*

<sup>124</sup> Shankar Vedantam, *Racial Disparities Found in Pinpointing Mental Illness*, WASHINGTONPOST.COM (June 28, 2005), <http://www.washingtonpost.com/wp-dyn/content/article/2005/06/27/AR2005062701496.html>.

<sup>125</sup> JONATHAN METZL, *THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE* (2009).

tensions rise to the fore of American consciousness.”<sup>126</sup> Metzl found that the shifting demographics of nearby Detroit, and the concomitant surge in social and political unrest, had led to a similar shift in the population of the Ionia State Hospital.<sup>127</sup> The archetypal schizophrenic of the 1920s—white, Midwestern, female, her psychosis rooted in concerns of domesticity—had been transformed by the 1950s into something altogether different: black, urban, male, his dissatisfaction with the status quo threatening to boil over.<sup>128</sup> The diagnosis had not changed; only the prevailing fear that it tracked.<sup>129</sup>

By the 1960s, with the rise of the Black Power movement, resistance to racism took on a more serious tenor and created the specter of armed revolt.<sup>130</sup> As a result, schizophrenia ceased to be a diagnosis responsive to fears of internalized disharmony but rather to a perceived new scourge: an onslaught of black men set on destabilizing public order by any means necessary.<sup>131</sup> As Gilles Deleuze and Felix Guattari wrote in their seminal work of schizoanalysis, *Anti-Oedipus*, suggesting why the state fears minds unbent to its will: “The schizophrenic process . . . is the potential for revolution.”<sup>132</sup>

As social concerns change, so too do the clinical methods by which psychiatric illness is understood and defined. Metzl cautioned against viewing the results of his study as providing easy answers, in particular the notion that a psychiatrist who may hold racist attitudes, consciously or not, can simply be reformed.<sup>133</sup> The so-called cultural competency approach to this reform, initiated in 2000 after the Association of American Medical Colleges advised schools to train students in how culture-specific belief systems inform the perception and treatment of illness, did nothing to address the underlying cultural and historical processes that made mere superficial awareness of such differences sorely deficient.<sup>134</sup> While the approach at least showed a good-faith effort on the part of the psychiatric community, Metzl argues that “focusing on the

<sup>126</sup> *Id.* at xii.

<sup>127</sup> *See id.* at 6–16.

<sup>128</sup> *Id.* at xv, 111.

<sup>129</sup> *Id.* at 6–16.

<sup>130</sup> *See id.* at 121–28.

<sup>131</sup> *See id.* at 109–28.

<sup>132</sup> GILLES DELEUZE & FELIX GUATTARI, *ANTI-OEDIPUS: CAPITALISM AND SCHIZOPHRENIA* 341 (1972).

<sup>133</sup> METZL, *supra* note 125, at xi, 202–12.

<sup>134</sup> METZL, *supra* note 125, at 200.

individual [trainee/physician] obscures the impact of the structural, while putting undue pressure on even well-intentioned patients or doctors to solve problems in ten-minute office visits that have taken decades or even centuries to evolve.”<sup>135</sup>

Psychiatric diagnoses of disorders with criteria associated with longstanding biological assumptions also lead to disproportionate diagnoses among women, leaving them at the mercy of a medical-professional judgment that has been informed by these assumptions. Histrionic personality disorder, for example, is a condition diagnosed more frequently in women than in men, according to one research study on the role of sex biases.<sup>136</sup> Oddly, the researchers found that it was the diagnosis, not the *criteria* underlying these disorders—e.g., “the presence of irrational, angry outbursts or tantrums; overreaction to minor events; or proneness to manipulative suicidal threats or gestures”—that was affected by the patient’s sex.<sup>137</sup> In other words, while psychiatrists reveal no bias in labeling, say, a heated monologue as impulsive invective, they are less likely to identify a male patient delivering the same speech as manifesting some identifiable pathology. These results are unlikely to surprise many, as the “stereotypic expectations”<sup>138</sup> of gender essentialist attitudes persist: here, it is the notion that irrationality is not so much a symptom of a personality disorder as it is a symptom of being a woman. Of course, sex stereotypes cut both ways. Consider that men are three times more likely to be diagnosed with antisocial disorder, a condition with symptoms—social aloofness, difficulty in establishing close relationships, etc.—that track common assumptions about the typical male affect.<sup>139</sup>

Borderline personality disorder (BPD) is an especially controversial diagnosis, found in three women for every one man,<sup>140</sup> that labels the behavior of those “prone to sudden rage, suicidal thoughts, self-injury, and inappropriate attempts at intimacy followed by sudden rejection.”<sup>141</sup> The

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<sup>135</sup> *Id.*

<sup>136</sup> Maureen Ford & Thomas A. Widiger, *Sex Bias in the Diagnosis of Histrionic and Antisocial Personality Disorders*, 57:2 J. CONSULTING & CLINICAL PSYCHOL. 301, 304 (1989).

<sup>137</sup> *Id.*

<sup>138</sup> *Id.*

<sup>139</sup> Cf. Joseph Flaherty, *Antisocial Personality Disorder*, in *ENCYCLOPEDIA OF DISABILITY* 118–19 (Gary L. Albrecht ed., 2006) (describing common symptoms of antisocial personality disorder).

<sup>140</sup> Marilyn I. Korzekwa et al., *Estimating the Prevalence of Borderline Personality Disorder in Psychiatric Outpatients Using a Two-Phase Procedure*, 49 COMPREHENSIVE PSYCHIATRY 380, 383–84 (2008).

<sup>141</sup> *In Brief: The Stigma of Borderline Personality*, HARVARD MENTAL HEALTH LETTER

name itself suggests the ambiguity inherent in the classification, which attempts to capture those who fall somewhere in the continuum between psychotic and neurotic.<sup>142</sup> Although this disparity is worth a careful inspection on its own terms, since BPD has such a strong stigmatizing effect on those to whom it is attached, it is all the more critical that sexism, purposive or otherwise, not lie behind the diagnosis.<sup>143</sup> The taint of a BPD diagnosis is so pervasive it can extend to the therapeutic community itself:

Therapists often react that way to the behavior of borderline patients, who may call them in the middle of the night, frighten them by suicide attempts, and denounce them as malevolent or deride them as incompetent . . . . They feel helpless, besieged, and manipulated by patients who seem both ungrateful and unreasonably demanding.<sup>144</sup>

The straining effect this has on the patient-therapist relationship also means that traditional talk therapies are often ineffective as a result of the patient's heightened sensitivities, because he or she may believe that the therapist is unable to commit fully to treatment.<sup>145</sup> And as no medication exists specifically targeting personality disorders, antipsychotics are prescribed to combat mere symptoms.<sup>146</sup> As such, the forced medication of individuals with BPD is even more problematic, as it subjects patients to side effects without the promise of treating the condition as a whole.<sup>147</sup>

Because psychiatry continues to face charges of institutional racism and sexism that have not effectively been purged, and because diagnoses of disorders are in part based on the "antisocial" behavior of individuals, treatments that work to suppress rebellious sentiments and inhibit these individuals' liberties must be met with strong skepticism.

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(2007).

<sup>142</sup> Kenneth R. Silk, *Borderline Personality Disorder: The Liability of Psychiatric Diagnosis*, 1 CURRENT PSYCHIATRY 24, 26 (2002).

<sup>143</sup> This difference cannot, studies suggest, be explained by sampling bias alone, that is, by the greater likelihood that women will reach out for help. Cf. Andrew Skodol & Donna Bender, *Why Are Women Diagnosed Borderline More Than Men?*, 74 PSYCHIATRIC Q. 349, 355 (2003) (indicating that the higher prevalence of BPD diagnoses in women could also be due to a patient's individual biological and environmental risk factors).

<sup>144</sup> *In Brief: The Stigma of Borderline Personality*, *supra* note 141.

<sup>145</sup> *See In Brief: The Stigma of Borderline Personality*, *supra* note 141.

<sup>146</sup> *Borderline Personality Disorder*, NAT'L INST. OF MENTAL HEALTH (Aug. 11, 2011), [http://www.nimh.nih.gov/health/publications/borderline-personality-disorder/borderline\\_personality\\_disorder\\_508.pdf](http://www.nimh.nih.gov/health/publications/borderline-personality-disorder/borderline_personality_disorder_508.pdf).

<sup>147</sup> *See id.*



## V. WHAT COURTS, LEGISLATURES, AND MEDICAL PROFESSIONALS CAN DO

Likening slavery and psychiatry as institutions, Thomas Szasz once described the “[s]elf-determination of self-ownership” as “the freedom to choose how to use one’s body.”<sup>148</sup> This notion of the sovereign individual, especially as it is contrasted with the crushing contingency of life as a slave, is particularly poignant in light of the once-held psychiatric belief that Black protests and threats of violent insurrection in the 1960s and 1970s were no more than symptoms of a schizophrenic mind. In the one hundred years between Emancipation and the rise of the Black Power movement, the freed body became the fettered mind. Nor has the feminist project to throw off the yoke of patriarchy succeeded entirely in expelling essentialist assumptions about female psychology that still inform psychiatric diagnoses. A persistent, unthinking faith in the medical-professional judgment of psychiatrists has contributed to the unequal diagnoses of borderline, histrionic, and multiple personality disorders in more women than men.

Solutions are required. At stake are not only the rights of individuals to be protected from a legal framework that disproportionately burdens them on the basis of their race or sex, but also the rights of those individuals to forge their own intellectual destinies. These include the freedom to voice ideas anathematic to the larger culture and to express within wide bounds those emotions that have often been pathologized by practitioners whose bias is difficult to measure and almost impossible to uproot.<sup>149</sup> In his dissent in *Harper*, Stevens expressed the vital importance of input from those outside the insular medical community, whose judgments were caught up in their training and naturally slanted by the psychiatric culture out of which they arose.<sup>150</sup> He found the Washington State policy of providing a non-judicial panel to decide a patient’s fate to be constitutionally deficient; due process required a true judicial hearing, not an *ad hoc* gathering of intra-institutional members whose attitudes regarding the medication they authorize, supply, and deliver, were unlikely to bend.<sup>151</sup> Yet another procedural defect of in-house administrative panels is that they cannot be relied on to show true

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<sup>148</sup> THOMAS SZASZ, *LIBERATION BY OPPRESSION: A COMPARATIVE STUDY OF SLAVERY AND PSYCHIATRY* 108 (2002).

<sup>149</sup> See *supra* text accompanying notes 91–93.

<sup>150</sup> See *Washington v. Harper*, 494 U.S. 210, 250 (1990) (Stevens, J., dissenting).

<sup>151</sup> See *id.* at 255–57.

objectivity in the face of intractable conflicts of interest.<sup>152</sup> While judicial hearings naturally come at the expense of judicial resources, the freedom to choose how and what to think are, as Cardozo put it, “indispensable.”<sup>153</sup> Medical personnel, psychologists, and institutional officials would all be free to participate in the process, backing their case for medication with the same facts and arguments they are now free to deploy in an administrative panel. In the end, a judge who exists outside of the medical-psychiatric establishment is best suited to weigh these facts in light of the individual’s liberty interest and the state’s security interest.

The biggest obstacle to convincing the Supreme Court that an individual is entitled to a judicial, rather than an administrative, hearing, is the low level of review with which the Court currently analyzes such cases. It is for this reason that lawyers are advised to make arguments that race-based and sex-based discrimination have called the fundamental fairness of diagnoses into question, implicating the guarantees protected by the Equal Protection Clause of the Fourteenth Amendment.<sup>154</sup> It may not be necessary, or even coherent, to argue that the mentally ill are a suspect classification; the argument elaborated herein is that the classification itself is often made in error owing to racist or sexist beliefs. A more promising approach would be to argue that decisions of mental-health institutions regarding the need to forcibly medicate, while governed by facially neutral state law, have had a disparate impact on women and minorities by way of their administration. Following the rationale of *Arlington Heights v. Metropolitan Housing Development Corp.*,<sup>155</sup> in which a municipal zoning ordinance allowing only single-family dwellings was challenged as effectively preventing many individuals of different ethnic and racial backgrounds from joining the community, lawyers could show that legislation such as that found at issue in *Harper* leads to a denial of equal protection. Still, the *Arlington Heights* standard requires a showing of intent,<sup>156</sup> and intent cannot be shown by effect alone unless the resultant disparity is extraordinary.<sup>157</sup> But even if discrimination

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<sup>152</sup> See *id.* at 251–54.

<sup>153</sup> *Palko v. Connecticut*, 302 U.S. 319, 327.

<sup>154</sup> U.S. CONST. amend. XIV, § 1.

<sup>155</sup> *Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 255–60 (1977).

<sup>156</sup> *Id.* at 264–65.

<sup>157</sup> See *Yick Wo v. Hopkins*, 118 U.S. 356 (1886) (finding that an ordinance, though facially neutral, requiring persons owning laundries made of wood to obtain a permit from a Board of Supervisors was unconstitutional because the decisions of the Board, which had discretion in granting such permits, clearly showed that Chinese persons were targeted).

is not the sole reason for the policy, the Court made space for “the historical background of the [policy] decision . . . particularly [insofar as] it reveals a series of official actions taken for invidious purposes.”<sup>158</sup> Thus, the claims made in this Note suggest an avenue through which forcible medication can be viewed as part of an enduring legacy of mislabeling and mistreating individuals, often because they represent a class of people that the larger society has decided it has reason to fear.

The Court’s decisions in *Riggins* and *Sell* suggest an increased recognition of the importance of the right to less intrusive alternatives as a safeguard against forcibly medicating when it is not strictly necessary to meet the government’s objectives. The burden falls on the state to establish the lack of alternatives or their inevitable futility. Beyond the problematic alternatives of restraint and seclusion, institutions should offer alternative drugs or experiment with reduced dosages that might prove significantly more amenable to the consumer, so long as the end results are substantially similar. Regardless of the alternatives offered, individuals stand to gain from the enhanced autonomy inherent in choice. Psychological therapies like cognitive behavioral treatment are also available and offer an outstanding chance for medical professionals to build a more complete picture of the individuals they serve. Though these therapies can come at a considerable cost to the state, financial concerns should have no place in the decision process. Talk therapies are perhaps the most agreeable alternative available to mental health consumers, being non-invasive and interpersonal. Just as consumers can benefit from therapy, so too can the medical and psychological personnel administering it: professionals can gain more exposure to the interior lives of persons who have been disproportionately singled out as mentally ill.

Whatever may come of such legal arguments, it is perhaps more sensible to seek out solutions from the source: state legislatures engaged in policymaking. As attention continues to be drawn to the flaws and uncertainties inherent in defining what it means to be mentally ill, and particularly when members of the public are thrown into mental institutions and medicated against their will, legislators will be far more reluctant to put the rights of the citizens they represent into the hands of those whose knowledge and beliefs about mental illness have led to the tensions already described. Thus, education, continued scholarship, and even congressional lobbying can all be effective means by which to secure human rights for those in the care of psychiatric hospitals.

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<sup>158</sup> *Arlington*, 429 U.S. at 267.

Judicial precedent in the right-to-refuse realm has foreclosed none of the arguments made here. In fact, given the narrow facts of *Harper*, which involved the rights of a *prisoner* to decline psychotropic medication, its holding can really only offer guidance, rather than a clear rule, in cases involving mental health consumers who clearly stand in a far different relation to the state. As such, the lower courts are free to test the robustness of the *Harper* holding in the civil context and to consider both new and traditional arguments that cast doubt on the wisdom of nearly unchecked deference to medical-professional judgment. The discriminatory impact that results when psychiatric institutions rely on their notions of mental illness in making diagnoses and prescribing powerful, mind-altering medications should be put forward as a substantial argument for vindicating people's right to choose what may enter their bodies, and, as a consequence, what thoughts may enter their heads.

## VI. CONCLUSION

In *Cruzan v. Director, Missouri Department of Health*, Chief Justice Rehnquist wrote that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."<sup>159</sup> In arguing for the right to refuse psychotropic medication, it is appropriate to invoke judicial opinions like these, which tout the centrality of bodily and cognitive integrity while carving out exceptions for the incompetent. Institutionalization is not *per se* evidence of one's incompetence, and a competency determination alone is not sufficient to overcome all possible state interests to medicate forcibly.

This Note has not concerned itself with the right to refuse of those with *bona fide* mental health issues rendering them incompetent to understand and protect their own interests; neither does it seek to deny flatly that a state may ever have a compelling reason to compromise an individual's liberty interest. Instead, it has argued that the *methods* of determining competency and of weighing individual and state interests are defective. It has suggested two principle reasons for this and called for courts to adjudicate the competency of those who would refuse medication rather than effectively recuse themselves, leaving decision-making to deeply conflicted administrative panels. First, the rights to integrity of mind and body, in essence the fundamental rights to thought and privacy, must not be dispensed with cavalierly. Second, because the psychiatric diagnoses on which such administrative panels base their competency

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<sup>159</sup> See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990).

findings are not free from racial and gender biases, courts must become involved in balancing the rights of individuals with mental illness against the interest of the state, a delicate task for which no amount of medical, clinical, or personal knowledge alone is enough.