

OVERCROWDING ON THE SHIP OF FOOLS: HEALTH CARE REFORM, PSYCHIATRY, AND THE UNCERTAIN FUTURE OF NORMALITY

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I. INTRODUCTION

Unbeknownst to most Americans, the Wall Street bailout and the health care overhaul that were signed into law in 2008 and 2010, respectively, marked a bold new direction in federal mental health policy. Parity requirements in the bailout law eliminated much of the disparity between mental and physical health care coverage in employer-sponsored health insurance plans.¹ The health care reform law signaled an even more significant shift. In a few years, the federal government will require most Americans to have health insurance coverage that must include a minimum basic mental health and substance abuse benefit.² Along with insurance market reforms, subsidies, and a dramatic expansion of the Medicaid program, this mandate is expected to expand access to affordable mental health services and treatments for an additional thirty-two million

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¹ See Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511–12, 122 Stat. 3765, 3881–93 (2008) (amending 26 U.S.C. § 9812, 29 U.S.C. § 1185a, and 42 U.S.C. § 300gg-5).

² See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 119 (2010).

Americans by 2019.³

For reformers, the epidemic of mental illness has created a crisis of unmet need that justifies these sweeping reforms. In 2009, for example, Health and Human Services Secretary Kathleen Sebelius made the Obama administration's case for mental health care reform by claiming that although "[o]ne in 5 Americans will have a mental health illness this year and almost half will have a mental illness in their lifetimes[,] . . . 10 million people didn't get the mental health care they needed last year"False⁴ Yet mental illness may be more prevalent than reformers would like to admit. A few months before Sebelius spoke, a study suggested that nearly sixty percent of the population suffers from an anxiety disorder, depression, alcohol dependence, or marijuana dependence by age thirty-two.⁵ At first blush, a higher prevalence rate might appear useful to those making the case for reform. However, if more than half the population experiences a mental disorder early in life, mental illness is not just common—it's normal.⁶ For cancer and other diseases that involve clear-cut and observable physical abnormalities, similarly high prevalence rates would lead to few, if any, questions about whether the conditions should be considered diseases in the first place. But these are illnesses of the mind, and contrary to the reductive claims of mental health advocates—Sebelius argued that "[i]f ten or twenty million Americans were walking around bleeding," rather than suffering from hidden mental conditions, "we'd have alarm bells going off"⁷—mental illness is not equivalent to somatic illness.

³ Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives (Mar. 20, 2010), available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

⁴ Richard E. Vatz & Jeffrey A. Schaler, *Mental Health Trojan Horse*, WASH. TIMES (Dec. 31, 2009), <http://www.washingtontimes.com/news/2009/dec/31/mental-health-trojan-horse/>.

⁵ T.E. Moffitt et al., *How Common Are Common Mental Disorders? Evidence That Lifetime Prevalence Rates Are Doubled by Prospective Versus Retrospective Ascertainment*, 40 PSYCHOL. MED. 899, 899 (2010).

⁶ See Bruce Bower, *Mental Disorders More Widespread Than Estimated*, SCI. NEWS, Oct. 10, 2009, available at <http://www.usnews.com/science/articles/2009/09/18/rates-of-common-mental-disorders-double-up.html>.

⁷ Vatz & Schaler, *supra* note 4, at 1 (quoting a Dec. 16, 2009 speech by Secretary Sebelius).

Traditionally, medicine has attempted to define physical illnesses more in terms of signs—i.e., objective, measurable bodily antecedents—than symptoms—i.e., the subjective experiences reported by the patient.⁸ Clinical diagnosis of many physical conditions has therefore been based on self-report, objective signs of illness discovered by the physician, and objective confirmatory tests.⁹ In contrast, psychiatry defines mental disorders almost exclusively in terms of symptoms because the pathophysiology and etiology of most mental disorders remain elusive.¹⁰ The lack of explanatory pathophysiologies is a serious challenge to the validity of mental disorders and a source of the widespread skepticism that bedevils psychiatry. Indeed, in the absence of objective determinants of disease, what is and what is not a mental disorder must be based on a shared cultural and medical consensus.¹¹

The purpose of this Article is not to question the existence of mental illness or to trivialize the anguish caused by mental illnesses. Serious mental illnesses, such as schizophrenia, bipolar I disorder, and severe depression, are chronic conditions that are responsible for an enormous amount of suffering. The severity of the symptoms, as well as evidence indicating these conditions have the marks of true illness, supports the traditional assumption that serious mental illnesses involve some underlying pathogenic process.¹² As a result, there is a shared cultural and professional consensus that psychotic disorders and other serious mental illnesses should be considered

⁸ Robert A. Aronowitz, *When Do Symptoms Become a Disease?*, 134 ANNALS INTERNAL MED. 803, 803 (2001).

⁹ *Id.*; see also Mary Boyle, *The Problem with Diagnosis*, 20 PSYCHOLOGIST 290, 290 (2007).

¹⁰ See Assen Jablensky, *The Nature of Psychiatric Classification: Issues Beyond ICD-10 and DSM-IV*, 33 AUSTL. & N.Z. J. PSYCHIATRY 137, 139 (1999); David Pilgrim & Richard Bentall, *The Medicalisation of Misery: A Critical Realist Analysis of the Concept of Depression*, 8 J. MENTAL HEALTH 261, 263 (1999).

¹¹ See Charles E. Rosenberg, *Contested Boundaries: Psychiatry, Disease, and Diagnosis*, 49 PERSP. BIOLOGY & MED. 407, 420 (2006); Gerald L. Klerman, *Mental Illness, the Medical Model, and Psychiatry*, 2 J. MED. & PHIL. 220, 221 (1977).

¹² See generally Klerman, *supra* note 11, at 231–34; Steven K. Erickson, *The Myth of Mental Disorder: Transsubstantive Behavior and Taxometric Psychiatry*, 41 AKRON L. REV. 67, 111, 112 & n.239 (2008) (discussing the evidence of brain abnormalities associated with schizophrenia and bipolar disorder).

diseases despite the lack of explanatory pathophysiologies.¹³ However, psychopathology has been far more concerned with conditions other than serious mental illnesses since the rise of dynamic psychiatry in the twentieth century.¹⁴ Even though dynamic psychiatry fell out of favor over thirty years ago,¹⁵ modern psychiatry's penchant for diagnostic expansion has ensured that the boundaries of mental illness have not narrowed.¹⁶ The current edition of psychiatry's "bible," the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), is a "ponderous octavo" consisting of 886 pages and 297 diagnoses, nearly three times the number of disorders listed in the first manual when it was published almost sixty years ago.¹⁷ The proposals for the next edition indicate further expansion is planned for the future.¹⁸ A growing number of critics from both within and outside of psychiatry contend that psychiatry has recklessly medicalized variants of normal human existence and that increases in the number of Americans with mental illness include millions of false positives, i.e., individuals whose behavior satisfies the diagnostic criteria for a diagnosis even though they are not disordered.¹⁹ Thus, it has proven difficult to arrive at a stable negotiated consensus between society and psychiatry as to the validity of mental disorders that lie on the fringe of normality.

In the past, the failure of reformers to accept the limits of psychiatry's understanding of mental illness and its therapeutic abilities has repeatedly distorted mental health policy. This Article posits that the new direction in federal mental health policy continues this trend by broadening access to mental health services and treatments, despite legitimate concerns about medicalization,

¹³ Klerman, *supra* note 11, at 221.

¹⁴ *See id.* at 233.

¹⁵ *See* Joseph M. Pierre, *The Borders of Mental Disorder in Psychiatry and the DSM: Past, Present, and Future*, 16 J. PSYCHIATRIC PRAC. 375, 376 (2010).

¹⁶ *See id.* at 377.

¹⁷ Rosenberg, *supra* note 11, at 417; Rick Mayes & Allan V. Horwitz, *DSM-III and the Revolution in the Classification of Mental Illness*, 41 J. HIST. BEHAV. SCI. 249, 251 (2005).

¹⁸ *See* Pierre, *supra* note 15, at 376-79.

¹⁹ Jerome C. Wakefield, *False Positives in Psychiatric Diagnosis: Implications for Human Freedom*, 31 THEORETICAL MED. & BIOETHICS 5, 6 (2010).

overdiagnosis, and false positives. Psychiatry's controversial plan to expand the boundaries of mental illness just before millions of Americans gain access to mental health services will likely translate into higher utilization rates, compounding the risk of overdiagnosis and unnecessary exposure to psychotropic drugs. Increased spending will eventually force the mental health system to confront the problem of how to pay for the broadening spectrum of mental illness. However, given the close ties between the pharmaceutical industry, government, and psychiatry, as well as public demand for psychiatric labels and prescription medications, it is clear that restricting access to psychiatric treatments will be unpopular. Rather than mandates and regulations, the reform that the nation desperately needs must start with a candid assessment of the nature of mental illness and the ethical, philosophical, and legal implications of psychiatric diagnosis and treatment. It is incumbent on the public to demand that psychiatry, the drug industry, and the government engage in an open and honest discussion about the true nature of mental illness and the real risks and benefits of psychotropic drug treatments.

Part I explores the development of modern psychiatry in the twentieth century and the evolution of federal mental health policy between World War II and the present. Part II discusses diagnostic classification, the expansion of the borders of mental illness, and the influence of the pharmaceutical industry on the definition of mental illness. Part III considers the potential consequences of a mental health policy approach that fails to account for the limitations of psychiatry's understanding of mental illness, as well as its therapeutic abilities. This paper concludes that the nation's mental health would best be served by an open and honest discussion between the public, psychiatry, mental health advocates, and the government about the true scientific understanding of mental illness and the benefits and risks of psychotropic drug treatments.

II. THE TROUBLED HISTORY OF PSYCHIATRY AND MENTAL HEALTH POLICY

A. Origins of Psychodynamic Psychiatry and the Public Mental Health Model

Psychiatry emerged as one of the first medical specialties in the mid-nineteenth century after physicians began serving as superintendents of the state institutions responsible for the care and treatment of those suffering from severe and chronic mental illnesses.²⁰ Prior to the twentieth century, psychiatrists believed that mental illnesses had somatic causes, i.e., physical defects or diseases of the nervous system.²¹ With few available somatic treatments,²² psychiatry was primarily an “administrative and managerial” endeavor.²³ There was little a psychiatrist could do apart from delivering a gloomy prognosis and supervising the patients’ confinement, feeding, and restraint.²⁴ Psychiatry’s pessimistic outlook stood in stark contrast to general medicine’s new scientific identity, exemplified by the germ theory of disease and the emergence of a laboratory-based profession seeking to discover the causes of disease and develop new treatments.²⁵

As the nineteenth century came to a close, psychiatry’s gaze began to gradually shift from the asylum, where it dealt almost exclusively with psychotic illness, to society in general.²⁶ Inspired by

²⁰ John Chynoweth Burnham, *Psychiatry, Psychology and the Progressive Movement*, 12 AM. Q. 457, 459 (1960); GERALD N. GROB, *THE MAD AMONG US: A HISTORY OF THE CARE OF AMERICA’S MENTALLY ILL*, 55–56 (The Free Press 1994).

²¹ Burnham, *supra* note 20, at 459; See GROB, *supra* note 20, at 64–65.

²² See Erickson, *supra* note 12, at 100 (noting that “treatment of any sort was almost nil”).

²³ GROB, *supra* note 20, at 130.

²⁴ Burnham, *supra* note 20, at 459.

²⁵ GROB, *supra* note 20, at 130.

²⁶ *Id.* At the dawn of the twentieth century, Americans were coming to terms with a changing social order precipitated by industrialization and urbanization. See Warren I. Susman, *Personality and the Making of Twentieth-Century Culture*, in *CULTURE AS HISTORY: THE TRANSFORMATION OF AMERICAN SOCIETY IN THE TWENTIETH CENTURY* 271, 277 (1984). An emerging morality centered on personality and self-fulfillment began to subvert the traditional moral virtues of character and self-sacrifice, signaling the rise of a new therapeutic culture. See *id.* at 278. More densely populated urban areas also provoked new

the optimism of the Progressive movement,²⁷ psychiatrists set out to reform the profession in an effort to reintegrate psychiatry into mainstream medicine.²⁸ To do this, the specialty needed a new understanding of mental illness and new therapeutic interventions.²⁹ A new approach to mental illness began to materialize after 1900.³⁰ “Dynamic psychiatry” proposed that behavior occurred on a continuum ranging from the normal to the abnormal, a break from the traditional somatic distinction between health and illness, where marked deviations from prior normal behavior indicated the presence of illness.³¹ By emphasizing an individual’s life history and prior experiences, the dynamic approach obscured the distinction between health and illness, opening the door to psychiatric interventions prior to the onset of more acute symptoms.³² Although it did not explicitly reject the somatic tradition, dynamic psychiatry suggested that mental disorders were primarily psychological conditions caused by the inability to adapt to the environment.³³

fears of crime, poverty, infectious disease, and other new social ills. See Vera Hassner Sharav, *Screening for Mental Illness: The Merger of Eugenics and the Drug Industry*, 7 *ETHICAL HUM. PSYCHOL. & PSYCHIATRY* 111, 114 (2005); Daniel F. Piar, *A Welfare State of Civil Rights: The Triumph of the Therapeutic in American Constitutional Law*, 16 *WM. & MARY BILL RTS. J.* 649, 653-55 (2008), available at <http://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=1061&context=wmborj>.

²⁷ Burnham, *supra* note 20, at 459. The Progressive social reform movement swept across the nation, bringing with it optimism, meliorism, environmentalism, moral fervor, and leadership by the enlightened elite. *Id.* at 458-59. Progressive reformers embraced an ideology of social planning and social control as a means to confront the social ills and human suffering caused by unchecked social evolution. See Stephen J. Kunitz, *Professionalism and Social Control in the Progressive Era: The Case of the Flexner Report*, 22 *SOC. PROBS.* 16, 18 (1974). For progressives, the primacy of individual freedom was the root of the inefficiency and inequity that threatened the promise of American life. *Id.* By virtue of their educated status and benevolent goals, Progressives bestowed upon themselves the moral authority to manage social evolution. See *id.*; Burnham, *supra* note 20, at 458. Some reformers advocated far-reaching social and economic reforms while others favored more coercive measures to address social ills. GROB, *supra* note 20, at 141.

²⁸ GROB, *supra* note 20, at 140-41.

²⁹ *Id.* at 141.

³⁰ *Id.* at 142.

³¹ *Id.*

³² *Id.*

³³ Burnham, *supra* note 20, at 461.

This new way of understanding mental illness broadened psychiatry's jurisdiction and geographic scope of practice to include less severe psychological distress in the general population.³⁴ Though psychiatric practice would remain eclectic until World War II, a few psychiatrists began to break ties with mental hospitals in the beginning of the twentieth century in search of new ways of understanding mental illness.³⁵ For some Progressive-minded psychiatrists, this new understanding of mental illness imposed broad responsibilities on the profession, including the reform of "allegedly dysfunctional social structures and relationships."³⁶

1. *Mental Hygiene*

One of the many social reform movements of the Progressive era was the mental hygiene movement.³⁷ In 1909, a group of reform-minded dynamic psychiatrists, social workers, physicians, and academics founded The National Committee for Mental Hygiene (NCMH).³⁸ Inspired by medicine's success in controlling tuberculosis, the interdisciplinary movement launched a public mental health campaign predicated on the notion that it was more efficient to prevent mental illness than it was to treat and cure it.³⁹ Psychiatry's crude understanding of the nature and cause of mental illness limited NCMH's early activities to improving conditions for the institutionalized insane.⁴⁰ However, World War I was a catalyst for

³⁴ GROB, *supra* note 20, at 142.

³⁵ *Id.*

³⁶ *Id.*; Burnham, *supra* note 20, at 462. For example, some Progressive psychotherapists saw themselves as moral directors over the lives of patients and qualified to address the "psychic infections of civilization." *Id.*

³⁷ See Kunitz, *supra* note 27, at 18 (noting that the social reform movement produced "birth control, efficiency engineering, conservation in the use of natural resources, mental hygiene, good government, Prohibition, anti-trust legislation, pure food and drug laws, the Harrison Narcotics Act, [and] juvenile court reform").

³⁸ Sol Cohen, *The Mental Hygiene Movement, The Development of Personality and the School: The Medicalization of American Education*, 23 HIST. EDUC. Q. 123, 125 (1983).

³⁹ *Id.* at 126; GROB, *supra* note 20, at 151.

⁴⁰ GROB, *supra* note 20, at 156.

dynamic psychiatry and the mental hygiene movement.⁴¹ In 1917, NCMH helped assemble the psychiatric services of the armed forces, and military psychiatrists' subsequent success in treating "shell-shock" appeared to confirm the roles of personality and the environment in mental illness.⁴² These experiences inspired more psychiatrists to embrace a new professional identity – private practice dealing with general psychological problems – and a new therapeutic approach – psychotherapy.⁴³ For dynamic psychiatrists, mental illness was a personality disorder of a behavioral and social nature caused by the inability to cope with the stresses of life.⁴⁴ Due to the malleability of personality, dynamic psychiatrists believed that psychoanalytic and psychotherapeutic treatments could be used to prevent mental illness by re-educating patients so that they could adjust to the realities of modern life.⁴⁵ Moreover, new possibilities emerged for preventing mental illness by correcting environmental factors that were considered deleterious to personality development.⁴⁶ Deviant behaviors became symptoms of maladjustment, and psychiatric jurisdiction broadened to include the prevention of a host of social problems, such as delinquency, dependency, and alcoholism.⁴⁷

After World War I, the mental hygiene movement appeared to

⁴¹ Cohen, *supra* note 38, at 127–28.

⁴² *Id.* at 127.

⁴³ *Id.* at 128; Burnham, *supra* note 20, at 459–60.

⁴⁴ Cohen, *supra* note 38, at 126–27.

⁴⁵ Burnham, *supra* note 20, at 461.

⁴⁶ *Id.*

⁴⁷ Cohen, *supra* note 38, at 127. After World War I, studies detailing the distribution of intelligence among military recruits caused concern that mental deficiency posed a threat to social order. *Id.* at 128. Supported by professionals claiming that social pathology was the result of hereditary feeble-mindedness, the eugenics movement was the most coercive response to this problem. *Id.* States used their police powers "to prevent reproduction of criminality, deviancy, and dependency." Michael Willrich, *The Two Percent Solution: Eugenic Jurisprudence and the Socialization of American Law, 1900–1930*, 16 L. & HIST. REV. 63, 64 (1998). In an era of crusading zeal, psychiatry's role in social policy included mental hygiene, the reform of mental institutions, eugenics, the management of problem children, the treatment of criminals, and the prevention of a slew of social ills. GROB, *supra* note 20, at 152. See Hans Pols, *Divergences in American Psychiatry During the Depression: Somatic Psychiatry, Community Mental Hygiene, and Social Reconstruction*, 37 J. HIST. BEHAV. SCI. 369, 374 (2001).

have scientific support for its broad social aspirations, and funding became easier to attract.⁴⁸ Consequently, the movement commenced with an administrative and organizational undertaking to apply psychiatry on a mass scale.⁴⁹ Hygienists shied away from legal and regulatory social control mechanisms favored by other social movements and instead relied on existing institutions and laws to promote personality development.⁵⁰ Although NCMH would target prisons, courts, and industry for reform,⁵¹ mental hygiene in public education was its most ambitious goal.⁵² In the early 1920s, NCMH and the Commonwealth Fund launched the "Program for the Prevention of Delinquency," a campaign to "prevent dependency, delinquency, insanity, and general inadequacy" through early intervention and the promotion of mental health in the nation's public schools.⁵³ Driven by utopian zeal, hygienists set expectations high, as illustrated by NCMH Medical Director Thomas Salmon's bold claim that "not less than fifty percent of mental illness could be prevented by the application in childhood of the psychiatric understanding and techniques then available."⁵⁴

The Program's initial approach was to provide psychiatric services for "predelinquent" or "problem" children, using visiting teachers to identify children with minor personality problems and refer them to child guidance clinics staffed by psychiatrists, social

⁴⁸ See GROB, *supra* note 20, at 151; Cohen, *supra* note 38, at 127-28.

⁴⁹ GROB, *supra* note 20, at 157-58. Put another way, the mental hygiene movement sought to expand psychiatric authority over everyday American life. See *id.*

⁵⁰ Cohen, *supra* note 38, at 141. Cf. Joseph R. Gusfield, *Constructing the Ownership of Social Problems: Fun and Profit in the Welfare State*, 36 SOC. PROBS. 431, 433 (1989) (discussing the ownership of a social problem and the authority to enlist public facilities to address the problem).

⁵¹ Cohen, *supra* note 38, at 126.

⁵² See *id.* at 128.

⁵³ *Id.* at 128-29, 141 (quoting Ralph P. Truitt, *Mental Hygiene and the Public School*, 11 MENTAL HYGIENE 261, 270 (1927)). Compulsory education guaranteed that schools had close contact with almost every American child, and hygienists recognized that targeting schools could have far-reaching implications for applied mental hygiene—schools could be the "greatest social welfare agency." *Id.* at 129 n.27 (quoting COMMONWEALTH FUND, ANNUAL REPORT 1, 21 (1922)).

⁵⁴ Cohen, *supra* note 38, at 140.

workers, and other mental health professionals.⁵⁵ Because childhood was “the conditioning period of personality” and mental problems developed gradually, early identification and treatment would correct maladjustment years in advance of acute mental illness.⁵⁶ Early on, however, hygienists recognized that this approach could not fulfill their preventive aspirations.⁵⁷ By the time children were referred to the child guidance clinics, it was too late to prevent the development of subsequent problems.⁵⁸ Increasing the number of mental health professionals in schools was not enough; psychiatry’s concepts and techniques had to be applied before children became “problems.”⁵⁹ For hygienists, the solution was a school-based intervention aimed at integrating mental hygiene into the educational environment.⁶⁰ Schools would need to be transformed into therapeutic institutions in the name of personality development.⁶¹

Hygienists envisioned an educational environment more conducive to proper personality development; schools would strengthen the personalities of all children and cure individual cases of maladjustment.⁶² Believing that stress was the principal environmental trigger of mental illness, the ideal school had to be free of several sources of stress—school failure, curriculum, and discipline.⁶³ According to hygienists, saving “misfit children [from] a misfit curriculum” required that schools prioritize personality development over all other objectives, including academic

⁵⁵ *Id.* at 129.

⁵⁶ *Id.* at 126–27.

⁵⁷ *See id.* at 129.

⁵⁸ *See id.*

⁵⁹ *See* Cohen, *supra* note 38, at 129. Rather than question the possibility of prevention, the Program’s strategy shifted to parent education, based on the belief that parents could identify the early signs of personality disorder. *Id.* Hygienists ran into a serious limitation: parents could not be compelled to attend mental hygiene classes. *Id.*

⁶⁰ *Id.* With all social problems tied to childhood development, all children were ‘more or less a problem’ in the eyes of hygienists. *Id.* at 140.

⁶¹ *See id.* at 129–30.

⁶² *Id.* at 140.

⁶³ *Id.* at 129–30.

instruction.⁶⁴ Teachers needed to nurture the personalities of children and de-emphasize academic subject matter. Moreover, the “scientific approach” to discipline involved the treatment or adjustment of disobedient children.⁶⁵ Like psychiatrists, teachers had to assume a detached role and focus on children’s underlying, unconscious motives rather than simply punishing misbehavior.⁶⁶ In addition to the deviant behaviors that were signs of less serious disorders, the early sign of the most serious mental illnesses was the “shut-in personality,” a set of personality traits including shyness, passivity, and introversion.⁶⁷ To prevent these suppressed emotions, teachers had to create a less strict and rigid classroom environment by assuming a non-authoritarian role.⁶⁸

According to historian Sol Cohen, NCMH’s fundamental objective was “to persuade the teaching profession to change its view of the field of education, its methods, its goals, its values, its notion of what problems were important and unimportant, what to emphasize and deemphasize.”⁶⁹ Only certain kinds of people could be trusted as stewards of fragile personalities, and hygienists encouraged teacher-training institutions to evaluate prospective teachers to assure that candidates had personality traits, such as flexibility, lack of hostility, emotional sensitivity, and creativity, that were appropriate for this new therapeutic role.⁷⁰ Teachers also had to be properly indoctrinated with the principles of mental hygiene. Training institutions therefore needed to emphasize the role of personality development rather than focusing only on training in academic

⁶⁴ *Id.* at 130.

⁶⁵ Cohen, *supra* note 38, at 130. Children’s misconduct was “not a sin, but a symptom,” and because children had little control over their behavior and were not responsible for their misconduct, traditional forms of discipline were harmful. *Id.* (citation omitted).

⁶⁶ *Id.* at 130–31.

⁶⁷ *Id.* at 129.

⁶⁸ *See id.* at 131.

⁶⁹ *Id.* at 132.

⁷⁰ *See id.* at 131; Jennifer de Forest, *Antecedents of Dispositions Testing: Lessons from the History of the Good Teacher*, J. EDUC. CONTROVERSY, Summer 2007, <http://www.wce.wvu.edu/Resources/CEP/eJournal/v002n002/a007.shtml>.

curriculum and teaching methods.⁷¹ In this psychiatric utopia, teachers would function as diagnosticians and therapists, and classrooms would become psychiatric clinics.⁷²

In 1922, NCMH and the Commonwealth Fund launched a vigorous educational campaign with the goal of “develop[ing] a consciousness regarding the value of mental hygiene” among mental health professionals, social workers, as well as parent education and child welfare groups.⁷³ This strategy was designed to indirectly effectuate change in schools as the mental hygiene point of view spread from these groups to educational policy-makers and teachers.⁷⁴ Although the Program ended in 1933, the campaign was instrumental in the proliferation of hygienist principles throughout the educational establishment.⁷⁵ Indeed, in the late 1930s and early 1940s, mental hygiene had taken on a life all its own.⁷⁶ Powerful organizations in the professional educational establishment espoused mental hygiene concepts, and teacher-training institutions performed personality screenings on prospective teachers and offered courses in mental hygiene.⁷⁷ By the early 1950s, mental hygiene “had been incorporated into educational ideology and institutionalized at the center of American society. . . .”⁷⁸ After NCMH formed the National Association for Mental Health in 1950, the mental health movement continued to promote mental health as a government responsibility.⁷⁹

⁷¹ See Cohen, *supra* note 38, at 131.

⁷² *Id.*

⁷³ *Id.* at 133–34 (citation omitted).

⁷⁴ *Id.* at 134.

⁷⁵ *Id.* at 133–39 (documenting the evidence of the campaign’s success).

⁷⁶ See *id.* at 138–39.

⁷⁷ *Id.* at 137–38. See generally de Forest, *supra* note 70. In 1950, the Mid-Century White House Conference on Children and Youth, with the slogan “A Healthy Personality for Every Child,” charged schools with “the primary responsibility for the healthy development of the whole personality of each child.” Cohen, *supra* note 38, at 139.

⁷⁸ Cohen, *supra* note 38, at 139. In the post-war period, mental hygiene had “deeply penetrated the *zeitgeist* of the country.” *Id.*

⁷⁹ *Id.* See JAN POLS, THE POLITICS OF MENTAL ILLNESS: MYTH AND POWER IN THE WORK OF THOMAS S. SZASZ 67 (Mira de Vries trans., 2005), available at <http://www.janpols.net/Pols-PDF.pdf>.

In hindsight, there was little scientific support for hygienists' optimism.⁸⁰ Though they sincerely, if naively, believed that applied mental hygiene could rid society of unhappiness, social problems, and even war,⁸¹ psychiatrist Sol Ginsburg explained that mental hygiene "flowered . . . without benefit of a sound body of scrutinized and validated facts."⁸² Nearly a century later, it is hard to reconcile the blinding optimism of Progressive-minded psychiatry with the dismal state of the nation's mental health. While it may have had little or no impact on the problem of mental illness, the movement was the impetus for the insertion of psychiatry in all facets of American education and a major contributor to the "medicalization" of childhood.⁸³

B. World War II and Psychodynamic Hegemony

Psychiatry had no unified, dominant theory of mental illness prior to World War II.⁸⁴ Instead, various somatic and hereditary theories of insanity co-existed with psychoanalytic concepts.⁸⁵ By 1940, a majority of psychiatrists were still employed by mental hospitals and associated with the somatic tradition.⁸⁶ Because psychoanalysis was considered "practically useless" in mental hospitals, a few psychodynamic and psychoanalytic psychiatrists were in private practice with a "relatively affluent" and educated

⁸⁰ Cohen, *supra* note 38, at 126.

⁸¹ *Id.* at 141-42.

⁸² Michael Hakeem, *A Critique of the Psychiatric Approach to the Prevention of Juvenile Delinquency*, 5 SOC. PROBS. 194, 204 (1957-1958) (quoting Sol W. Ginsburg, *The Mental Health Movement and its Theoretical Assumptions*, in COMMUNITY PROGRAMS FOR MENTAL HEALTH: THEORY, PRACTICE, EVALUATION 6 (Ruth Kotinsky & Helen L. Witmer eds., 1955)).

⁸³ See Cohen, *supra* note 38, at 124, 142-43; THERESA R. RICHARDSON, THE CENTURY OF THE CHILD 151, 151, 181, 191 (1989) (discussing mental hygiene movement's contribution to the medicalization of childhood and "the transformation of the family, school context and family court in the United States[.] . . . [r]egardless of its reflection of the 'truth' of science").

⁸⁴ GROB, *supra* note 20, at 144.

⁸⁵ *Id.*

⁸⁶ *Id.* at 196 (stating that "[i]n 1940, the [American Psychiatric Association] had only 2,295 members, perhaps two-thirds of whom were employed in mental hospitals and were associated with an older somatic tradition.").

clientele.⁸⁷ World War II, however, would elevate psychodynamic concepts to the forefront of psychiatric practice.⁸⁸

Early on in the War effort, the military implemented a psychiatric screening program to identify recruits likely to have nervous breakdowns in combat.⁸⁹ When this failed to deter psychiatric casualties, psychiatrists provided treatment close to the front lines, as soon as symptoms developed.⁹⁰ These experiences altered and broadened the conception of mental illness.⁹¹ All soldiers were susceptible to mental breakdowns depending on the intensity and duration of combat, and no preexisting psychological symptoms could predict individual sensitivity.⁹² Instead of a pathological condition of abnormal minds, nervous breakdowns resulted from the normal reactions of healthy minds to the extraordinarily stressful

⁸⁷ *Id.* at 144–45.

⁸⁸ *Id.*

⁸⁹ Hans Pols, *War Neurosis, Adjustment Problems in Veterans, and an Ill Nation: The Disciplinary Project of American Psychiatry During and After World War II*, 22 *OSIRIS* 72, 75–76 (2007). The screening program was based on the notion that an individual who was incapable of adjusting to the problems of everyday life would not be able to handle the stresses of military life. *Id.* The many somatic psychiatrists believed that the screening program would mitigate misguided attempts to treat soldiers in the battlefield. *Id.* The military subsequently rejected more than 1,750,000 individuals for psychiatric reasons following brief examinations by psychiatrists. GROB, *supra* note 13, at 192–93. Relying on the screening program to weed out unfit recruits, Army policy required the evacuation and discharge of psychiatric casualties, rather than battlefield treatment. Pols, *supra* note 89, at 75–76.

⁹⁰ As U.S. involvement in the War expanded and troops were exposed to longer stretches of combat, the screening program proved a disappointment. *See* GROB, *supra* note 20, at 192–93; Pols, *supra* note 89, at 79. By 1943, the number of soldiers suffering nervous breakdowns spiked, including many previously normal soldiers who developed debilitating anxiety, nightmares, tremors, and stuttering. *Id.* at 77. With breakdowns accounting for up to a third of total casualties in the 1943 Tunisian campaign, practical considerations forced the military to reconsider battlefield psychiatric treatment. *Id.* The military enlisted and trained psychiatrists to provide treatment close to the front lines. *Id.* Treatments varied from a combination of psychotherapy and sodium pentothal injections, to more straightforward approaches involving rest, food, and sedation. *Id.* at 78–79.

⁹¹ Pols, *supra* note 89 at 77–78.

⁹² ALLAN V. HORWITZ & JEROME C. WAKEFIELD, *THE LOSS OF SADNESS* 125 (Oxford University Press 2007). According to a military psychiatrist, the more rational question given the large number of psychiatric casualties became “why the soldier does *not* succumb to anxiety, rather than why he does.” Pols, *supra* note 89, at 78.

conditions of war.⁹³

After the War, military psychiatrists claimed that up to eighty percent of psychiatric casualties returned to the front lines within a week using psychotherapy.⁹⁴ The perceived success of military psychiatry provided a much-needed boost of confidence as one-third of America's psychiatrists returned from service eager to apply their new understanding of mental illness in civilian life.⁹⁵ Everyone had a breaking point, and without an early intervention, even the stressful experiences of everyday civilian life could lead to a breakdown.⁹⁶ Psychiatric treatment was not only efficacious for individuals outside of institutional settings, but a new understanding of intragroup relationships opened up possibilities for prevention.⁹⁷ Psychiatrists sympathetic to the mental hygiene movement returned with ambitions of preventive interventions directed at groups of normal, non-symptomatic individuals.⁹⁸ Post-war America proved fertile ground for psychiatry. Media reports of psychiatry's wartime efforts helped foster public admiration, and public regard for psychiatry grew to new heights in the post-war era.⁹⁹ In the years following

⁹³ Pols, *supra* note 89, at 78.

⁹⁴ *Id.* at 79. However, like the screening program, the implementation of forward psychiatry was a disappointment for the military. *Id.* Post-war studies showed that most psychiatric casualties returned to duty with little or no treatment. HORWITZ & WAKEFIELD, *supra* note 92, at 125-26. However, only a small percentage of those given psychotherapeutic treatment returned to the front lines. Pols, *supra* note 89, at 79.

⁹⁵ Pols, *supra* note 89, at 79; HORWITZ & WAKEFIELD, *supra* note 92, at 126.

⁹⁶ HORWITZ & WAKEFIELD, *supra* note 92, at 126.

⁹⁷ Pols, *supra* note 89 at 80-81. Military studies revealed that breakdowns were associated with low morale, leading to the implementation of morale boosting initiatives focusing on improving the quality of intragroup relationships. *Id.* at 81.

⁹⁸ *Id.* at 81.

⁹⁹ *See id.* at 89-90. Psychiatry's first post-war project involved managing the reintegration of veterans into civilian life using psychotherapy on a mass scale. Psychiatrists created an imminent mental health crisis—damaged and dangerous returning veterans were a “threat to society”—that could only be prevented by a broad public health intervention. *See id.* at 83-84. The media encouraged the lay public to use psychiatric techniques to manage the emotions of returning veterans. *Id.* at 85. However, veterans were offended and publically denounced the psychiatric profession as paternalistic and motivated by self-interest. *Id.* at 87. Thus, psychiatry failed in its initial attempt to expand its jurisdiction after the War. *Id.* at 89.

World War II, the psychodynamic paradigm came to dominate psychiatry, inspiring psychiatrists to set up private practices in the community.¹⁰⁰ Moreover, psychodynamic psychiatry provided new ways for society to approach the problem of serious mental illness.¹⁰¹

C. Deinstitutionalization, Psychopharmacologics, and Federal Policy

After the establishment of the first psychiatric hospital in the eighteenth century, state mental institutions proliferated, and by the late nineteenth century, hundreds of public asylums were responsible for the care and treatment of those with serious mental illness.¹⁰² At the turn of the twentieth century, the population of state-financed psychiatric hospitals began to swell, a trend that would continue for over fifty years.¹⁰³ The Great Depression and World War II had a catastrophic impact on public institutions, and by the 1940s, state mental hospitals were underfunded, understaffed, overcrowded, and in a state of physical decay.¹⁰⁴ The dismal state of asylums became the focus of public scrutiny after World War II. A series of books, articles, and movies revealed the deplorable conditions in many state hospitals.¹⁰⁵ These shocking exposés, along with the efforts of

¹⁰⁰ Erickson, *supra* note 12, at 105. Immediately following World War II, a schism developed within psychiatry. Somatic psychiatrists, who generally focused on severely ill patients, believed that mental illness had a physiological basis, whether caused by disease or general malfunction, and were committed to organic therapies. GROB, *supra* note 20, at 197–202. See Pols, *supra* note 47, at 369. Psychodynamic psychiatrists focused primarily on the environmental causes of mental illness and believed in a broader role for psychiatry in the community using psychotherapy and psychoanalysis to treat and prevent mental illness. GROB, *supra* note 20, at 197–202.

¹⁰¹ Gerald N. Grob, *The Forging of Mental Health Policy in America: World War II to New Frontier*, 42 J. HIST. MED. & ALLIED SCI. 410, 413 (1987).

¹⁰² See GROB, *supra* note 20, at 31–53 (discussing the expansion of the nation's public mental health system in the nineteenth century); Joanmarie Illaria Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J.L. & MED. 159, 167–68 (2003). In 1880, there were nearly 140 public and private mental hospitals caring for around 41,000 patients. *Id.* at 168.

¹⁰³ See Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 378 (1982).

¹⁰⁴ See *id.*; GROB, *supra* note 20, 169–70.

¹⁰⁵ See GROB, *supra* note 20, at 203–07; Mayes & Horwitz, *supra* note 17, at 254.

reformers and civil libertarians, elevated mental health on the political agenda.¹⁰⁶ It was in this context that deinstitutionalization—the release of state hospital patients into the community where limited outpatient treatment would function as an alternative to hospitalization—came to mean the liberation of the oppressed.¹⁰⁷

Advances in the treatment of mental illness helped bridge the gap between calls for the end of segregation of the mentally ill and definitive policies and programs.¹⁰⁸ Before the 1950s, psychiatric drugs had crude effects and were used mainly as chemical restraints.¹⁰⁹ Effective psychotropic drug treatments became a reality when pharmaceutical company Smith Kline introduced the first antipsychotic in 1954.¹¹⁰ Marketed as Thorazine, chlorpromazine was the first successful psychotropic drug treatment for psychosis and other severe mental illnesses.¹¹¹ As the population of state hospitals peaked at 559,000 patients in 1955, psychiatry finally had an effective pharmaceutical weapon against intractable mental illness.¹¹² In 1956, the population of patients in public mental hospitals declined for the first time since the early 1900s.¹¹³ Although other factors contributed to this initial period of deinstitutionalization,¹¹⁴ the therapeutic impact of antipsychotic drug treatment was unprecedented. Thorazine was not a cure, but was over seventy percent effective in controlling the most debilitating symptoms of psychosis and

¹⁰⁶ GROB, *supra* note 20, at 207, 274–75.

¹⁰⁷ Rhoden, *supra* note 103, at 380–81.

¹⁰⁸ GROB, *supra* note 20, at 223.

¹⁰⁹ See Joanna Moncrieff, *Is Psychiatry For Sale? An Examination of the Influence of the Pharmaceutical Industry on Academic and Practical Psychiatry*, MAUDSLEY DISCUSSION PAPERS, No. 13 (June 2003), available at <http://www.critpsynet.freeuk.com/pharmaceuticalindustry.htm>.

¹¹⁰ Lawrence C. Rubin, *Merchandising Madness: Pills, Promises, and Better Living Through Chemistry*, 38 J. Popular Culture 369, 371–72 (2004).

¹¹¹ Michael Rosenbloom, *Chlorpromazine and the Psychopharmacologic Revolution*, 287 JAMA 1860, 1860 (2002).

¹¹² Rhoden, *supra* note 103, at 378.

¹¹³ PETER CONRAD & JOSEPH W. SCHNEIDER, *DEVIANCE AND MEDICALIZATION: FROM BADNESS TO SICKNESS* 62–63 (THE C.V. MOSBY CO. 1980).

¹¹⁴ See Rhoden, *supra* note 103, at 375.

schizophrenia, including delusions, hallucinations, and agitation,¹¹⁵ and over two million patients used the drug within eight months of its introduction.¹¹⁶ The improved behavior of severely mentally ill patients transformed the atmosphere within state hospitals, improved staff morale, and gave hope to families.¹¹⁷ At around the same time, new psychotropic treatments for depression and manic-depression entered clinical practice.¹¹⁸ The potential for shorter hospitalizations and more discharges was not lost on states, since mental hospitals were routinely the largest item on state budgets.¹¹⁹ Two decades after the introduction of Thorazine, inpatient populations had declined by about two-thirds.¹²⁰

The emergence of antipsychotics marked the beginning of the psychopharmacological era.¹²¹ As a result of new drug treatments, unreliable and dangerous somatic treatment methods introduced in the 1930s, such as insulin convulsive therapy, lobotomy, and electroconvulsive therapy,¹²² gave way to pharmacologic agents.¹²³ For psychiatry, Thorazine transformed intractable mental illness into a manageable problem and fostered therapeutic optimism.¹²⁴ Effective drug treatments also suggested the possibility of the

¹¹⁵ Rosenbloom, *supra* note 111, at 1860.

¹¹⁶ *Id.*

¹¹⁷ GROB, *supra* note 20, at 230.

¹¹⁸ See Joanna Moncrieff, *The Creation of the Concept of an Antidepressant: An Historical Analysis*, 66 SOC. SCI. & MED. 2346, 2349–50 (2008) (discussing the early antidepressants, imipramine and the anti-tuberculosis drug iproniazid); Samuel Gershon, *Lithium Salts in the Management of the Manic-Depressive Syndrome*, 23 ANN. REV. MED. 439, 439 (1972) (discussing lithium as a treatment for manic depression).

¹¹⁹ Carol T. Mowbray & Mark C. Holter, *Mental Health and Mental Illness: Out of the Closet?*, 76 Soc. Serv. Rev. 135, 140 (2002). See Rhoden, *supra* note 87, at 380–82 (arguing that fiscal concerns had already led to increasing discharges prior to the introduction of Thorazine).

¹²⁰ CONRAD & SCHNEIDER, *supra* note 113, at 62; Erickson, *supra* note 11, at 101; Rosenbloom, *supra* note 111, at 1861.

¹²¹ *Id.*

¹²² Pols, *supra* note 89, at 75.

¹²³ Rosenbloom, *supra* note 111, at 1861.

¹²⁴ *Id.* at 1860–61. Even psychotherapeutic psychiatrists shared in the sense of optimism, since many believed that drug treatments made severely mentally ill patients amenable to psychotherapy. GROB, *supra* note 20, at 231.

reintegration of psychiatry into medicine.¹²⁵ Indeed, psychotropic drug treatments led to new theories about the biological basis of mental illness, such as the dopamine theory of schizophrenia and the monoamine theory of depression, which precipitated research into neurotransmitter and receptor abnormalities.¹²⁶ Moreover, the success of Thorazine caught the attention of the pharmaceutical industry. Supported by an extensive marketing campaign, Thorazine raked in seventy-five million dollars in revenues for Smith Kline in 1955.¹²⁷ Pharmaceutical companies raced to develop new psychotropic drugs and supported marketing efforts with promotional campaigns.¹²⁸

1. Federal Policy

State governments were traditionally responsible for the care and treatment of the mentally ill.¹²⁹ After the New Deal and World War II, however, the federal government increasingly broadened its authority.¹³⁰ Signed into law in 1946, the National Mental Health Act (NMHA) established the National Institute of Mental Health (NIMH), and authorized federal funds for research into mental illness and the training of mental health professionals.¹³¹ Although modest, this new bureaucratic structure signaled an increasing federal role in mental health policy.¹³²

¹²⁵ GROB, *supra* note 20, at 229. Drug treatments played a central role in the transformation of psychiatry into a genuine medical specialty. Rosenbloom, *supra* note 112, at 1861.

¹²⁶ Moncrieff, *supra* note 109.

¹²⁷ Erickson, *supra* note 12, at 101. Drug company ads for antipsychotics, including chlorpromazine, claimed that the drugs made patients amenable to the only “true cure” in psychiatry, psychotherapy. Edward Shorter, A HISTORICAL DICTIONARY OF PSYCHIATRY 6, 19 (2005). See Rubin, *supra* note 110, at 370–72 (discussing the early ads for Thorazine and other drugs).

¹²⁸ Moncrieff, *supra* note 109.

¹²⁹ GROB, *supra* note 20, at 207.

¹³⁰ *Id.* at 208.

¹³¹ *Id.* at 210 (detailing the general goals of NMHA, including support for research, fellowships and institutional grants to train mental health professionals, and grants for states to establish clinics and treatment centers).

¹³² *Id.* at 210–11.

By the 1960s, state hospitals were still overcrowded and underfunded, despite the initial phase of deinstitutionalization.¹³³ A new movement within psychiatry proposed a professional-public partnership to deliver services in the community.¹³⁴ Community psychiatrists, supported by NIMH, claimed that new knowledge about diagnosis, treatment, and prevention, combined with a national community care program, could eliminate the need for institutionalization.¹³⁵ As the prestige of psychiatry soared to unprecedented levels, the mental health rhetoric shaped the federal political agenda, despite the paucity of evidence to support these claims.¹³⁶ The Community Mental Health Centers Act of 1963, along with later grants for staffing and services, was the federal government's official commitment to developing Community Mental Health Centers (CMHCs) to provide inpatient, outpatient, and partial hospitalization services.¹³⁷

The program, however, would fall far short of expectations. The federal commitment to covering some of the costs of providing care in the community aligned national policy with deinstitutionalization.¹³⁸ But despite the increasing rate of state hospital discharges, only less than half of an estimated 2000 CMHCs needed nationwide were funded by 1980.¹³⁹ Many CMHCs underserved those with the most serious and persistent mental illnesses and instead favored using psychotherapies to treat new categories of individuals dealing with emotional and personal problems, as well as substance abuse.¹⁴⁰ As a result, the national mental health program did not even provide the minimal level of

¹³³ Rhoden, *supra* note 103, at 381–82.

¹³⁴ See GROB, *supra* note 20, at 250–51.

¹³⁵ See *id.*

¹³⁶ See *id.* at 254–55, 278; David Mechanic & David A. Rochefort, *Deinstitutionalization: An Appraisal of Reform*, 16 ANN. REV. SOC. 301, 304 (1990).

¹³⁷ See Mechanic & Rochefort, *supra* note 136, at 305; Rhoden, *supra* note 103, at 383.

¹³⁸ See Mechanic & Rochefort, *supra* note 136, at 323 (“The Community Mental Health Centers Act of 1963 staked out a national interest in mental healthcare, one consciously designed to bypass the state role which was viewed as too tradition-bound for the necessary reforms.”).

¹³⁹ GROB, *supra* note 20, at 262.

¹⁴⁰ *Id.* at 263–64, 268.

supportive care that state hospitals were capable of providing.¹⁴¹

The passage of Medicare and Medicaid in 1965 provided an economic basis for accelerating deinstitutionalization.¹⁴² In particular, the Medicaid program had a significant impact on the rate of decline of state hospital populations.¹⁴³ Under Medicaid, the federal and state governments provided health care services for the poor and needy, with states paying no more than half of the Medicaid costs.¹⁴⁴ Under the regulations governing Medicaid, states were fully responsible for the costs of providing treatment and services in state hospitals, but the federal government would pay up to half or more for the cost of services provided in Medicaid-eligible facilities such as nursing homes and general hospital psychiatric units.¹⁴⁵ This incentive led states to move Medicaid-eligible patients, usually elderly persons, out of state hospitals and into nursing homes,¹⁴⁶ and there was a massive increase in the number of acute care beds in general hospitals.¹⁴⁷ In addition, the expansion of the federal welfare state, such as expanded disability insurance and public housing, provided an economic and residential base that made it easier to release patients into the community.¹⁴⁸ These changes in federal health policy, particularly the opportunity to cost-shift under Medicaid, led to a dramatic decline in state hospital populations.¹⁴⁹ After declining

¹⁴¹ *Id.* at 263–64.

¹⁴² Mechanic & Rochefort, *supra* note 136, at 305. See Grob, *supra* note 101, at 445 (describing the impact of Medicare on mental hospitals).

¹⁴³ See Rhoden, *supra* note 103, at 384.

¹⁴⁴ Mechanic & Rochefort, *supra* note 136, at 305.

¹⁴⁵ *Id.*; Richard G. Frank et al., *Medicaid and Mental Health: Be Careful What You Ask For*, 22 HEALTH AFF. 101, 105 (2003) (“The regulations governing Medicaid prohibit payments to institutions for mental diseases for people between ages 22 and 64.”).

¹⁴⁶ Frank et. al., *supra* note 145, at 106. This movement of patients—called transinstitutionalization—caused the population of mentally ill residents in nursing home populations to skyrocket; DAVID MECHANIC, MENTAL HEALTH AND SOCIAL POLICY: BEYOND MANAGED CARE 138 (5th ed. 2007).

¹⁴⁷ CHRIS KOYANAGI, LEARNING FROM HISTORY: DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS AS PRECURSOR TO LONG-TERM CARE REFORM 6 (2007), available at <http://www.kff.org/medicaid/upload/7684.pdf>.

¹⁴⁸ Mechanic & Rochefort, *supra* note 136, at 305.

¹⁴⁹ See Frank et al., *supra* note 145, at 106–07.

by around 1.5% per year between 1955 and 1965, populations fell by about 6% per year after the establishment of Medicaid.¹⁵⁰ There were only 171,000 patients in the nation's state hospitals in 1976¹⁵¹, and fewer than 50,000 in 2005.¹⁵²

Although it clearly benefited some individuals who would otherwise have been institutionalized, life in the community was less than idyllic for those who needed supportive care and services in addition to medication.¹⁵³ In general, CMHCs were focused on serving the growing population of people with more minor psychological problems, rather than those with serious mental illness.¹⁵⁴ General hospitals offered short-term inpatient care for many severely and chronically ill persons, but failed to provide the necessary long-term supportive care and services after discharge.¹⁵⁵ As a result, public hospitals continued to care for more severely impaired individuals than any other type of facility in the mid-1970s.¹⁵⁶ However, shorter lengths of stay at state hospitals ultimately allowed many patients to fall through the cracks of the nation's mental health system.¹⁵⁷ According to historian Gerald Grob, "severely and persistently mentally ill persons [were left] scattered through society, but no single organization accepted longitudinal responsibility for their basic human needs."¹⁵⁸ Consequently, "some of the changes in the mental health system that began during the 1960s only exacerbated [the] plight" of many of the most vulnerable

¹⁵⁰ *Id.*

¹⁵¹ Rhoden, *supra* note 103, at 378.

¹⁵² Ronald W. Manderscheid et al., *Changing Trends in State Psychiatric Hospital Use From 2002 to 2005*, 60 *PSYCHIATRIC SERVS.* 29, 30 tbl.1 (2009).

¹⁵³ GROB, *supra* note 20, at 262–63.

¹⁵⁴ *Id.* at 263.

¹⁵⁵ *Id.* at 267–68.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* at 268.

¹⁵⁸ *Id.* As the states accelerated deinstitutionalization, many severely mentally ill persons, particularly younger individuals who did not qualify for Medicaid, ended up being cycling between the streets, emergency rooms, psychiatric wards, and correctional institutions. Mayes & Horwitz, *supra* note 17, at 255.

individuals in our society.¹⁵⁹

D. Psychiatric Classification: From Psychodynamic Liability to Atheoretical Legitimacy

A basic theme of psychodynamic theory was that mental health and illness were not discrete entities susceptible to categorization.¹⁶⁰ Instead, mental health and illness lay on a continuum of symptom severity caused by adaptive failure, from mild neuroses to severe psychoses.¹⁶¹ Everyone exhibited symptoms at some point in life, and psychiatrists were increasingly preoccupied with common maladaptive behavior, character, and personal problems.¹⁶² With jurisdiction over the treatment of general discontent, “[p]sychiatry had been transformed from a discipline that was concerned with insanity to one concerned with normality.”¹⁶³ Psychodynamic psychiatry therefore did not emphasize clinical diagnosis or classification; rather, a psychiatrist interpreted symptoms in the context of a patient’s life history to ascertain the unique underlying problem.¹⁶⁴ Psychoanalysis derived its therapeutic power from the psychiatrist making the patient aware of the reasons for the patient’s adaptive failure.¹⁶⁵

1. DSM-I and DSM-II

Published in 1952, the first edition of American Psychiatric Association’s (APA) official psychiatric manual, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I), reflected the psychodynamic theoretical framework.¹⁶⁶ DSM-I identified three broad categories of mental disorders—“organic brain syndromes,

¹⁵⁹ GROB, *supra* note 20, at 268; *see also* Mayes & Horwitz, *supra* note 17, at 255.

¹⁶⁰ HORWITZ & WAKEFIELD, *supra* note 92, at 126.

¹⁶¹ Mayes & Horwitz, *supra* note 17, at 250.

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *See* Isaac R. Galatzer-Levy & Robert M. Galatzer-Levy, *The Revolution in Psychiatric Diagnosis: Problems at the Foundations*, 50 PERSP. BIOLOGY & MED. 161, 171 (2007).

¹⁶⁶ Erickson, *supra* note 12, at 96.

functional disorders, and mental deficiency"¹⁶⁷—and 106 diagnostic categories.¹⁶⁸ Consistent with psychoanalytical theory, the manual emphasized unconscious psychological mechanisms rather than the biological bases of mental disorders.¹⁶⁹ Descriptive concepts and unproven psychodynamic etiological theories described disorders, but there were no explicit diagnostic criteria to distinguish different types of mental illness.¹⁷⁰ Thus, clinical diagnosis relied on the idiosyncratic judgments of clinicians who used vague, ambiguous psychodynamic concepts to interpret symptoms and patient histories.¹⁷¹ The second edition of DSM (DSM-II), published in 1968, generally retained the first edition's psychodynamic formulations,¹⁷² and broadened to include ten categories of mental disorders with over 160 diagnoses, an expansion unsupported by any research.¹⁷³

DSM-II would mark the apex of dynamic psychiatry's influence over the diagnostic manual. Thereafter, a combination of external and internal pressures converged to create a crisis of legitimacy for the specialty. In the period of social unrest and anti-authoritarianism in the mid-1960s, a number of so-called "antipsychiatrists" publicly questioned the nature and existence of mental illness and psychiatry's medical status.¹⁷⁴ The inclusion of homosexuality as a

¹⁶⁷ *Id.* "[O]rganic mental illnesses included the dementias, such as Alzheimer's disease, and the toxic psychoses, such as those that follow the chronic use of cocaine, heroin, and alcohol. Functional mental illnesses included . . . the neurotic illnesses[,] . . . the depressive illnesses[,] and the schizophrenias." Eric R. Kandel, *A New Intellectual Framework for Psychiatry*, 155 AM. J. PSYCHIATRY 457, 464 (1998).

¹⁶⁸ Duncan Double, *The Limits of Psychiatry*, 324 BRIT. J. MED. 900, 902 (2002).

¹⁶⁹ HORWITZ & WAKEFIELD, *supra* note 92, at 85.

¹⁷⁰ See Mayes & Horwitz, *supra* note 17, at 249; Galatzer-Levy & Galatzer-Levy, *supra* note 165, at 171-72.

¹⁷¹ See Andrew Lakoff, *Adaptive Will: The Evolution of Attention Deficit Disorder*, 36 J. HIST. BEHAV. SCI. 149, 158 (2000); Mayes & Horwitz, *supra* note 17, at 260-61.

¹⁷² Lloyd H. Rogler, *Making Sense of Historical Changes in the Diagnostic and Statistical Manual of Mental Disorders: Five Propositions*, 38 J. HEALTH & SOC. BEHAV. 9, 10 (1997). However, DSM-II did include incremental changes that foreshadowed the shift that would come in the third edition. *Id.*

¹⁷³ See Mayes & Horwitz, *supra* note 17, at 251; Erickson, *supra* note 12, at 105.

¹⁷⁴ Erickson, *supra* note 12, at 104. Psychiatrist and libertarian Thomas Szasz argued that mental illness was merely a "myth" used to control nonconformists and psychiatry, as a pseudo-science, was an authoritarian extension of the state. Mayes & Horwitz, *supra* note

mental disorder in DSM-I and -II, and the protests that led to its removal in 1973, seemed to affirm the role of values in diagnostic classification.¹⁷⁵ As more psychiatrists moved into private practice and deinstitutionalization progressed, the specialty appeared to have abandoned the severely mentally ill for a more affluent clientele with far more trivial problems.¹⁷⁶ By the 1970s, psychiatry was largely focusing on the problems of living rather than mental illness, and private and public third party payors, which were increasingly covering mental health services, threatened to reduce or altogether stop reimbursement unless changes were made to assure more accountable diagnoses.¹⁷⁷ Within psychiatry, an influential group of psychiatrists called the neo-Kraepelinians believed the psychodynamic approach had moved psychiatry away from

17, at 252.

¹⁷⁵ Erickson, *supra* note 12, at 106. After years of protests by gay rights activists, the APA removed homosexuality as a disorder in the seventh printing of the DSM-II in 1974, referring to it instead as a "sexual orientation disturbance." Mayes & Horwitz, *supra* note 17, at 258-59. Pathologizing homosexuality, along with other described sexual acts, suggested that the dominant social group's construction of deviance, public opinion, and political considerations strongly influenced what were supposed to be scientifically valid psychiatric diagnoses. *See id.* at 258. The APA's deletion was also troubling. Wanting to put an end to the embarrassing protests, the APA formed a task force, which voted to delete homosexuality as a mental illness. David J. Rissmiller & Joshua H. Rissmiller, *Evolution of the Antipsychiatry Movement Into Mental Health Consumerism*, 57 PSYCHIATRIC SERVS. 863, 864 (2006). With the stroke of a pen, "what had been considered for a century or more a grave psychiatric disorder ceased to exist." Mayes & Horwitz, *supra* note 17, at 259 (quoting EDWARD SHORTER, A HISTORY OF PSYCHIATRY 303 (1997)). Regardless of whether this was the correct outcome, the removal of an established mental disorder under these conditions is susceptible to political pressure. Erickson, *supra* note 12, at 106.

¹⁷⁶ Mayes & Horwitz, *supra* note 17, at 254. Many psychiatrists were in private practice serving clients who were responsive to psychoanalysis. *Id.* at 255. As such, the profession lacked the ability and desire to respond to the needs of this severely ill population. *Id.* at 254.

¹⁷⁷ Mayes & Horwitz, *supra* note 17, at 254, 264. Third-party payors will reimburse only for the treatment of categorical diseases. However, DSM-II's vague diagnostic criteria and the continuum concept of the psychodynamic model were incompatible with the categorical disease requirement. *See id.* The lack of specific symptom sets, coupled with unproven assumptions about causation, left individual diagnoses heavily reliant on the subjective understandings and subtle judgments of diagnosticians. Rogler, *supra* note 172, at 11, 14. Consequently, DSM-II had "horrifyingly low" reliability, i.e., diagnostic variability from clinician to clinician. *Id.* at 11. Thus, large-scale clinical research was simply impossible. Mayes & Horwitz, *supra* note 17, at 263. Third-party payors therefore demanded more accountable diagnoses and also requested evidence of the cost-effectiveness of psychotherapy. *See id.* at 264; HORWITZ & WAKEFIELD, *supra* note 92, at 98.

medicine.¹⁷⁸ To restore scientific legitimacy, neo-Kraepelinians advocated a symptom-based classification system based on more reliable diagnoses, which would enable research into the biology of mental illness.¹⁷⁹

2. DSM-III and DSM-IV

The third edition of the manual (DSM-III), published in 1980, ended psychiatry's crisis and ushered in the modern era of psychiatry.¹⁸⁰ Influenced by the neo-Kraepelinians, DSM-III introduced a new symptom-based classification that included 265 discrete, bounded mental disorders.¹⁸¹ This categorical approach was based on a dichotomous, "all or nothing" categorization, and the presence or absence of disease depended almost entirely on whether the patient's condition satisfied a particular set of decontextualized criteria consisting of patterns of behaviors, emotions, and psychological experiences.¹⁸² Moreover, DSM-III was atheoretical about etiology, so psychodynamic determinants became irrelevant to establishing the presence of a mental disorder.¹⁸³ The fourth edition of DSM (DSM-IV) was published in 1994 and is substantively similar to DSM-III.¹⁸⁴ DSM-IV, however, expanded to include 297 total

¹⁷⁸ Rogler, *supra* note 172, at 17. The social aspirations and activism pioneered by the hygienists and emphasized after World War II had, according to one prominent psychiatrist Alan Stone, 'brought the profession to the edge of extinction.' Mayes & Horwitz, *supra* note 17, at 256. Squeezed between the growing competition from non-physicians seeking to provide outpatient talk therapy and more demanding reimbursement standards, the future of the profession was in doubt. *Id.* at 256.

¹⁷⁹ Rogler, *supra* note 172, at 11. Moreover, the presumed effects of new psychotropic drugs and treatment specificity suggested a need for finer diagnostic distinctions. Alison C. Boyle, *Neuroimaging in Psychiatry: Evaluating the Ethical Consequences for Patient Care*, 23 *BIOETHICS* 349, 356 (2009).

¹⁸⁰ Rogler, *supra* note 172, at 10.

¹⁸¹ *Id.* at 11; Mayes & Horwitz, *supra* note 17, at 251.

¹⁸² Erickson, *supra* note 12, at 108; Boyle, *supra* note 9, at 290.

¹⁸³ James E. Sabin & Norman Daniels, *Determining "Medical Necessity" in Mental Health Practice*, *HASTINGS CTR. REP.* 5, 7 (1994) (noting that a patient's "maladaptive" behavior may not satisfy the criteria for a DSM-III personality disorder).

¹⁸⁴ Mayes & Horwitz, *supra* note 17, at 251.

diagnoses organized under seventeen categories.¹⁸⁵ Like DSM-III, DSM-IV utilizes a five-level “axis” system that classifies personality disorders under Axis II and all other mental disorders, which are considered more “florid,” classified under Axis I.¹⁸⁶

The so-called “paradigm shift” of DSM-III restored medical diagnosis as the core of psychiatric practice and research.¹⁸⁷ The symptom-based approach allowed psychiatry to claim that disorders were defined objectively, and it legitimized psychiatrists as bona fide medical doctors treating real diseases; both of these developments facilitated reimbursement from insurance companies and the government.¹⁸⁸ Although atheoretical about etiology and pathogenesis, DSM-III shifted psychiatry towards a biomedical model, which views a cluster of abnormal behaviors and mental states as a manifestation of a common underlying disease process involving brain dysfunction.¹⁸⁹ However, this approach to diagnostic classification was not the result of any new scientific knowledge about mental illness or its treatments.¹⁹⁰ Instead of diagnostic validity, the central focus was on increased diagnostic reliability – the ability of different diagnosticians to arrive at the same diagnosis when presented with the same clinical information¹⁹¹ – a prerequisite

¹⁸⁵ *Id.*; see AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 13–25 (4th ed., text rev. 2000). Categories include schizophrenia and other psychotic disorders, mood disorders, personality disorders, adjustment disorders, and others. AM. PSYCHIATRIC ASS'N, *supra*, at 13–25.

¹⁸⁶ See Rogler, *supra* note 172, at 13; Nick Manning, *Actor Networks, Policy Networks and Personality Disorder*, 24 SOC. HEALTH & FITNESS 644, 644 (2002). Although the remaining axes encourage the clinical consideration of other factors, the central components of DSM-IV are the psychiatric diagnoses under Axis I and II. See Rogler, *supra* note 172, at 12–13.

¹⁸⁷ See Boyce, *supra* note 179, at 356.

¹⁸⁸ See Mayes & Horwitz, *supra* note 17, at 251–52.

¹⁸⁹ Boyce, *supra* note 179, at 356. After DSM-III, clinicians increasingly relied on psychotropic drugs rather than talk-oriented therapies, resolving a professional turf battle as psychiatry secured jurisdiction over psychopharmacological therapies and ceded psychotherapy to non-physician professionals. See Mayes & Horwitz, *supra* note 17, at 251–52, 265 (“With the DSM-III, biomedical investigators replaced clinicians as the most influential voices in the field.”).

¹⁹⁰ Mayes & Horwitz, *supra* note 17, at 265.

¹⁹¹ HORWITZ & WAKEFIELD, *supra* note 92, at 98. See OFFICE OF THE SURGEON GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 14, 15

for adequately validated diagnoses.¹⁹² Improved reliability allowed researchers to study more homogenous groups so that results could be understood and generalized, and biomedical psychiatrists hoped that research into etiology and treatment would eventually illuminate the biological basis of mental illness.¹⁹³ The categorical model also had a significant impact on the development of psychotropic drugs.¹⁹⁴ Under the 1962 Food and Drug Act amendments, the U.S. Food and Drug Administration approved the marketing of a medication only if the drug manufacturer could show that it was an effective treatment for a specific disease.¹⁹⁵ The lack of reliability under DSM-I and -II made large-scale clinical research impossible,¹⁹⁶ and both editions framed mental illness as a continuum from mild to severe rather than discrete disorders.¹⁹⁷ It was therefore difficult for drug manufacturers to broaden the psychotropic market and develop drugs for more prevalent but less serious mental illnesses.¹⁹⁸ After DSM-III, large-scale clinical research was suddenly feasible, and drug companies could market new treatments for any of the hundreds of specific mental disorders.¹⁹⁹ With the influence of psychodynamic psychiatry waning, physicians began to rely on psychopharmacological treatments.²⁰⁰ Moreover, community studies could finally provide realistic estimates of the prevalence of mental

(1999), available at <http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c1.pdf> (concluding that psychiatric diagnoses "made using specific criteria are as reliable as those for general medical disorders.").

¹⁹² HORWITZ & WAKEFIELD, *supra* note 92, at 99.

¹⁹³ See Boyce, *supra* note 179, at 355.

¹⁹⁴ David Healy, *Good Science or Good Business*, HASTINGS CENTER REP., Mar.-Apr. 2002, at 20.

¹⁹⁵ See HORWITZ & WAKEFIELD, *supra* note 92, at 182; David Healy, *supra* note 194, at 20.

¹⁹⁶ Mayes & Horwitz, *supra* note 17, at 263.

¹⁹⁷ HORWITZ & WAKEFIELD, *supra* note 92, at 135.

¹⁹⁸ See Healy, *supra* note 194, at 20. Early attempts to market tranquilizers for more minor mental problems led to concerns about the misuse of drugs. HORWITZ & WAKEFIELD, *supra* note 92, at 135, 180-81. By the late 1960s and early 1970s, when between 15 and 25 percent of the population had used a tranquilizing drug, studies showed that most tranquilizer prescriptions were written for people not diagnosed with mental disorders. *Id.* at 180.

¹⁹⁹ HORWITZ & WAKEFIELD, *supra* note 92, at 182; Mayes & Horwitz, *supra* note 17, at 263.

²⁰⁰ See HORWITZ & WAKEFIELD, *supra* note 92, at 182.

illness.²⁰¹ In the 1980s and 1990s, studies found that around thirty percent of participants had a mental disorder in the twelve months prior to the interview, but only about a fourth of these individuals received treatment.²⁰² Suddenly, mental illness was far more prevalent than ever before, and something had to be done to broaden access to care.

E. Federal Mental Health Policy in the Modern Era

1. Parity

Until the 1960s, the state-financed public mental health system was primarily responsible for the delivery of mental health services.²⁰³ As deinstitutionalization progressed and outpatient mental health services expanded in the 1960s, public and private health insurance programs increasingly financed both outpatient and inpatient mental health services.²⁰⁴ By the 1980s, employers and private insurers were concerned about the potential cost liabilities of outpatient and inpatient mental health care because of uncertain treatment standards.²⁰⁵ To limit potential liabilities, insurers imposed

²⁰¹ *Id.* at 130.

²⁰² Ronald C. Kessler et al., *Prevalence and Treatment of Mental Disorders, 1990-2003*, 352 *NEW ENG. J. MED.* 2515, 2516 (2005).

²⁰³ Richard G. Frank et al., *Will Parity in Coverage Result in Better Mental Health Care?*, 345 *NEW ENG. J. MED.* 1701, 1701 (2001).

²⁰⁴ *Id.* Public and private insurance programs accounted for sixty percent of total mental health expenditures in 1997. *Id.* In addition, a variety of other state and federal programs provide support for those with serious mental illnesses, including the federal government's two largest support programs—Supplemental Security Income and Social Security Disability Insurance. See John K. Inglehart, *The Mental Health Maze and the Call for Transformation*, 350 *NEW ENG. J. MED.* 507, 510 (2004).

²⁰⁵ David Mechanic, *Is the Prevalence of Mental Health Disorders a Good Measure of the Need for Services*, 22 *HEALTH AFF.* 8, 15–16 (2003). More specifically, insurers were concerned about the overutilization of outpatient mental health services due to more hazard—i.e., “hazard” refers to the idea that people overutilize health services when insurance covers the costs—and adverse selection—i.e., the fear of attracting sicker individuals due to better mental health coverage. Frank, *supra* note 188, at 1701–02. Because mental illnesses can be costly and chronic and those with mental illness tend to select health plans with more generous mental health coverage, insurers stand to benefit by offering restricted benefits that discourage the mentally ill from enrolling. Colleen L. Barry & Susan M. Ridgely, *Mental Health and Substance Abuse Insurance Parity for Federal Employees: How Did Health Plans*

more restrictions on mental health care than other illnesses.²⁰⁶ For instance, plans restricted inpatient care to 30 days—as opposed to 120 days for other illnesses—and set lower lifetime and yearly expenditure maximums for mental health benefits.²⁰⁷ As for outpatient services, plans required more cost-sharing, such as a fifty percent coinsurance rate instead of twenty percent for other illnesses.²⁰⁸ With studies finding that many of those suffering from mental illness were not receiving care, concern mounted that such restrictions were inhibiting access to vital mental health services.²⁰⁹

Congress attempted to address these disparities with the Mental Health Parity Act of 1996 (MHPA), which was implemented in 1998.²¹⁰ MHPA prohibited private plans from imposing different lifetime and annual dollar limits for mental health benefits and medical health benefits.²¹¹ However, the impact of MHPA was limited since insurers were free to impose other limitations on mental health benefits.²¹² Moreover, employers with fifty or fewer employees were exempt from these requirements,²¹³ and although the MHPA

Respond? 155, 156–57 (2008).

²⁰⁶ Sherry A. Glied & Richard G. Frank, *Shuffling toward Parity – Bringing Mental Health Care under the Umbrella*, 359 NEW ENG. J. MED. 113, 113 (2008).

²⁰⁷ Richard G. Frank, et al., *The Politics and Economics of Mental Health ‘Parity’ Laws*, 16 HEALTH AFF. 108, 110 (1997).

²⁰⁸ *The Medicare Improvements for Patients and Providers Act (MIPPA): Summary of Key Provisions*, NAT’L COMM. TO PRESERVE SOC. SEC. & MEDICARE, (Sept. 2008), available at http://www.ncpssm.org/news/archive/mippa_summary/ (last visited March 1, 2011).

²⁰⁹ DAVID MECHANIC, MENTAL HEALTH AND SOCIAL POLICY 139–41 (Linda Schuman ed., Prentice-Hall, Inc. 2d ed. 1980).

²¹⁰ Mental Health Parity Act of 1996, Pub. L. No. 104-204, Title VII, § 702(a), 110 Stat. 2944 (1996).

²¹¹ Matt Boucher, *Turning a Blind (White) Eye in Legislating Mental Health Parity: The Unmet, Overlooked Needs of the Working Poor in Racial and Ethnic Minority Communities*, 19 J. CONTEMP. HEALTH L. & POL’Y 465, 482 (2003).

²¹² Yuhua Bao & Roland Sturm, *The Effects of State Mental Health Parity Legislation on Perceived Quality of Insurance Coverage, Perceived Access to Care, and Use of Mental Health Specialty Care*, 39 HEALTH SERVICES RES. 1361, 1362 (2004).

²¹³ EMP. BENEFITS SEC. ADMIN., *Frequently Asked Questions About the Mental Health Parity Act*, U.S. DEPT. OF LAB., http://www.dol.gov/ebsa/faqs/faq_consumer_mentalhealthparity.html (last visited March 1, 2011).

required parity if an employer offered mental health benefits, it did not require employers to offer mental health benefits in the first place.²¹⁴

Disappointed, advocates continued to push for comprehensive parity. Dozens of states responded to the limited reach of the MHPA by passing parity legislation that often went further than the federal requirements.²¹⁵ However, because the Employment Retirement Income Security Act of 1974 preempts state insurance regulation as to self-insured employers, state parity legislation did not reach self-insured plans that covered up to half of the nation's workforce.²¹⁶ Pursuant to a presidential directive, the Federal Employees Health Benefits (FEHB) Program instituted a comprehensive parity policy in 2001, affecting the health insurance of 8.5 million people.²¹⁷ FEHB parity went further than the MHPA, applying to "all aspects of . . . mental health and substance abuse benefits including cost sharing, deductibles, . . . and . . . [all] dollar, day, and visit limits."²¹⁸ Five years later, a study found that although the FEHB parity policy had only a modest impact on access to care, utilization of care, and quality, some beneficiaries did have lower out-of-pocket costs for mental health services.²¹⁹ Importantly, however, there was little impact on costs.²²⁰ That FEHB parity did not result in increased spending was largely attributable to federal employee plans carving-out mental health benefits and contracting with managed behavioral healthcare organizations (MBHOs) to administer the expanded mental health benefits.²²¹ Plans contracted with MBHOs to provide a range of services, from full service behavioral healthcare

²¹⁴ *Id.*

²¹⁵ See Bao & Sturm, *supra* note 212, at 1362–63, 1374.

²¹⁶ *Id.* at 1374–75.

²¹⁷ Barry & Ridgely, *supra* note 205, at 156.

²¹⁸ *Id.*

²¹⁹ U.S. DEP'T OF HEALTH & HUMAN SERVS., EVALUATION OF PARITY IN THE FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM: FINAL REPORT 6 (2004), available at <http://aspe.hhs.gov/daltcp/reports/parity.pdf>.

²²⁰ See Colleen L. Barry et al., *The Costs of Mental Health Parity: Still an Impediment?*, 25 HEALTH AFF. 623, 629–30 (2006).

²²¹ See Barry & Ridgely, *supra* note 212, at 166.

management contracts to discrete services, including utilization review and case management.²²²

The FEHB parity experiment emboldened the push for more comprehensive parity legislation at the federal level by undermining the insurance industry's claim that increased parity would lead to increased spending because limitations were necessary to control overutilization.²²³ Tucked into the Wall Street bailout bill, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008.²²⁴ Under regulations issued in 2010, MHPAEA expanded parity requirements to mental health and substance abuse disorder benefits, including deductibles, cost-sharing, and aggregate lifetime and annual dollar limits.²²⁵ The regulations also require that medical necessity determinations and formulary design be no more restrictive than with respect to medical and surgical benefits.²²⁶ However, group health plans covering employers with 50 or fewer employees are exempt from the parity requirements.²²⁷ Moreover, MHPAEA does not require that group plans cover mental health or substance abuse disorder treatments at all, but only mandates parity if the plan already covers mental illness

²²² *Id.* at 157–58.

²²³ See Barry et al., *supra* note 220, at 632 (A comprehensive parity bill, the Paul Wellstone Mental Health Equitable Treatment Act, is pending in Congress. . . . The main argument against enacting a comprehensive federal parity law of this kind is that generous coverage would drive up mental health spending, increase premiums, and expand the number of people unable to afford coverage. . . . In our view, the relevant research implies that parity implemented in the context of managed care would have little impact on mental health spending and would increase risk protection.”).

²²⁴ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511-12, 122 Stat. 3765, 3881-93 (amending 26 U.S.C. § 9812, 29 U.S.C. § 1185a, and 42 U.S.C. § 300gg-5). See John R. Graham, *The Stealth Mental Health Parity Act: An Attack on Innovation and Choice in Health Care*, HEALTH POL'Y PRESCRIPTIONS, Oct. 14, 2008, at 1.

²²⁵ See Parity in Mental Health and Substance Abuse Disorder Benefits, 29 C.F.R. § 2590.712 (b)(1)–(b)(2) (2010).

²²⁶ 29 C.F.R. § 2590.712.

²²⁷ See 29 C.F.R. § 2590.712(e)(1). MHPAEA does not require employers and plans that offer mental health benefits to cover services for all DSM-IV mental health and addiction diagnoses. Christopher J. Churchill, *The Parity Cure: Solving Unequal Treatment of Mental Illness Health Insurance Through Federal Legislation*, 44 GA. L. REV. 511, 529 (2010).

or substance abuse benefits.²²⁸ Nevertheless, because the vast majority of persons covered by employer-sponsored health insurance had mental health coverage in 2002, MHPAEA extends comprehensive parity to most of the workforce.²²⁹ Although comprehensive federal parity may have increased protection for those treated for a mental illness, it did not address the needs of those without private or public insurance coverage.

2. New Freedom Commission on Mental Health

Appointed by President George W. Bush,²³⁰ the New Freedom Commission on Mental Health (Commission) issued a final report in 2003 that included an assessment of the nation's mental health care system and recommendations that in the aggregate would completely overhaul the mental health system.²³¹ Among the many recommendations in the report, the Commission urged an expansion of preventive mental health efforts.²³² Based on the equivocal claim that "[e]merging research indicates that intervening early can interrupt the negative course of some mental illnesses and may, in some cases, lessen long-term disability," the Commission recommended the implementation of mental health screening programs in the nation's schools.²³³ Echoing the logic of the mental hygiene movement, the report stated that schools were an ideal site for this intervention because "almost one-fifth of the population passes through the Nation's schools on any given weekday."²³⁴ Similarly, because "mental disorders that occur before the age of six can interfere with critical emotional, cognitive, and physical

²²⁸ See 29 C.F.R. § 2590.712(6)(1); Churchill, *supra* note 228, at 529.

²²⁹ See Colleen L. Barry et al., *Design of Mental Health Benefits: Still Unequal After All These Years*, 22 HEALTH AFF. 127, 128 (2003) (suggesting that ninety-eight percent of workers with employer-sponsored health insurance had coverage for mental health care in 2002).

²³⁰ Exec. Order No. 13,263, 67 Fed. Reg. 22,337 (Apr. 29, 2003).

²³¹ See THE PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, *ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA* 4-15 (2003), available at <http://store.samhsa.gov/shin/content//SMA03-3831/SMA03-3831.pdf>.

²³² See generally *id.*

²³³ *Id.* at 57-58, 62-64.

²³⁴ *Id.* at 58.

development, and can predict a lifetime of problems in school, at home, and in the community,” school screening and early treatment could halt the “downward spiral of school failure, poor employment opportunities, and poverty in adulthood.”²³⁵ Although the report was controversial, the federal government has been funding a variety of state and local mental health screening programs for adolescents and children since 2003, including suicide prevention programs, violence prevention programs, and even mandatory mental health screening of children under five years of age in some Medicaid programs.²³⁶

3. Patient Protection and Affordable Care Act

While MHPAEA was hailed as a significant victory, the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010 signaled an even bolder new federal mental health policy.²³⁷ Under PPACA, all Americans must obtain health insurance in 2014 or face a tax penalty, unless an exception applies.²³⁸ For the lowest income Americans, PPACA expands Medicaid to cover all individuals, including childless adults, under age 65 with incomes up to 133% of the Federal Poverty Level (FPL), a change that is estimated to provide

²³⁵ *Id.*

²³⁶ See generally SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., TRANSFORMING MENTAL HEALTH CARE IN AMERICA, THE FEDERAL ACTION AGENDA: FIRST STEPS (2005), available at http://www.samhsa.gov/Federalactionagenda/NFC_FMHAAspx. See also D. RUSSELL LYMAN ET AL., STATE CASE STUDIES OF INFANTS AND EARLY CHILDHOOD MENTAL HEALTH SYSTEMS: STRATEGIES FOR CHANGE 11 (2010), available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jul/1427_Lyman_state_case_studies_child_mental_hlt.pdf; *Federal Funding for Universal Mental Health Screening*, EDWATCH (June 19, 2006) <http://www.crossroad.to/articles2/006/edwatch/6-19-fed-funding-mh-screen.htm> (discussing suicide and violence prevention, as well as mental health screening generally).

²³⁷ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); HENRY J. KAISER FAMILY FOUND., SUMMARY OF NEW HEALTH REFORM LAW 1 (2010), available at <http://www.kff.org/healthreform/upload/8061.pdf>; KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID COVERAGE AND SPENDING IN HEALTH REFORM: NATIONAL AND STATE-BY-STATE RESULTS FOR ADULTS AT OR BELOW 133% FPL 2 (2010), available at <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>.

²³⁸ Patient Protection and Affordable Care Act § 1501, 124 Stat. at 244. See HENRY J. KAISER FAMILY FOUND., *supra* note 237, at 1.

mental health and substance abuse benefits and prescription drug coverage in accordance with MHPAEA to around 16 million more Americans by 2019.²³⁹ Individuals with incomes exceeding 133% of FPL and not otherwise covered by employer-sponsored insurance will be able to purchase coverage with pooled risk from state-based health insurance exchanges, and those with incomes below 400% of the FPL will qualify for premium and cost-sharing subsidies to reduce the cost of complying with the mandate.²⁴⁰ Additional provisions use tax credits and penalties to encourage employers to offer coverage rather than passing the cost on to taxpayers or employees.²⁴¹

PPACA also imposes many new requirements on the health insurance market. For example, effective January 1, 2014, plans may not establish eligibility rules based on health status and must cover all “essential health benefits,” which will be specified by the federal government and must include mental health benefits that are no more restrictive than other health benefits, as well as limits on cost-sharing.²⁴² However, PPACA exempts “grandfathered plans” – plans in existence on March 23, 2010 and that remain in compliance with federal regulations – from these and other insurance market reforms, in an attempt to appease employers and many of the 170 million insured Americans who feared that reform, if passed, would force them to change their coverage.²⁴³ Contradicting reformers’ repeated claim that “[i]f you like your plan, you can keep your plan” prior to the passage of PPACA,²⁴⁴ the final regulations will strip plans of their

²³⁹ Patient Protection and Affordable Care Act §2001, 124 Stat. at 271. See HENRY J. KAISER FAMILY FOUND., *supra* note 237, at 1-2; KAISER COMM’N ON MEDICAID & THE UNINSURED, *supra* note 237, at 2.

²⁴⁰ See HENRY J. KAISER FAMILY FOUND., *supra* note 237, at 1-2.

²⁴¹ *Id.* at 1-3. Employers with up to 25 employees and average annual wages of less than \$50,000 are eligible for tax credits to cover insurance costs, while employers with 51 or more employees face a penalty for not offering coverage if at least one employee receives a subsidy. *Id.*

²⁴² See Patient Protection and Affordable Care Act § 1201, 124 Stat. at 154-60; § 1302, 124 Stat. at 163-67; § 1311, 124 Stat. at 181.

²⁴³ Robert Pear, *New Rules on Changes to Benefits*, N.Y. TIMES (June 14, 2010), <http://www.nytimes.com/2010/06/14/health/policy/14health.html>.

²⁴⁴ *Obama’s Remarks on Health Care*, N.Y. TIMES (Mar. 3, 2010),

exemption for a variety of changes in deductibles, cost-sharing, or benefits.²⁴⁵ The regulations estimate that around half of all employer-sponsored plans in existence on March 23, 2010 will make such changes and lose grandfather status by the end of 2013.²⁴⁶

In addition to other provisions relating to mental health,²⁴⁷ PPACA devotes substantial federal resources to public health interventions that may have mental health implications. PPACA established the "Prevention and Public Health Fund" and appropriated \$500 million in 2010, which will increase to \$2 billion a year from 2015 onward.²⁴⁸ The Fund will be administered through

<http://www.nytimes.com/2010/03/04/health/policy/04health-text.html?pagewanted=2>.

²⁴⁵ Pear, *supra* note 243. For instance, a plan would lose its exemption if it increases deductibles or co-payments by more than the rate of medical inflation plus fifteen percentage points, it increases an enrollees co-insurance by any amount, or if the employer reduces its share of the premium payment by more than 5 percent. See Preservation of Right to Maintain Existing Coverage, 45 C.F.R. § 147.140(g)(1) (2010). The regulations provide a notable example of a change in mental health coverage that results in a loss of grandfather status. A plan that provided benefits for a particular mental disorder treated by a combination of counseling and psychotropic drugs prior to March 23, 2010 that eliminates benefits for counseling thereafter loses its grandfather status because it "is considered to have eliminated substantially all benefits for the treatment of the condition." 45 C.F.R. § 147.140(g)(1)(i), (g)(4).

²⁴⁶ Pear, *supra* note 243. In addition, large employers reacting to premium increases after PPACA are already hinting that it may be cheaper to stop providing health coverage and pay a penalty than to continue providing coverage, which suggests that reform may erode the dominance of employer-sponsored insurance coverage. Shawn Tully, *Documents Reveal AT&T, Verizon, Others, Thought About Dropping Employer-Sponsored Benefits*, CNN (May 6, 2010), http://money.cnn.com/2010/05/05/news/companies/dropping_benefits.fortune/.

²⁴⁷ Among the changes that impact mental health, the PPACA includes a grant program for depression research, a grant program to combat postpartum depression, a demonstration program for Medicaid coverage of inpatient psychiatric facilities, a new state option in Medicaid to provide an alternative to institutional care for the mentally ill, an increase in funding for community health centers, Medicare coverage for preventive services approved by the United States Preventive Services Task Force and without cost-sharing, and a one percentage point increase in Federal Medicaid matching funds for states that cover preventive services and immunizations endorsed by the USPSTF for adults and without cost-sharing. See *The New Reform Law: A Summary of Provisions of Interest to Mental Health Advocates*, MENTAL HEALTH AM., <http://mentalhealthamerica.net/download.cfm?DownloadFile=3B53C316-1372-4D20-C87DAA32DB62327F>.

²⁴⁸ NAT'L ASS'N OF HEALTH UNDERWRITERS, WELLNESS AND PREVENTION PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 3 (2010), available at http://healthbenefitsnews.com/wp-content/uploads/2010/05/WELLNESS_ppaca_Issue-

the U.S. Department of Health and Human Services (HHS) to support prevention and public health programs, including prevention research and health screenings, grants to fund state and municipal wellness programs, a campaign to raise prevention awareness, and immunization programs.²⁴⁹ A new grant program will also provide fifty million dollars per year through 2013 to fund school-based health clinics and explicitly requires that clinics provide mental health assessments, treatments, and referrals.²⁵⁰ Pursuant to PPACA, President Barack H. Obama issued an Executive Order on June 10, 2010 establishing the National Prevention, Health Promotion and Public Health Council (Council).²⁵¹ Chaired by the Surgeon General,²⁵² the Council must submit an annual report to the President and Congress containing “a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (including . . . mental health, behavioral health, substance-use disorder, and domestic violence screenings)” and the prevention of the five most deadly diseases.²⁵³

Other market reforms compliment this broad federal commitment to prevention and public health. New private health plans and those that lose grandfather status are generally required to cover preventive care and screenings that are recommended by the U.S. Preventive Services Task Force (USPSTF) with no cost-sharing.²⁵⁴ Moreover, Medicare must offer similar coverage, and Medicaid programs will receive additional federal matching funds for covering USPSTF preventive services.²⁵⁵ In primary care settings, USPSTF recommends screening adults for depressive disorders²⁵⁶ and

Brief-May-2010.pdf.

²⁴⁹ *Id.*

²⁵⁰ MENTAL HEALTH AM., *supra* note 247.

²⁵¹ Exec. Order No. 13,544, 75 Fed. Reg. 33,983 (June 10, 2010).

²⁵² 75 Fed. Reg. at 33,983–84.

²⁵³ 75 Fed. Reg. at 33,985.

²⁵⁴ See HENRY J. KAISER FAMILY FOUND., *supra* note 237, at 11.

²⁵⁵ *Id.*

²⁵⁶ U.S. PREVENTIVE SERVS. TASK FORCE, THE GUIDE TO CLINICAL PREVENTIVE SERVICES, RECOMMENDATIONS OF THE U.S. PREVENTIVE SERVICES TASK FORCE (2010-2011), at 136, available at <http://www.ahrq.gov/clinic/pocketgd1011/pocketgd1011.pdf>.

adolescents ages twelve and older for major depressive disorder,²⁵⁷ as well as screening and behavioral counseling interventions to reduce alcohol misuse by adults.²⁵⁸ Unless grandfathered, private and public health insurers must also cover any additional mental health, preventive and wellness services that are included in the definition of minimum mandated benefits, which will be updated annually by the Secretary of HHS.²⁵⁹ Like the mental hygienists, mental health advocates hope that an emphasis on screening and prevention will translate into “universal identification of young children with mental health problems or risks and provide equal access to developmentally and culturally appropriate infant and early childhood mental health services.”²⁶⁰

Taking into account all the provisions of PPACA, the Congressional Budget Office estimates that the overhaul of the nation’s health care system will cost nearly \$940 billion over a decade and expand insurance coverage to thirty-two million people,²⁶¹ although economists suggest that the actual cost will be twice that amount in the likely scenario that many employers shift the cost of insurance coverage to taxpayers or employees.²⁶² In the acrimonious period prior to the passage of PPACA, neither advocates nor opponents of health care reform paid much attention to the possible mental health implications. As such, PPACA has been aptly described as a “mental health Trojan horse.”²⁶³ The concern is that insurance market reforms will force all plans to cover treatments for the entire population’s undesirable psychological conditions, i.e., everyday problems in living, rather than genuine mental disorders.²⁶⁴

²⁵⁷ *Id.* at 211.

²⁵⁸ *Id.* at 131.

²⁵⁹ 42 U.S.C. § 1302.

²⁶⁰ D. RUSSELL LYMAN ET AL., *supra* note 236.

²⁶¹ Elmendorf, *supra* note 3, at 9, tbl.4.

²⁶² Douglas Holtz-Eakin & Hames C. Capretta, *Resetting the ‘Obamacare’ Baseline*, POLITICO (Dec. 16, 2010), <http://dyn.politico.com/printstory.cfm?uuid=EB59A060-A6D6-55B6-0889D8CFD08FE0BF>.

²⁶³ Vatz & Schaler, *supra* note 4.

²⁶⁴ *Id.*

III. PROFILE OF THE MOST CONTESTED MEDICAL SPECIALTY

Modern psychiatry's authority over abnormal behaviors, thoughts, emotions, and beliefs is based on the notion that there is something medical, if not physical, about mental illness.²⁶⁵ The psychiatric profession, pharmaceutical companies, the government, advocacy groups, and the media have zealously promoted the idea that mental illness is the product of a diseased brain.²⁶⁶ Despite the reductive appeal of view, mental illness remains shrouded in mystery. Consequently, skeptics from within and outside of psychiatry continue to challenge the idea that mental and emotional problems are diseases and charge psychiatry with abusing its authority to serve as the arbiter of what is normal and what is not.²⁶⁷ Under these circumstances, mental illness is a "paradoxical reality of . . . fundamental skepticism coexisting with . . . triumphalist reductionism. . . ."²⁶⁸

A. Descriptive Diagnostic Classification: Deceptively Objective Foundation

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is psychiatry's attempt to create categories of mental distress and order

²⁶⁵ See, e.g., Derek Bolton, *Problems in the Definition of 'Mental Disorder,'* 51 PHIL. Q. 182, 188 (2001) (stating that DSM's definition of mental disorder suggests "there is apparently a background assumption in the whole enterprise that there is going to be a medical, objective basis for the norms in question.").

²⁶⁶ See generally Jonathan Leo & Jeffrey R. Lacasse, *The Media and the Chemical Imbalance Theory of Depression*, 45 SOC'Y 35 (2008). Accordingly, the mainstream view is that advances in scientific knowledge and greater conceptual refinement led to changes in the description and treatment of mental illness.

²⁶⁷ See, e.g., Gail A. Hornstein, *Who Owns the Mind?*, OPENMIND, May-June 2009, at 6, available at http://www.mind.org.uk/campaigns_and_issues/report_and_resources/777_who_owns_the_mind. According to one psychiatrist, "[n]o branch of medicine manifests such consistent misgivings and criticism about its nosology both from within and without." John Sorboro, *Prognosis Negative: Psychiatry and the Foibles of the Diagnostic and Statistical Manual V (DSM-V)*, SKEPTIC MAG., Jan. 1, 2010, at 44, 47.

²⁶⁸ Rosenberg, *supra* note 11, at 418.

them into a medical classification scheme.²⁶⁹ In general, the purpose of DSM is to assist clinicians with diagnosing and treating persons with mental illnesses and to help researchers generate new knowledge.²⁷⁰ DSM also imposes regulatory standards on mental health practice, determines access to social goods and services, triggers legal privileges and constraints, and defines the scope of research activity.²⁷¹ It can therefore be understood as both a “scientific classification of mental disorders and as an instrument of public policy.”²⁷² Moreover, the manual shapes the way we think about and understand ourselves, i.e., how we perceive the “suffering, disability, and deviance” associated with a host of behaviors, thoughts, emotions, and beliefs.²⁷³ In the aggregate, the diagnostic criteria in DSM establish the boundaries of what behaviors are regarded as normal and abnormal in society.²⁷⁴

Under DSM, individuals with the same diagnosis must have symptoms that meet the diagnostic criteria for a mental disorder, but because the symptom-based criteria are often polythetic, i.e., only a subset of symptoms from a larger list is necessary for diagnosis, some within the group may not share a single symptom in common, while others may share some or even all symptoms in common.²⁷⁵ The hope

²⁶⁹ See Patrick Bracken & Philip Thomas, *Postpsychiatry: A New Direction for Mental Health*, 322 BRIT. J. MED. 724, 725 (2001); Assen Jablensky & Robert E. Kendell, *Criteria for Assessing a Classification in Psychiatry*, in PSYCHIATRIC DIAGNOSIS AND CLASSIFICATION 1, 2 (Mario Maj et al. eds., 2002).

²⁷⁰ Jablensky & Kendell, *supra* note 269, at 1.

²⁷¹ John Z. Sadler & Bill Fulford, *Should Patients and Their Families Contribute to the DSM-V Process?*, 55 PSYCHIATRIC SERVICES 133, 136 (2004).

²⁷² *Id.* at 134.

²⁷³ See Sorboro, *supra* note 267, at 46. “DSM is a guidebook that tells us how we should think about manifestations of sadness and anxiety, sexual activities, alcohol and substance abuse, and many other behaviours. Consequently, the categories created for DSM reorient our thinking about important social matters and affect our social institutions.” HERB KUTCHINS & STUART A. KIRK, MAKING US CRAZY 11 (1997).

²⁷⁴ See, e.g., Phil Brown, *Naming and Framing: The Social Construction of Diagnosis and Illness*, J. HEALTH & SOC. BEHAV. 34, 39 (1995) (“Diagnosis locates the parameters of normality and abnormality, demarcates the professional and institutional boundaries of the social control and treatment system, and authorizes medicine to label and deal with people on behalf of the society at large.”).

²⁷⁵ Jablensky, *supra* note 10, at 142.

is that these clusters of symptoms progress similarly over time and respond to treatment in the same way.²⁷⁶ According to the general definition of mental disorder, each mental disorder is a manifestation of an internal dysfunction, i.e., some mental, physical, or behavioral process that is not functioning as expected in the individual.²⁷⁷ Diagnosis does not officially require that a clinician determine the existence of an underlying dysfunction.²⁷⁸

The 900-page manual is equivocal as to the nature of what is being classified, and there is no clear relationship between psychiatry's concept of disorder and the concepts of disease or syndrome in medical classifications.²⁷⁹ In very simple terms, disorder involves an undesirable deviation from some norm.²⁸⁰ Other areas of medicine operate in the physical world where it has been possible to establish normal morphology and function by observing, measuring, describing, and analyzing material objects.²⁸¹ This has allowed medicine to measure deviation against a more or less objective standard and to link demonstrated physical abnormalities to signs and symptoms.²⁸² Consequently, clinicians, patients, and the public have been able to objectify abnormalities.²⁸³ In contrast, psychiatry deals with mental states, and internal subjective experiences cannot

²⁷⁶ Dominic Murphy, *Philosophy of Psychiatry*, STAN. ENCYCLOPEDIA PHIL., (July 28, 2010), <http://plato.stanford.edu/entries/psychiatry/#DsmConMenIIIcri>.

²⁷⁷ Jerome C. Wakefield et al., *Should the DSM-IV Diagnostic Criteria for Conduct Disorder Consider Social Context?*, 159 AM. J. PSYCHIATRY 380, 380-81 (2002).

²⁷⁸ Murphy, *supra* note 276.

²⁷⁹ Jablensky & Kendell, *supra* note 269, at 6. The three-paragraph general definition of mental disorder is of limited value, as it is never again discussed or applied, and many of the hundreds of individual diagnostic categories appear to contradict the definition. ALLAN V. HORWITZ, *CREATING MENTAL ILLNESS* 20 (2002).

²⁸⁰ See Galatzer-Levy & Galatzer-Levy, *supra* note 165, at 171. *But see* Bolton, *supra* note 265, at 185-87 (2001) (suggesting an alternative model under which a mental disorder is the breakdown of intentionality).

²⁸¹ See Philip Thomas et al., *Explanatory Models for Mental Illness: Limitations and Dangers in a Global Context*, 2 PAK. J. NEUROLOGICAL SCI. 176, 177 (2007); John Sorboro, *The Trouble with Psychiatry*, SKEPTIC MAG., Sept. 22, 2007, at 37, 38-39.

²⁸² See Herbert W. Harris & Kenneth F. Schaffner, *Molecular Genetics, Reductionism, and Disease Concepts in Psychiatry*, 17 J. MED. & PHIL. 127, 136-37 (1992); Aronowitz, *supra* note 8, at 806.

²⁸³ See Sorboro, *supra* note 281, at 38-39; S. NASSIR GHAEMI, *THE CONCEPTS OF PSYCHIATRY* 139 (2003).

be readily observed.²⁸⁴ Since DSM-III, psychiatry has primarily relied on self-reported subjective experiences and behaviors to construct its symptom-based diagnostic categories.²⁸⁵ Indeed, DSM-III and subsequent editions embraced an atheoretical stance with regards to etiology and pathophysiology, except for a few disorders.²⁸⁶ The introduction of new diagnostic categories, as well as the diagnostic criteria for particular disorders, has been based on expert consensus, rather than objectively defined failures of functioning or known etiology.²⁸⁷ Thus, psychiatry has defined mental disorders in terms of dysfunction before any empirical research has established pathophysiology or etiology.²⁸⁸ Rather than a list of fully validated disorders, the modern DSM has therefore contained sets of “hypotheses, somewhat proved and somewhat unproved, that were reliably defined so as to be further studied and later further refined, proved, or disproved.”²⁸⁹ Nevertheless, the reification of DSM results in clinicians and the public treating diagnoses as proven and fixed entities, rather than hypotheses.²⁹⁰

²⁸⁴ GHAEMI, *supra* note 283, at 53. Thomas et al., *supra* note 281, at 177.

²⁸⁵ See Jablensky & Kendell, *supra* note 269, at 6 (“[T]he material from which most of the diagnostic rubrics are constructed consists primarily of reported subjective experiences and patterns of behavior.”). Diagnostic criteria include “observable (or reportable) behavioral, cognitive, and emotional symptoms. . . .” Peter S. Jensen & Kimberly Hoagwood, *The Book of Names: DSM-IV in Context*, 9 DEV. & PSYCHOPATHOLOGY 231, 232 (1997). See also Charles B. Pull et al., *Clinical Assessment Instruments in Psychiatry*, in PSYCHIATRIC DIAGNOSIS AND CLASSIFICATION 177, 178 (Mario Maj et al. eds., 2002). GHAEMI, *supra* note 283, at 181 (“Diagnoses cannot be established in psychiatry completely on the basis of empirical evidence.”); Steven K. Erickson, *Blaming the Brain*, 11 MINN. J. L. SCI. & TECH. 27, 41 (2010).

²⁸⁶ Pierre, *supra* note 15, at 376 (2010). For example, certain organic brain syndromes, adjustment disorder, and conversion disorder are exceptions to the atheoretical stance of DSM-III. *Id.*

²⁸⁷ Arthur C. Houts, *The Diagnostic and Statistical Manual’s New White Coat and Circularity of Plausible Dysfunctions: Response to Wakefield* (pt. 1), 39 BEHAV. RES. & THERAPY 315, 336 (2001); see Jablensky & Kendell, *supra* note 269, at 6; William C. Follette & Arthur C. Houts, *Models of Scientific Progress and the Role of Theory in Taxonomy Development: A Case Study of the DSM*, 64 J. CONSULTING & CLINICAL PSYCHOL. 1120, 1126 (1996).

²⁸⁸ See Jablensky & Kendell, *supra* note 269, at 7; Arthur C. Houts, *Harmful Dysfunction and the Search for Value Neutrality in the Definition of Mental Disorder: Response to Wakefield* (pt. 2), 39 BEHAV. RES. & THERAPY 1099, 1122 (2001).

²⁸⁹ GHAEMI, *supra* note 283, at 172.

²⁹⁰ See *id.* at 172–73; Jablensky & Kendell, *supra* note 269, at 6.

Although atheoretical, DSM-III shifted psychiatry towards a biomedical model and the idea that neuroanatomical disturbances or biochemical abnormalities in the brain caused mental disorders.²⁹¹ The hope was that more precise and explicit descriptions of symptomatic criteria would improve reliability to the point that neurobiological researchers would be able to illuminate the pathophysiology, i.e., the disease processes and mechanisms, underlying categorical diagnoses, and that validated disorders would then attain the exalted status of 'disease entities.'²⁹² Optimism returned to the specialty: mental disorders were brain diseases that would soon be validated by the discovery of their underlying pathophysiology and pathology.²⁹³ Beaming with confidence, psychiatry helped to convince the public that biochemical imbalances in the brain caused mental disorders, with the assistance of the pharmaceutical industry, mental health advocates, the government, and the media.²⁹⁴ Meanwhile, researchers targeted the brain, hoping to anchor DSM disorders to objective determinants of disease. In particular, neuroimaging studies began to look for neuroanatomical and physiological abnormalities in the brains of those suffering from disorders.²⁹⁵ Despite decades of research and tremendous advances in our understanding of brain function, however, the brain remains "by far the most complex and least understood organ in the human body."²⁹⁶ We do not know how consciousness – the mind – erupts out

²⁹¹ Boyce, *supra* note 179, at 356. Cf. GHAEMI, *supra* note 283, at 241 (explaining that according to the biomedical model of disease, illness involves "a breakdown of the physical constituents of the body, leading to a functional loss of a capacity to perform typical activities of the organism.").

²⁹² See Pierre, *supra* note 15, at 376–77. Under the biomedical model of disease, illness involves "a breakdown of the physical constituents of the body, leading to a functional loss of a capacity to perform typical activities of the organism." GHAEMI, *supra* note 283, at 241.

²⁹³ Cf. Bolton, *supra* note 265, at 188; Galatzer-Levy & Galatzer-Levy, *supra* note 165, at 168.

²⁹⁴ Cf. Leo & Lacasse, *supra* note 266, at 34–45 (reviewing the misleading ways that the press, pharmaceutical companies, and psychiatry portray the chemical imbalance theory); Arthur C. Houts, *Fifty Years of Psychiatric Nomenclature: Reflections on the 1943 War Department Technical Bulletin*, *Medical* 203, 56 J. CLINICAL PSYCHOL. 935, 961–63 (2000).

²⁹⁵ See Boyce, *supra* note 179, at 350; Lara Huber, *Imaging the Brain: Visualising "Pathological Entities"?* Searching for Reliable Protocols Within Psychiatry and Their Impact on the Understanding of Psychiatric Diseases, 6 POIESIS & PRAXIS 27, 29 (2009).

²⁹⁶ Walter Glannon, *Neuroethics*, 20 BIOETHICS 37, 51–52 (2006).

of molecular brain activity,²⁹⁷ much less the complex way in which psychology, biology, and the environment interact to produce undesirable mental states.²⁹⁸ Thus, the etiology and pathophysiology of most mental disorders remains unknown.²⁹⁹ Indeed, there is no scientifically established model of normal brain function.³⁰⁰ The lack of explanatory pathophysiologies is a challenge to the validity of mental disorders and the root of much of the public and academic skepticism that continues to haunt psychiatry.³⁰¹

²⁹⁷ See Gerard Roth, *The Quest to Find Consciousness*, SCI. AM. MIND, Jan. 1, 2004, available at <http://www.scientificamerican.com/article.cfm?id=the-quest-to-find-conscio>; Tejas Patil & James Giordano, *On the Ontological Assumptions of the Medical Model of Psychiatry: Philosophical Considerations and Pragmatic Tasks*, PHIL. ETHICS & HUMAN. MED., (Jan. 28, 2010), <http://www.peh-med.com/content/pdf/1747-5341-5-3.pdf> (“Yet, as neuroscience probes ever deeper into the workings of the brain, it becomes evident that the ‘mind’ remains somewhat enigmatic, and thus, any attempt to link mental events to biology must confront what Chalmers has referred to as the ‘hard problem’ of consciousness.”); Steven K. Erickson, *Blaming the Brain*, 11 MINN. J. L. SCI. & TECH. 27, 51-52 (2010).

²⁹⁸ See Boyce, *supra* note 179, at 354; Kandel, *supra* note 167, at 460 (“The details of the relationship between the brain and mental processes—precisely how the brain gives rise to various mental processes—is understood poorly, and only in outline.”). Neuroimaging research has many other limitations. See, e.g., Boyce, *supra* note 179, at 354; Huber, *supra* note 295, at 29-30.

²⁹⁹ See Thomas R. Insel & Francis S. Collins, *Psychiatry in the Genomics Era*, 160 AM. J. PSYCHIATRY 616, 618 (2003) (“[T]he current diagnostic system . . . has no evident biological basis.”); Pierre, *supra* note 15, at 376 (stating that the discovery of explanatory pathophysiologies “has been sadly unrealized.”); Thomas et al., *supra* note 281, at 177 (claiming that “there is no convincing empirical evidence that psychiatric disorders have a biological basis” except for organic brain syndromes); Douglas C. Smith, *The Limits of Biological Psychiatry*, 27 J. AM. ACAD. PSYCHOANALYSIS 671, 672 (1999) (“[N]o biochemical, anatomical, or functional signs have been found that reliably distinguish the brains of mental patients.”).

³⁰⁰ See Jeffrey R. Lacasse & Jonathan Leo, *Serotonin and Depression: A Disconnect between the Advertisements and the Scientific Literature*, 2 PLOS MED. 1211, 1212 (2005) (“While neuroscience is a rapidly advancing field, to propose that researchers can objectively identify a ‘chemical imbalance’ at the molecular level is not compatible with the extant science. In fact, there is no scientifically established ideal ‘chemical balance’ of serotonin, let alone an identifiable pathological imbalance. To equate the impressive recent achievements of neuroscience with support for the serotonin hypothesis is a mistake.”); Boyce, *supra* note 179, at 350.

³⁰¹ Pierre, *supra* note 15, at 376. Rather than clear and discrete “disease entities,” mental disorders may not be “real” at all. GHAEMI, *supra* note 266, at 172-73. See Gary J. Tucker, Editorial, *Putting DSM-IV in Perspective*, 155 AM. J. PSYCHIATRY 159, 159 (1998) (“[W]e have no identified etiological agents for psychiatric disorders. Our diagnoses are nowhere near the precision of the diagnostic processes in the rest of medicine.”).

The most extreme critics argue that psychiatric classification is entirely subjective or arbitrary.³⁰² These theories are frequently sympathetic to Szasz's view that mental illness is a fiction, so any classification of mental disorders necessarily depends solely on capricious or evaluative judgments.³⁰³ However, not every skeptic denies the very existence of mental illness. The dominant view holds that mental disorders exist, but genuine mental disorders are only a small part of what is described in DSM.³⁰⁴ In general, these critiques reflect unease with an entirely descriptive, symptom-based approach to classification that offers no explanation as to what is wrong, much less its cause.³⁰⁵ The concern is that grouping individuals together based on behavioral evidence alone can conceal fundamental underlying differences and therefore risks creating heterogeneous classes of dissimilar individuals, mixtures that can include troubled but nonetheless normal individuals, as well as genuinely disordered individuals who are suffering from different underlying pathologies.³⁰⁶ Such overinclusive diagnostic categories inhibit research and scientific progress,³⁰⁷ and medicalize normality, leading to the unnecessary labeling of individuals who are not disordered.³⁰⁸

Other areas of medicine have generally attempted to transcend the subjective nature of symptoms by discovering functional or

³⁰² See generally Rissmiller & Rissmiller, *supra* note 175, at 863–66 (discussing the evolving resistance to psychiatry).

³⁰³ See GHAEMI, *supra* note 283, at 151. See generally THOMAS SZASZ, *THE MYTH OF MENTAL ILLNESS* 1 (Harper Perennial 2010) (1961).

³⁰⁴ “It is not that there are no such phenomena as mental disorders, that their existence is all a myth or psychiatric hoax. The point is that mental disorders constitute a small part of what is described in the current *Diagnostic and Statistical Manual of Mental Disorders*.” KUTCHINS & KIRK, *supra* note 273, at 264.

³⁰⁵ See Nancy C. Andreasen, *DSM and the Death of Phenomenology in America: An Example of Unintended Consequences*, 33 *SCHIZOPHRENIA BULL.* 108, 111 (2006); Houts, *supra* note 288, at 1121 (“[T]he DSM tells us almost nothing about what went wrong.”).

³⁰⁶ Houts, *supra* note 288, at 1121.

³⁰⁷ See Galatzer-Levy & Galatzer-Levy, *supra* note 165, at 174–78 (discussing the possibility of heterogeneous groups); Andreasen, *supra* note 305, at 111 (“DSM diagnoses have given researchers a common nomenclature—but probably the wrong one. Although creating standardized diagnoses that would facilitate research was a major goal, DSM diagnoses are not useful for research because of their lack of validity.”).

³⁰⁸ See Wakefield, *supra* note 19, at 6–9.

anatomical abnormalities, or a causal condition for either, to anchor diagnostic categories and disease concepts.³⁰⁹ This allows medicine to refine and narrow diagnoses by differentiating between those individuals whose signs and symptoms are based on known etiology or pathophysiology and those whose are not, providing a more or less objective basis to the diagnosis in question.³¹⁰ Ultimately, the goal is to classify diseases in terms of etiologic agents because the discovery of necessary causal conditions opens new vistas for the prevention and treatment of disease.³¹¹ In psychiatry, however, disease is merely a construct that is useful for clinicians and researchers, rather than an “entity.”³¹² This approach focuses on observable and reportable phenomena and sidesteps any commitment to specific causal hypotheses about the etiology and pathophysiology of disease.³¹³ The subjective nature of mental

³⁰⁹ Harris & Schaffner, *supra* note 282, at 128. Historically, the starting point in medical classification is the syndrome, where medicine defines disorders first in terms of signs and symptoms. Houts, *supra* note 288, at 1104. Thereafter, physical medicine attempts to discover underlying physiological or anatomical abnormalities through a process of hypothesis generation and hypothesis testing by refutation, i.e., rigorous research into empirically testable hypothetical dysfunctions, some of which are discarded while others stand up over time. See Houts, *supra* note 287, at 340; GHAEMI, *supra* note 283, at 52. Thus, a theory is scientific only if it is open to falsification, meaning that it provides predictions that can be disproved, and once a theory is refuted by empirical data, it is absolutely false. *Id.* at 49. The evidence used to establish normality and abnormality in physical medicine is empirical and scientific, meaning it involves observation and experience that are “external, replicable, and quantifiable.” *Id.* at 53. If this process leads to the discovery of an underlying pathological function or structure, medicine defines disorders by the presence of pathological function, a more objective definition of disorder that replaces the syndromal description. Houts, *supra* note 288, at 1103–04. The ultimate goal of physical medicine, however, is to identify the cause of physiological or anatomical abnormality and etiologic classification, whereby disorders are defined in terms of etiology and categorized based on common etiology. *Id.* at 1104. Under an etiologic classification, a disorder might manifest itself in several different syndromes or have several different pathological pictures. See Caroline Whitbeck, *Causation in Medicine: The Disease Entity Model*, 44 PHIL. SCI. 619, 622 (1977). Etiologic classification provides several advantages over less developed approaches, including increasing knowledge of ways to prevent and treat disease. *Id.* But see Aronowitz, *supra* note 8, at 805–07 (discussing asthma and Lyme disease, two symptom clusters that are diseases in other areas of medicine).

³¹⁰ See Houts, *supra* note 288, at 1104; Aronowitz, *supra* note 8, at 803.

³¹¹ Whitbeck, *supra* note 309, at 628–30.

³¹² Karen Ritchie, *The Little Woman Meets Son of DSM-III*, 14 J. MED. & PHIL. 695, 704 (1989).

³¹³ See Andreasen, *supra* note 305, at 111; Houts, *supra* note 288, at 1121 (“Instead of explaining

phenomena blurs the boundary between normality and abnormality, so that obtaining a consensus on where to draw the line when defining mental illness is more of a challenge than it is when dealing with illnesses involving measurable and objective physical characteristics.³¹⁴ In addition to the lack of objective signs of disease, psychiatry has been unable to establish a functional definition of mental disorder or mental health to guide nosological and clinical decisions as to which undesirable conditions should be considered illnesses and which should not.³¹⁵ Thus, psychiatry defines mental illness “without objectively verifiable consensus boundaries between concepts of health and disease,” so that there are few, if any, objective or conceptual limitations on the creation and diffusion of hypothetical disease entities.³¹⁶ This is particularly problematic because the decision of where to draw the line between normal and abnormal is not a purely medical decision.³¹⁷ In the absence of objective determinants of disease, mental disorders “fall into a lowly position in a status hierarchy [of diseases] that is at once social, moral, medical, and epistemological.”³¹⁸ As such, DSM is a set of constructs that is based on a “negotiated consensus between society

the behavior and identifying the causes, we take false comfort in attributing the behavior to some woolly internal broken mechanism that cannot be specified or even checked. This is just psychoanalysis all over again. It is a recycling of what used to be called the medical model.”); Murphy, *supra* note 276.

³¹⁴ Harris & Schaffner, *supra* note 282, at 136.

³¹⁵ See Joseph M. Pierre, *Mental Disorder vs. Normality: Defining the Indefinable*, BULL. (Ass'n for the Advancement of Philosophy & Psychiatry), 2010, at 9 (“The inability to establish a functional definition of mental disorder is more than a hole in psychiatric nosology, it would seem to be a foundational, ground-zero crater that threatens to render the entire DSM meaningless.”).

³¹⁶ See Houts, *supra* note 287, at 341 (“What has been missing is any clear criteria for making judgments about dysfunctions. Absent such criteria, any and all human behavior can be included under the rubric of mental disorders. Such proliferation of mental disorders has been a scientific and public embarrassment for the mental health sciences. One way to stop the proliferation of mental disorder labels is to require more of the DSMs in terms of specifying the scientific basis for declaring that something has gone wrong inside the organism.”); Harris & Schaffner, *supra* note 282, at 136.

³¹⁷ Allen Frances, *It's Not Too Late to Save 'Normal,'* L.A. TIMES, Mar. 1, 2010, available at <http://articles.latimes.com/2010/mar/01/opinion/la-oe-frances1-2010mar01>.

³¹⁸ See Rosenberg, *supra* note 11, at 420.

and psychiatry.”³¹⁹

The problem, according to critics, is that psychiatry has turned its back on theory, which is the “glue that holds a classification together and gives it both its scientific and clinical relevance.”³²⁰ Merely declaring that a group of individuals share certain symptoms does not tell us whether, much less why, a group of individuals are mentally ill; only specific causal hypotheses can distinguish between normal and abnormal populations.³²¹

B. Diagnostic Expansion, Medicalization, and Disease Mongering

Eye-catching figures detailing the prevalence of mental illness are an integral part of the justification for expansive mental health policies.³²² The numbers are truly staggering. According to NIMH, around one in five adults suffer from an anxiety disorder,³²³ one in ten suffer from a mood disorder,³²⁴ one in ten suffer from a

³¹⁹ Klerman, *supra* note 11, at 221.

³²⁰ Jablensky & Kendell, *supra* note 269, at 9 (quoting Theodore Millon, *Classification in Psychopathology: Rationale, Alternatives, and Standards*, 100 J. ABNORMAL PSYCHOL. 245, 257 (1991)). Some critics suggest that DSM should require syndromally defined conditions be “associated with (never mind caused by) an empirically verified, observable, and demonstrated broken function” to be included in DSM. Houts, *supra* note 288, at 1127. See Erickson, *supra* note 12, at 111–13 (“Simply put, psychiatry needs to clearly state which mental illnesses are likely brain diseases and which are emotional difficulties and discard the disingenuous term of ‘disorder.’ It is not that psychiatry should abandon any efforts to understand or even treat emotional difficulties, but claiming that ‘antisocial personality disorder’ and schizophrenia are both ‘mental disorders’ appears faulty and disingenuous.”); Murphy, *supra* note 276 (psychiatry needs to commit “to the idea that there is a destructive neuropsychological process at work that causes an underlying dysfunction.”).

³²¹ Murphy, *supra* note 276.

³²² Brendan I. Koerner, *Disorders Made to Order*, MOTHER JONES, July/August 2002, at 58, available at <http://motherjones.com/politics/2002/07/disorders-made-order>.

³²³ NAT’L INST. OF MENTAL HEALTH, NIHM STATISTICS, http://www.nimh.nih.gov/statistics/1ANYANX_ADULT.shtml (last visited Mar. 26, 2011); Anxiety disorders include panic disorder, generalized anxiety disorder, social phobia, and post-traumatic stress disorder among others. NAT’L INST. OF MENTAL HEALTH, NIHM STATISTICS, <http://www.nimh.nih.gov/statistics/index.shtml> (last visited Mar. 26, 2011).

³²⁴ NAT’L INST. OF MENTAL HEALTH, NIHM STATISTICS, http://www.nimh.nih.gov/statistics/1ANYMOODDIS_ADULT.shtml (last visited Mar. 26, 2011); Mood disorders include major depressive disorder afflicts around one on fifteen

personality disorder,³²⁵ and one in twenty suffer from attention-deficit/hyperactivity disorder (ADHD).³²⁶ As for serious mental illness, schizophrenia has remained relatively stable over time, afflicting approximately one percent of the adult population.³²⁷ Bipolar disorder, which was considered rare prior to the 1950s, now afflicts almost 6 million adults, or around 2.6 percent of the population, though some studies estimate a prevalence of five percent or more.³²⁸ According to the U.S. Government Accountability Office, around a third of young adults aged eighteen through twenty-six experiences some degree of mental illness every year, and one in every fifteen young adults suffer from serious mental illness.³²⁹ As for the pediatric and adolescent populations, approximately one in five children have a diagnosable mental health condition, and about five percent experience "extreme functional impairment."³³⁰ Overall, recent epidemiologic studies indicate that around one in four Americans presently suffers from a mental disorder,³³¹ and at least half of the population will meet the criteria for a DSM-IV disorder at

adults, the majority of whom are "severely impaired" and is the leading cause of disability in the United States for those between fifteen and forty-four years old. http://www.nimh.nih.gov/statistics/1MDD_ADULT.shtml (last visited Mar. 26, 2011).

³²⁵ NAT'L INST. OF MENTAL HEALTH, NIHM STATISTICS, <http://www.nimh.nih.gov/statistics/1ANYPERS.shtml> (last visited Mar. 26, 2011); Personality disorders include antisocial, avoidant, borderline, and other personality disorders. *Id.*

³²⁶ NAT'L INST. OF MENTAL HEALTH, NIHM STATISTICS, http://www.nimh.nih.gov/statistics/1ADHD_ADULT.shtml (last visited Mar. 26, 2011).

³²⁷ NAT'L INST. OF MENTAL HEALTH, NIHM STATISTICS, <http://www.nimh.nih.gov/statistics/1SCHIZ.shtml> (last visited Mar. 26, 2011).

³²⁸ NAT'L INST. OF MENTAL HEALTH, NIHM STATISTICS, http://www.nimh.nih.gov/1BIPOLAR_ADULT.shtml (last visited Mar. 26, 2011); see ROBERT WHITAKER, ANATOMY OF AN EPIDEMIC 182 (2010).

³²⁹ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-678 YOUNG ADULTS WITH SERIOUS MENTAL ILLNESS: SOME STATES AND FEDERAL AGENCIES ARE TAKING STEPS TO ADDRESS THEIR TRANSITION CHALLENGES, at 17 (2008). Serious mental illness includes major depression, bipolar disorder, schizophrenia and another psychotic disorder, anxiety disorder, and personality disorder. *Id.* at 21.

³³⁰ OFFICE OF THE SURGEON GEN., *supra* note 191, at 193.

³³¹ Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R)*, 62 ARCHIVES GEN. PSYCHIATRY 617, 617 (2005).

some point in their lives.³³² With the ubiquity of mental illness, the use of psychotropic drugs has predictably increased. In 2009, physicians wrote approximately 300 million prescriptions for psychotropic drugs.³³³ Antidepressants are the most commonly prescribed class of medications in the United States, and over ten percent of the population aged six years or older used such drugs in 2005.³³⁴ Atypical antipsychotics are currently the biggest selling class of drugs in the United States, a testament to the apparently less severe side effects of these newer drugs compared to first-generation antipsychotics.³³⁵ Three of the top ten most prescribed psychotropic drugs in 2009 were anxiolytics.³³⁶ For example, Xanax was the most prescribed drug in the nation with forty-four million prescriptions in 2009, an increase of twenty-nine percent over the number of prescriptions for the drug in 2005.³³⁷ Among children and

³³² Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 593, 593 (2005). Another recent study suggests that well over half the country will need mental health services before the age of forty. Moffitt et al., *supra* note 5, at 899 (estimating that nearly 60 percent of the population suffers from anxiety disorder, depression, alcohol dependence, or cannabis dependence by age 32).

³³³ *The Top 25 Psychiatric Medications: Big Business and a Price to Pay*, PSYCHIATRIC TIMES (May 19, 2010), available at <http://www.psychiatrictimes.com/news/content/article/10168/1571724>.

³³⁴ Mark Olsson & Steven C. Marcus, *National Patterns in Antidepressant Medication Treatment*, 66 ARCHIVES GEN. PSYCHIATRY 848, 848 (2009). Only about a quarter of these 27 million people were being treated for depression. *Id.*

³³⁵ IMS Health, *Top Therapeutic Classes by U.S. Sales*, Apr. 6 2010, http://www.imshealth.com/deployedfiles/imshealth/Global/Content/StaticFile/Top_Line_Data/Top%20Therapy%20Classes%20by%20U.S.Sales.pdf (reporting that U.S. sales of antipsychotics totaled \$14.6 billion, while antidepressants sales totaled \$9.9 billion). By 2004, there were 6.9 million total prescriptions for atypical antipsychotics, and from 2004 through 2008, total prescriptions increased thirty-three percent to 9.2 million. Elisa Cascade et al., *Use of Antipsychotics in Children*, PSYCHIATRY, June 2009, at 21, 21–22, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2720841/pdf/PE_6_06_21.pdf.

³³⁶ John M. Grohol, *Top 25 Psychiatric Prescriptions for 2009*, PSYCH CENTRAL., (Apr. 27, 2010), <http://psychcentral.com/lib/2010/top-25-psychiatric-prescriptions-for-2009/>. The third most prescribed psychotropic drug in 2009 was Ativan with almost 26 million prescriptions, an increase of 36 percent over 2005, and the tenth most prescribed was Valium, with around 14 million prescriptions, an increase of 16 percent over 2005. *Id.* There were almost 30 million prescriptions for stimulants in 2009. *Id.*

³³⁷ *Id.*

adolescents, there has been a marked increase in the use of antidepressants, stimulants, and antipsychotics, and other psychotropic drugs.³³⁸

To mental health advocates, these statistics suggest widespread mental suffering and a tremendous need for psychiatric care. To many others, the idea that it is arguably normal to experience a mental disorder at some point in life raises serious questions about the true nature of mental illness.³³⁹ As has been discussed, the dominant view is that mental illness exists. For over a century, severe mental illnesses, such as schizophrenia, bipolar disorder, and severe depression, have been understood as chronic diseases with some presumed biological basis.³⁴⁰ The intensity and persistence of the symptoms of severe mental disorders, as well as the degree to which these symptoms interfered with perceptual norms and accepted social behavior, traditionally supported this presumption.³⁴¹ More recently, researchers have produced compelling evidence of structural and functional abnormalities in the brains of patients suffering from severe mental disorders, including schizophrenia and bipolar disorder.³⁴² Because of symptom severity and evidence of disease in the brain, critics generally accept that these conditions should be considered illnesses, even if their etiology and

³³⁸ See Ryne Paulose-Ram et al., *Trends in Psychotropic Medication Use Among U.S. Adults*, 16 PHARMACOEPIDEMIOLOGY & DRUG SAFETY 560, 560 (2006) (reporting that the prevalence of psychotropic drug use among adults increased from 6.1% in 1988–1994 to 11.1% in 1999–2002); Cindy Parks Thomas et al., *Trends in the Use of Psychotropic Medications Among Adolescents, 1994 to 2001*, 57 PSYCHIATRIC SERVS. 63, 63 (2006) (reporting that the percentage of office-based visits that resulted in a psychotropic prescription for adolescents aged fourteen to eighteen years rose from 3.4% in 1994–1995 to 8.3% in 2000–2001); Mark Olsson et al., *National Trends in the Treatment of Attention Deficit Hyperactivity Disorder*, 160 AM. J. PSYCHIATRY 1071, 1071 (2003) (estimating that 3.4% of children ages three to eighteen were treated for ADHD, most often with stimulants, in 1997, up from around 1% in 1987).

³³⁹ Pierre, *supra* note 15, at 377.

³⁴⁰ See Klerman, *supra* note 11, at 232–34 (arguing serious mental illnesses are best understood as chronic diseases).

³⁴¹ See *id.* at 234.

³⁴² See Erickson, *supra* note 12, at 112 n.239. See Steven K. Erickson et al., *Legal Fallacies of Antipsychotic Drugs*, 35 J. AM. ACAD. PSYCHIATRY & LAW 235, 235 (2007) (summarizing the evidence of disease in the brains of schizophrenia patients).

pathophysiology are unknown.³⁴³ In contrast, most mental disorders involve far more subtle behavioral deviations and are not supported by evidence of disease in the brain.³⁴⁴ These milder disorders account for much of the 300% increase in the number of psychiatric diagnoses since DSM-I, a proliferation partly justified as an attempt to make finer distinctions between disorders that had been previously grouped together.³⁴⁵ There is concern that diagnostic expansion has also lowered the threshold for diagnosing mental illness, resulting in an incremental intrusion on what had previously been considered within normal limits.³⁴⁶ As a result, it has been difficult to maintain a stable consensus between society and psychiatry as to the validity of milder conditions at or near the border of normality.³⁴⁷ According to

³⁴³ See Klerman, *supra* note 11, at 23–34; Erickson, *supra* note 12, at 112; Bengt Brülde, *The Concept of Mental Disorder*, PHIL. COMM.-WEB SERIES, NO. 29, at 19 (2003). See also GHAEMI, *supra* note 283, at 239 (“On the one hand, subtle forms of mental illness are hard to distinguish from normality, and in fact the general concept of mental illness, conceived broadly, is subject to real philosophical debate. On the other hand, severe mental conditions like schizophrenia and mania are associated with impairment of insight on the part of the person who possesses those conditions. Further, research and evidence indicate that those conditions have the marks of true illness and thus represent abnormal states of mind.”). Outside of the context of medicalization, however, not even the validity of schizophrenia is free from dispute. See D.S. Goel, *Does Schizophrenia Exist?*, 63 MED. J. ARMED FORCES INDIA 104, 104–05 (2007) (arguing that schizophrenia has “no evidence of a specific underlying brain disease” and does not exist “as a homogenous diagnostic monolith.”).

³⁴⁴ See Erickson, *supra* note 12, at 110–13.

³⁴⁵ Pierre, *supra* note 15, at 377. Psychiatry’s jurisdiction began to expand beyond serious mental illness between the 1940s and 1970s, a time when psychiatrists believed that everyone fell somewhere on the neurosis-psychosis continuum. See GHAEMI, *supra* note 283, at 151, 186. In the psychodynamic era, psychiatric treatment involved counseling and focused on psychological functioning, rather than an underlying disease. *Id.* at 14, 185–86. With the arrival of new drug treatments, however, diagnosis became an important way of identifying which patients might benefit from these new treatments. *Id.* at 186. The development of psychopharmacology was therefore a driving force behind the shift in nosology, as well as the proliferation of diagnostic categories, that occurred with the publication of DSM-III. *Id.* at 153. What is rarely acknowledged, however, is that no new scientific discoveries precipitated this shift in perception. Mayes & Horwitz, *supra* note 17, at 262. Nevertheless, as discrete entities defined by purportedly objective criteria, problems that had never been understood as having a biological basis gained a status on par with severe mental illness. See Erickson, *supra* note 12, at 106.

³⁴⁶ Pierre, *supra* note 15, at 377.

³⁴⁷ See Sorboro, *supra* note 281, at 40. (“The concept of disease may be nebulous but it has the greatest historical and sociological validity when it is understood as a process that results in

many critics from both within and outside of the profession, psychiatry has abused its authority by medicalizing variants of normal human behavior and existence.³⁴⁸ From this view, the increasing number of Americans with mental illness includes millions of false positives who would have been better off not being brought into the mental health system.³⁴⁹ These arguments implicate a number of prevalent DSM diagnoses, such as major depression,³⁵⁰ ADHD,³⁵¹ post-traumatic stress disorder (PTSD),³⁵² and personality disorders,³⁵³ as well as social anxiety disorder (SAD) and bipolar

dramatic and observable alterations in morphology. . . . [I]t is hard to think of Huntington's Chorea or MS as anything but a disease process. Feelings and behavior can be looked at from many different perspectives.”).

³⁴⁸ Pierre, *supra* note 15, at 377.

³⁴⁹ See *id.*

³⁵⁰ HORWITZ & WAKEFIELD, *supra* note 92, at 9–10 (arguing the symptom-based criteria for depression encompass not only symptoms of harmful dysfunction, but also both disordered behavior and normal human responses to adverse events. As such, so that normal human sadness in response to negative events, such as a loss of employment, the discovery of marital infidelity, or academic failure, becomes a mental illness even though it is not the product of an underlying dysfunction); Gordon Parker, *Is Depression Overdiagnosed?*, 335 BRIT. MED. J. 328, 328 (2007) (arguing that the low threshold for diagnosing depression risks medicalizing normal human distress); cf. *Science Friday: Is Depression Overdiagnosed in America?* (NPR radio broadcast Feb. 5, 2010), available at <http://www.npr.org/templates/transcript/transcript.php?storyId=123410032>.

³⁵¹ See, e.g., Peter R. Breggin, *What Psychologists and Therapists Need To Know About ADHD and Stimulants*, 18 CHANGES: AN INT'L J. PSYCHOL. & PSYCHOTHERAPY 13, 17 (2000) (arguing that “[t]he concept of ADHD was developed to rationalize a pre-existing motivation within medicine and psychology to use stimulant drugs to control the behavior of children.”) Cf. Jonathan Leo & David Cohen, *Broken Brains or Flawed Studies? A Critical Review of ADHD Neuroimaging Research*, 24 J. MIND & BEHAV. 29, 29 (2003) (finding that most neuroimaging research on ADHD involves subjects who have had prior medication use, which “invalidates any suggestion of ADHD-specific neuropathology”).

³⁵² See Robert L. Spitzer et al., *Saving PTSD from itself in DSM-V*, 21 J. ANXIETY DISORDERS 233 (2005); see also Derek Summerfield, *The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category*, 322 BRIT. MED. J. 95 (2001). But cf. David Wilson & Peter Barglow, *Posttraumatic Stress Disorder: PTSD Has Unreliable Diagnostic Criteria*, 26 PSYCHIATRIC TIMES 30 (2009), available at <http://www.psychiatrictimes.com/display/article/10168/1426942>.

³⁵³ Critics assail the validity of personality disorders as mental illnesses and claim that these diagnoses represent the non-scientific medicalization of social mores. For example, anti-social personality disorder explicitly incorporates the “failure to conform to social norms” as a symptom, in addition to other inappropriate social interactions. See Galatzer-Levy & Galatzer-Levy, *supra* note 165, at 172; Kevin Corbett & Tristen Westwood, *Dangerous and*

disorder, which are discussed below.

1. *Social Anxiety Disorder*

In general, SAD, or social phobia, is a “marked and persistent fear of . . . social or performance situations” in which embarrassment may occur, i.e., extreme shyness or self-consciousness.³⁵⁴ Social phobia was a fairly insignificant diagnosis when it was first recognized in DSM-III, which described it as “relatively rare.”³⁵⁵ Accordingly, the diagnosis remained fairly obscure throughout the 1980s, with an estimated prevalence rate of just under three percent.³⁵⁶ In the 1990s, however, a study estimated that SAD might be as prevalent as depression, suggesting that the disorder was massively underdiagnosed.³⁵⁷ The manufacturer of Paxil, now called GlaxoSmithKline, pounced on this previously unknown market after introducing this serotonin reuptake inhibitor (SSRI) into a saturated market for depression treatments in the mid-1990s.³⁵⁸ After

Severe Personality Disorder: A Psychiatric Manifestation of the Risk Society, 15 CRITICAL PUB. HEALTH 121, 124 (2005). Indeed, this dubious diagnosis is used by the law as an aggravating factor in criminal sentencing of antisocial defendants. See Erickson, *supra* note 12, at 73–74. Critics claim that diagnoses such as anti-social personality disorder and oppositional defiant disorder are not illnesses, but personality flaws that are inseparable from personal identity and require moral accountability. See *id.* at 114–16 (discussing personality disorders generally); Sam Vaknin, *Psychiatry as a Means of Social Control: Oppositional Defiant Disorder (ODD)*, VOICES UNREASON, Jan. 4, 2007, [http://www.voicesofunreason.com/fullThread\\$9512](http://www.voicesofunreason.com/fullThread$9512). See also Susie Scott, *The Medicalisation of Shyness*, 28 SOC. HEALTH & ILLNESS 133, 140–47 (2006) (arguing that avoidant personality disorder is one of several disorders that medicalize shyness). See generally Thomas A. Widiger, *The DSM-III-R Categorical Personality Disorder Diagnoses: A Critique and an Alternative*, 4 PSYCHOL. INQUIRY 75, 84 (1993) (describing avoidant personality disorder as primarily involving “the facets of low warmth, low gregariousness, and low assertiveness”).

³⁵⁴ Scott, *supra* note 353, at 135 (quoting DSM-IV). See Koerner, *supra* note 322, at 58–63.

³⁵⁵ HORWITZ, *supra* note 279, at 95.

³⁵⁶ *Id.*

³⁵⁷ *Id.*; see NAT’L INST. OF MENTAL HEALTH, NIHM STATISTICS, http://www.nimh.nih.gov/statistics/1MDD_ADULT.shtml (last visited Mar. 26, 2011); (estimating that depression affects about 6.7% of adults in the U.S. in a given year). This growth—the prevalence rate quintupled over a ten-year period—illustrates how community studies can overestimate rates of mental disorders. See HORWITZ, *supra* note 279, at 94.

³⁵⁸ Peter Conrad & Valerie Leiter, *Medicalization, Markets and Consumers*, 45 J. HEALTH & SOC. BEHAV. 158, 163–64 (2004).

submitting an application to market Paxil to the “anxiety market” in 1998, GlaxoSmithKline used a public relations firm to put together a coalition of several nonprofit groups, one of which was the APA, to launch a sophisticated campaign to create public awareness about SAD.³⁵⁹ Hundreds of stories about SAD appeared in major publications and television news programs.³⁶⁰ Although no drugs were mentioned, GlaxoSmithKline had primed the market and redefined SAD as simultaneously common and abnormal, as well as amenable to drug treatment.³⁶¹ After the FDA approved the use of Paxil for SAD in 1999, a series of ads promoted Paxil in the context of social situations that predictably evoke fear in many people, such as dinner parties and public speaking.³⁶² Thereafter, SAD blossomed into a major mental illness of almost epidemic proportions. Presently, conservative estimates are that one in fifteen adults have SAD in a given year,³⁶³ and some surveys report that the lifetime prevalence is almost thirteen percent.³⁶⁴ After a similar marketing effort for generalized anxiety disorder, Paxil became one of the ten most prescribed pharmaceuticals, supplanting Zoloft as the second best-selling SSRI.³⁶⁵

For critics, SAD is a textbook case of medicalization in the post-Prozac era. What started as a vaguely defined, rare disorder turned into a public health crisis after surveys revealed the “true presence” of the disorder in the population.³⁶⁶ Using a complex marketing campaign, a drug company, psychiatry, and journalists worked together to convince the public that everyday shyness was an

³⁵⁹ *Id.*; see Koerner, *supra* note 322, at 59.

³⁶⁰ Conrad & Leiter, *supra* note 358, at 163–64. See Koerner, *supra* note 322, at 58–63.

³⁶¹ Conrad & Leiter, *supra* note 359, at 164.

³⁶² See *id.*; Koerner, *supra* note 322, at 58–63.

³⁶² Conrad & Leiter, *supra* note 358, at 163–64; Koerner, *supra* note 322, at 58–63.

³⁶³ NAT'L INST. OF MENTAL HEALTH,
http://www.nimh.nih.gov/statistics/1SOC_ADULT.shtml (last visited Mar. 26, 2011).

³⁶⁴ Ronald C. Kessler et al., *Epidemiology of Anxiety Disorders*, in OXFORD HANDBOOK OF ANXIETY AND RELATED DISORDERS 19, 24 (Martin M. Anthony & Murray B. Stein, eds. 2009).

³⁶⁵ Conrad & Leiter, *supra* note 358, at 163–64; Koerner, *supra* note 322, at 58–63.

³⁶⁶ C. Faravelli et al., *Social Phobia*, in ANXIETY DISORDERS: AN INTRODUCTION TO CLINICAL MANAGEMENT AND RESEARCH 137 (Eric J. L. Griez et al., eds. 2001).

incredibly common but treatable disease, further blurring the distinction between normality and disorder. Then, advertisements promoted a drug as a cure for this sickness. Critics argue that the rise of SAD reflects the medicalization of normal shyness and worry, even if extreme forms of SAD are legitimate mental disorders.³⁶⁷ Indeed, psychiatry admits that “[a] certain degree of social or performance anxiety is ubiquitous and may have some evolutionary adaptive advantage,” suggesting that it is extraordinarily difficult for clinicians to distinguish between normal and abnormal.³⁶⁸ According to critics, many of those diagnosed with SAD are experiencing the types of feelings that humans are supposed to feel in certain social situations, especially the pervasive fear of public speaking, which is known to be the primary pathway to satisfying SAD’s diagnostic criteria.³⁶⁹ Instead of a measure of mental illness, the increased prevalence of SAD is therefore an expression of dominant social values, such as assertiveness.³⁷⁰ Of particular concern is that using SSRIs for SAD can amount to “cosmetic psychopharmacology.”³⁷¹ Indeed, fears that the softer conditions in DSM are being used for neuroenhancement (i.e., improving the psychological function of those who are not ill) raises a distinct set of ethical, social, and policy concerns in addition to those associated with medicalization.³⁷²

By the end of the 1990s, other drug companies embraced the

³⁶⁷ See Peter Conrad, *The Shifting Engines of Medicalization*, 46 J. HEALTH & SOC. BEHAV. 3, 6–7 (2005) (“[I]t is clear that GlaxoSmithKline’s campaign for Paxil increased the medicalization of anxiety, inferring that shyness and worrying may be medical problems, with Paxil as the proper treatment.”); Moncrieff, *supra* note 109.

³⁶⁸ Faravelli et al., *supra* note 366, at 137.

³⁶⁹ See Jerome C. Wakefield, *Misdiagnosing Normality: Psychiatry’s Failure to Address the Problem of False Positive Diagnoses of Mental Disorder in a Changing Professional Environment*, 19 J. MENTAL HEALTH 337, 348–49 (2010); Scott, *supra* note 353, at 149 (arguing that shyness is “a socially intelligible response to the dramaturgical stresses of everyday interaction”).

³⁷⁰ Wakefield, *supra* note 369, at 349. Scott, *supra* note 353, at 134–135, 148–49 (arguing that shyness has become a health concern because of the tension between introversion and assertiveness, the dominant social value, and that “psychiatric knowledge serves the social function of prescribing normative codes of behaviour.”).

³⁷¹ See Conrad & Leiter, *supra* note 358, at 164.

³⁷² See Martha J. Farah et al., *Neurocognitive Enhancement: What Can We Do and What Should We Do?*, 5 NATURE REV. NEUROSCIENCE 421, 421 (2004); CARL ELLIOTT, *BETTER THAN WELL passim* (2003).

SAD marketing model. For example, Pfizer targeted PTSD in search of a larger market for the antidepressant Zoloft.³⁷³ In the process, PTSD transformed from a condition that was primarily associated with combat veterans and victims of violent crime to a widespread adult and childhood mental illness that could be triggered by the death of a loved one or even the terrorist attacks of September 11, 2001.³⁷⁴ This trend suggests that the pharmaceutical industry's exploitation of the inherent weaknesses of psychiatric diagnosis and classification—the difficulty defining the boundary between normal and abnormal and the lack of objective signs—has been a contributing factor in the broadening of the boundaries of mental illness.³⁷⁵

2. *Bipolar Disorder in Adults and Children*

Generally, bipolar disorder is a recurring mood disorder characterized by “one or more episodes of mania or mixed episodes of mania and depression.”³⁷⁶ At the turn of the twentieth century, manic depression (now considered bipolar disorder) was a rare disorder with a lifetime prevalence rate of 0.1%.³⁷⁷ When bipolar disorders were officially introduced in DSM-III, the condition had broadened, though the criteria for bipolar I disorder involved a hospitalization for a prior episode of mania, which limited the estimated lifetime prevalence rate to around one percent.³⁷⁸ In subsequent editions of DSM, psychiatry introduced community-based disorders: bipolar II disorder, bipolar disorders NOS (not

³⁷³ Koerner, *supra* note 322, at 58–63.

³⁷⁴ *Id.*

³⁷⁵ *Id.*

³⁷⁶ OFFICE OF THE SURGEON GEN., *supra* note 191, at 246. A history of manic or hypomanic (i.e., a milder, non-psychotic form of mania) episodes distinguishes bipolar disorder from major depressive disorder. *Id.* at 249. Mania is a mood disturbance that ranges from “pure euphoria or elation to irritability to a labile admixture that also includes dysphoria” and frequently marked by grandiosity—overvalued ideas and frank delusions—or paranoid thought content. *Id.* Severe manic episodes may include auditory and visual hallucinations, and patients can be difficult to distinguish from those suffering from schizophrenia. *Id.*

³⁷⁷ David Healy, *The Latest Mania: Selling Bipolar Disorder*, 3 PLOS MED. 0441, 0442 (2006).

³⁷⁸ See Jules Angst, *The Emerging Epidemiology of Hypomania & Bipolar II Disorder*, 50 J. AFFECTIVE DISORDERS 143, 143 (1998); Healy, *supra* note 377, at 0442.

otherwise specified), and cyclothymia.³⁷⁹ These subtype classifications lowered the threshold for diagnosing bipolar disorder, and their criteria relied on subjective clinical judgments, unlike the more objective criteria of bipolar I disorder.³⁸⁰ After these community-based disorders appeared, lifetime prevalence estimates rose to as high as 6.4%.³⁸¹ The sudden discovery of a larger “bipolar market” caught the attention of drug companies eager to market newly developed mood stabilizers and atypical antipsychotics.³⁸² Disease awareness campaigns followed, suggesting that bipolar disorder in adults was more common than previously believed, and by the mid-2000s, several antipsychotics had been approved for treating acute mania, as well as for preventing or delaying its reoccurrence.³⁸³ According to researchers, the diagnosis of bipolar disorder in adults nearly doubled between 1994 and 2003.³⁸⁴ Their research also showed the majority of bipolar adults, between 1999 and 2003, received cocktails of antidepressants, mood stabilizers, and atypical antipsychotics.³⁸⁵ While the evolution of adult bipolar disorder raised some eyebrows, the controversy surrounding the overdiagnosis of bipolar disorder in children was a “colossal embarrassment” to psychiatry.³⁸⁶

Prior to the advent of psychopharmacology, very few children

³⁷⁹ See Angst, *supra* note 378, at 143; Healy, *supra* note 377, at 0442.

³⁸⁰ Healy, *supra* note 377, at 0443. For example, bipolar II involves only prior hypomania, a milder, non-psychotic counterpart of mania that is not associated with markedly impaired judgment or performance. OFFICE OF THE SURGEON GEN., *supra* note 191, at 249.

³⁸¹ See Lewis L. Judd, *The Prevalence and Disability of Bipolar Spectrum Disorders in the US Population: Re-Analysis of the ECA Database Taking Into Account Subthreshold Cases*, 73 J. AFFECTIVE DISORDERS 123, 123 (2003).

³⁸² Healy, *supra* note 377, at 0442.

³⁸³ *Id.* at 0441.

³⁸⁴ Carmen Moreno et al., *National Trends in the Outpatient Diagnosis & Treatment of Bipolar Disorder in Youth*, 64 ARCHIVES GEN. PSYCHIATRY 1032, 1034 (2007).

³⁸⁵ *Id.* at 1036 tbl.2

³⁸⁶ Sharon Kirkey, *Just a Bad Temper, or Is Your Child Mentally Ill?*, CANADA.COM (Apr. 27, 2010), available at <http://www.canada.com/health/Just+temper+your+child+mentally/2956049/story.html> (quoting Edward Shorter, professor of psychiatry at the University of Toronto).

were diagnosed with mental illness.³⁸⁷ But after the introduction of modern psychotropic drugs, and especially after DSM-III provided drug companies categorical diagnoses to target new drug products, psychiatry discovered that a surprising number of children suffered from brain-based mental illnesses that required psychotropic drug treatments.³⁸⁸ Parents learned to accept that a significant number of their children were mentally ill in the 1980s and 1990s, when ADHD and childhood depression appeared and millions of children began using stimulants and antidepressants.³⁸⁹ With childhood mental

³⁸⁷ WHITAKER, *supra* note 328, at 217.

³⁸⁸ *Id.* at 217-18.

³⁸⁹ The first major childhood mental illness was attention-deficit disorder (ADD), which latter became attention-deficit/hyperactivity disorder (ADHD). ADD's roots date back to the early 1900s and the discovery that stimulants could help subdue hyperactive children in 1937. WHITAKER, *supra* note 328, at 218-20. Both DSM-I and DSM-II therefore recognized a childhood disorder marked by hyperactivity and inattentiveness, and by the 1970s psychiatrists and general practitioners increasingly diagnosed and treated hyperactivity and disruptiveness. *Id.* See Peter Conrad & Deborah Potter, *Hyperactive Children to ADHD Adults: Observations on the Expansion of Medical Categories*, 47 SOC. PROBS. 559, 563-64 (2000). ADD was officially recognized as a disease when DSM-III was published in 1980. WHITAKER, *supra* note 328, at 220. See Conrad & Potter, *supra*, at 563-64. With symptoms such as hyperactivity, inattention, and impulsiveness, ADD quickly became a popular pediatric diagnosis for children who could not sit still in school. Lakoff, *supra* note 171, at 160. In a revised edition of DSM-III released in 1987, ADD became ADHD and its diagnostic boundaries relaxed to include more children who were hyperactive, but less inattentive. Conrad & Potter, *supra*, at 564. As a result, over fifty percent more children received ADHD diagnoses, and by 1990, almost one million children aged five through eighteen were diagnosed with ADHD. Linda M. Robison et al., *National Trends in the Prevalence of Attention-Deficit/Hyperactivity Disorder and the Prescribing of Methylphenidate among School-Age Children: 1990-1995*, 38 CLINICAL PEDIATRICS 209, 209 (1999). Moreover, public awareness campaigns and lobbying efforts by patient advocacy groups helped persuade Congress to include ADHD as a disability entitling children to special services funded by the government, and schools took the lead role in identifying children who might suffer from ADHD. WHITAKER, *supra* note 328, at 220. By 1995, almost 2.5 million children had been diagnosed with ADHD, more than doubling the number in 1990, and around 3.4% of children were using stimulants, nearly tripling the rate in 1990. Robison et al., *supra*, at 209; Conrad & Potter, *supra*, at 564. In the mid-2000s, more than 7% of children had been diagnosed with ADHD, including one out of every ten boys. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH & HUMAN SERVS., SUMMARY HEALTH STATISTICS FOR U.S. CHILDREN: NATIONAL HEALTH INTERVIEW SURVEY 12 (2007), available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_234.pdf. Accordingly, more than 4.3% of children aged four to seventeen took stimulants for ADHD. CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., MORBIDITY & MORTALITY WKLY., Sept. 2005, at 842, available at

illness firmly established and schools deeply involved in identifying potential patients, psychiatry then discovered a hidden epidemic of childhood bipolar disorder (CBD) in the 1990s.³⁹⁰ As recently as 1995, children and adolescents under the age of twenty were rarely diagnosed with bipolar disorder.³⁹¹ In the mid-1990s, however, an influential child psychiatrist proposed that “severe irritability” was the “predominant mood” associated with CBD.³⁹² Consequently, there was a fortyfold increase in the number of children being diagnosed with CBD between 1995 and 2003, and almost two-thirds of CBD patients received drug cocktails between 1999 and 2003, while most of the rest received at least one psychotropic drug.³⁹³ Beyond CBD, antipsychotics became the treatment of choice for a range of childhood problems from aggression to moodiness.³⁹⁴ As a

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a2.htm>. After ADHD, childhood depression emerged, and millions of depressed teenagers and prepubertal children began using antidepressants in the 1990s. WHITAKER, *supra* note 328, at 318. Prior to the 1980s, depression was a controversial childhood diagnosis, primarily because of the cultural belief that bouts of moodiness were a normal part of childhood. Savita Malhotra & Partha Pratim Das, *Understanding Childhood Depression*, 125 INDIAN J. MED. RES. 115, 115 (2007). Between 1988 and the 1994, the percentage of children taking antidepressants tripled, and in the mid-1990s, the American Academy of Child and Adolescent Psychiatry declared that around 5% of children and adolescents suffered from depression. WHITAKER, *supra* note 328 at 318. By 2002, 2.5% of children under the age of nineteen were taking an antidepressant. *Id.* at 229.

³⁹⁰ Whitaker, *supra* note 328, at 232.

³⁹¹ See Moreno et al., *supra* note 384, at 1034 (estimating that the annual number of office visits resulting in a diagnosis of bipolar disorder for a child was 25 visits per 100,000 population in 1994–1995).

³⁹² Joseph Biederman et al., *Attention-Deficit Hyperactivity Disorder and Juvenile Mania: An Overlooked Comorbidity?*, 35 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 997, 1005 (1996).

³⁹³ Moreno et al., *supra* note 384, at 1034 (estimating that the annual number of office visits resulting in a diagnosis of bipolar disorder for a child grew from 25 (1994–1995) to 1003 (2002–2003) visits per 100,000 population).

³⁹⁴ Psychiatrist Mark Olfson explains the clinical progression that culminated in physicians perceiving these powerful drugs as appropriate treatments to address normal childhood behavior: “What had been a relatively narrow focus on psychotic symptoms in rare early-onset psychotic disorders and irritability in pervasive developmental disorders has widened to include aggressive behaviors and mood dysregulation that occur in a wide range of child and adolescent psychiatric disorders and sometimes in otherwise normal youth.” Mark Olfson, *Antipsychotic Prescribing in Children: What We Know – What We Need to Know*, PSYCHIATRIC TIMES, Feb. 2, 2010, available at <http://www.psychiatrictimes.com/display/article/10168/1499811>. Indeed, research

result, there was an approximate sixfold increase in antipsychotic prescriptions for individuals aged twenty years and younger between 1993 and 2002.³⁹⁵ From 2001 to 2007, the use of atypical antipsychotics in children, age ten to age nineteen, grew by about ninety percent.³⁹⁶

The recent evolution of both adult and childhood bipolar disorder is understandably controversial. Fifty years ago, manic depression was a far less prevalent adult disorder involving behaviors and mental states that clearly deviated from normality. Today bipolar disorder is far more prevalent among adults, many of whom probably would not have been considered manic depressive prior to DSM-III; and, more importantly, clinicians have been diagnosing children with a serious mental illness that was recently considered rare or even nonexistent among adolescents and

suggests that less than a third of children using antipsychotics have been diagnosed with schizophrenia, bipolar disorder, or a pervasive developmental disorder. *Id.* As evidence mounted that children were experiencing serious side effects from drug treatments, a backlash against CBR has tempered the diagnosis in recent years. *See id.* However, institutional psychiatry is attempting to address the overdiagnosis of pediatric bipolar disorder by proposing a new childhood disorder for DSM-V that critics claim will likely be treated with similar drug cocktails. *See* Allen France, *Opening Pandora's Box: The 19 Worst Suggestions for DSM5*, PSYCHIATRIC TIMES, Feb. 10, 2010, available at <http://www.psychiatrictimes.com/dsm/content/article/10168/1522341>.

³⁹⁵ Mark Olsson et al., *National Trends in the Outpatient Treatment of Children and Adolescents with Antipsychotic Drugs*, 63 ARCHIVES GEN. PSYCHIATRY 679, 683 (2006) (finding that prescriptions increased from 201,000 to 1,224,000 between 1993 and 2002).

³⁹⁶ Ed Silverman, *Antipsychotic Use Among Children Is Soaring*, PHARMALOT, Sept. 16, 2008, <http://www.pharmalot.com/2008/09/antipsychotic-use-among-children-is-soaring/>. Around 20,500 children under the age of six received at least one antipsychotic prescription in 2007. Gardiner Harris & Benedict Carey, *supra* note 36 *Researchers Fail to Reveal Full Drug Pay*, N.Y. TIMES, June 8, 2008, available at http://www.nytimes.com/2008/06/08/us/08conflict.html?_r=1. Lower-income children probably make up a disproportionate share of this increase, as evidence indicates that Medicaid-insured children are up to four times as likely as privately insured children to fill a prescription for antipsychotic drugs. *See* Duff Wilson, *Poor Children Likelier to Get Antipsychotics*, N.Y. TIMES, Dec. 11, 2009, at A1, available at <http://www.nytimes.com/2009/12/12/health/12medicaid.html>. However, reports also suggest that the growth of children's use of antipsychotic drugs is slowing due to increased scrutiny among state Medicaid agencies. David Armstrong, *Children's Use of Psychiatric Drugs Begins To Decelerate*, WALL ST. J., May 18, 2009, at B1, available at http://online.wsj.com/article/NA_WSJ_PUB:SB124260376459428599.html.

children.³⁹⁷ The concern is that diagnostic expansion of bipolar disorder led to overdiagnosis and the unnecessary exposure of false positives to the risks of psychiatric medications, particularly polypharmacy.³⁹⁸ In addition to marketing pressures, however, psychiatry played an active role in creating this problem by perpetually lowering diagnostic thresholds, changes that critics claim were not driven by appropriate levels of evidence.³⁹⁹ Studies indicate that as many as four out of every ten bipolar adults may not meet the diagnostic criteria for bipolar disorder.⁴⁰⁰ As for CBD, critics charge that, with the help of parents and the media,⁴⁰¹ psychiatry has

³⁹⁷ Jennifer Harris, *The Increased Diagnosis of "Juvenile Bipolar Disorder": What Are We Treating?*, 56 *CHILD & ADOLESCENT PSYCHIATRY* 529, 529 (2005).

³⁹⁸ Charlene Laino, *Bipolar Disorder Overdiagnosed?*, WEBMD, May 6, 2008, <http://www.webmd.com/bipolar-disorder/news/20080506/bipolar-disorder-overdiagnosed>. For example, the most frequent adverse effects associated with newer atypical antipsychotics include an increased risk of obesity, hyperglycemia, diabetes, pancreatitis, and movement disorders, such as tremor and akathisia. Robert Whitaker, *The Case Against Antipsychotic Drugs: A 50-year Record of Doing More Harm Than Good*, 62 *MED. HYPOTHESES* 5, 10 (2004). Taken together, these side effects increase the risk of metabolic dysfunction, so that the long-term use of atypicals may lead to early death. Allen Frances, *DSM5 'Psychosis Risk Syndrome' – Far Too Risky*, *PSYCHOL. TODAY*, Mar. 18, 2010, available at <http://www.psychologytoday.com/print/39703>. See Christoph U. Correll et al., *Cardiometabolic Risk of Second-Generation Antipsychotic Medications During First-Time Use in Children & Adolescents*, 302 *JAMA* 1765, 1765 (2009).

³⁹⁹ See Healy, *supra* note 377, at 0443 (discussing the expansion of diagnostic boundaries, as well as the influence of pharmaceutical companies); Scott B. Patten & Joel Paris, *The Bipolar Spectrum – A Bridge Too Far?*, 53 *CANADIAN J. PSYCHIATRY* 762, 766 (2008) (“[T]he rising popularity of the [bipolar spectrum disorder] concept appears to have occurred in the absence of any clear and accepted definition for what the term means, and in the absence of high-level evidence demonstrating its value in clinical practice.”); Charlene Laino, *supra* note 398. According to psychiatrist John Sorboro, “We know hardly anything more of real scientific significance about bipolar disorder than we did in 1980, but we sure have gotten good at diagnosing and medicating it along with lots of other things.” Sorboro, *supra* note 267, at 48.

⁴⁰⁰ Mark Zimmerman, *Is Underdiagnosis the Main Pitfall in Diagnosing Bipolar Disorder?* No, 340 *BRIT. MED. J.* 855 (2010), available at <http://www.bmj.com/content/340/bmj.c855.long>.

⁴⁰¹ Reports about CBD in the mainstream media suggested that extremely common childhood traits such as aggression and irritability might be signs of bipolar disorder, a treatable new childhood illness. Healy, *supra* note 377, at 0443–44. Assuming exposure to such reports shaped some parents’ perception of their children’s behavior, a deluge of parents seeking CBD diagnoses explains, in part, the rapid increase in CBD diagnoses, since clinical diagnosis depends on subjective clinical judgments primarily based on parent reports, and clinicians have neither the time nor training to scrutinize parental complaints. *Id.* at 0443.

overdiagnosed a vaguely defined disorder of questionable validity, exposing an untold number of children who will not later be bipolar adults to harmful psychotropic drugs.⁴⁰² Indeed, speaking of his time as chair of the DSM-IV Task Force, Allen Frances now acknowledges that his panel “inadvertently contributed to three false ‘epidemics’ – attention deficit disorder, autism and childhood bipolar disorder.”⁴⁰³ Frances explains that their “net was cast too wide and captured many ‘patients’ who might have been far better off never entering the mental health system.”⁴⁰⁴ According to some critics, conflicts of interest may help explain the expansion of bipolar disorder to children, as illustrated by reports suggesting that an influential group of researchers who advocated for the aggressive diagnosis and drug treatment of CBD had close ties to the pharmaceutical industry.⁴⁰⁵

See also Harris, *supra* note 397, at 530–31 (stating that out of a group of bipolar children, a quarter “were believed to have bipolar disorder by their parents, who requested that appropriate medications be started”).

⁴⁰² *See* Anne Duffy, *Does Bipolar Disorder Exist in Children? A Selected Review*, 52 CANADIAN J. PSYCHIATRY 409, 414–15 (2007) (concluding that “[t]here is a lack of supporting evidence for the hypothesis that [bipolar disorder], as currently defined, exists in very young children” and “accurate early identification of [bipolar disorder] in youth must not rely on symptoms only”); Harris, *supra* note 397, at 531 (“When a psychiatrist accepts juvenile bipolar disorder as a diagnosis before it has been shown conclusively to be valid, he or she is forced into a host of shaky assumptions about treatment, particularly medication treatment: ‘Medication is needed.’ ‘Antidepressants are likely harmful.’ ‘Mood stabilizers are necessary.’ ‘Medication treatment should be aggressive.’ Medications are not benign agents. They have both short- and long-term effects that have not yet been thoroughly studied.”); WHITAKER, *supra* note 328, at 242; Frances, *supra* note 317.

⁴⁰³ Frances, *supra* note 317.

⁴⁰⁴ *Id.* According to psychiatrist John Sorboro, “We know hardly anything more of real scientific significance about bipolar disorder than we did in 1980, but we sure have gotten good at diagnosing and medicating it along with lots of other things.” Sorboro, *supra* note 267, at 48.

⁴⁰⁵ Gardiner Harris & Benedict Carey, *Researchers Fail to Reveal Full Drug Pay*, N.Y. TIMES, June 8, 2008, available at http://www.nytimes.com/2008/06/08/us/08conflict.html?_r=1. Harvard researchers Joseph Biederman failed to disclose over a million dollars in consulting fees he earned from drug companies. *See* Benedict Carey & Gardiner Harris, *Psychiatric Group Faces Scrutiny Over Drug Pay Industry Ties*, N.Y. TIMES, (July 12, 2008), available at <http://www.nytimes.com/2008/07/12/washington/12psych.html> (detailing a Congressional investigation that revealed extensive ties between drug companies and psychiatry generally, including the APA and its president, and quoting one psychiatrist as arguing that these ties meant that researchers who promoted new treatments for bipolar disorder were giving a “sales pitch”).

In sum, the dramatic increase in the diagnosis of mental illness in the last forty years, as well as the related increase in the use of psychotropic drugs, was facilitated by the controversial expansion of the boundaries of mental illness. Although drug companies certainly played a role in the public's acceptance of the broadening of mental illness, psychiatry's diagnostic manual and clinical practice patterns were the fundamental drivers of the decline of the nation's health.

C. DSM-V and the Broadening of the Boundaries of Mental Illness

The development of the fifth edition of DSM (DSM-V) has been mired in controversy from the outset. The first signs of trouble related to the openness and honesty of the revision process. This was due to a confidentiality agreement that precluded the disclosure of any information related to DSM-V by Work Group or Task Force members.⁴⁰⁶ Robert Spitzer and Allen Frances, chairs of the DSM-III and DSM-IV Task Forces, respectively, lambasted this as a "secretive and closed DSM process."⁴⁰⁷ A related concern was the potential influence of the pharmaceutical industry on the Task Force's decisions, stemming from reports that nearly seventy percent of the DSM-V Task Force members had direct ties to the pharmaceutical industry, a fourteen percent increase over the DSM-IV Task Force.⁴⁰⁸ The real fear, however, was that this environment would encourage reckless diagnostic expansion.⁴⁰⁹ Indeed, unease about the scope of

⁴⁰⁶ The agreement prohibited the disclosure of any written or unwritten information, including notes and discussions, relating to the members' work on DSM-V. Robert L. Spitzer, Letter to the Editor, *Transparency: Fact or Rhetoric?*, PSYCHIATRIC NEWS, March 6, 2009, available at <http://www.psychiatristimes.com/display/article/10168/1385346>. The purpose of the agreement was to avoid "premature conclusion and misconceptions . . . that could damage the viability of DSM-V." Nada L. Stotland et al., Response, *DSM-V: Open and Transparent?*, PSYCHIATRIC NEWS, July 18, 2008, available at <http://pn.psychiatryonline.org/content/43/14/26.2.full>.

⁴⁰⁷ Letter from Allen Frances & Robert Spitzer to the American Psychiatric Association Board of Trustees (July 6, 2009) (on file with author), available at <http://www.scribd.com/doc/17172432/Letter-to-APA-Board-of-Trustees-July-7-2009-From-Allen-Frances-and-Robert-Spitzer>.

⁴⁰⁸ Cosgrove et. al., *Toward Credible Conflict of Interest Policy*, in *Clinical Psychiatry*, Psychiatric Times, Jan.2009, 40, at 40.

⁴⁰⁹ In a letter to the APA, Frances and Spitzer charged that the DSM-V Task Force was

DSM-V existed early on within the profession. For example, psychiatrist Paul Chodoff sarcastically recommended a new diagnostic entity—"the human condition"—for inclusion in DSM-V in a 2005 letter to the editor of *Psychiatric News*, an APA publication.⁴¹⁰ With criteria such as dislike of school for children, and unhappiness, shyness, nervousness, anger, and orderliness for adults, the human condition distilled the high level of cynicism about the future of psychiatry.⁴¹¹

In early 2010, the APA released the proposed revisions for DSM-V, which is to be published in 2013.⁴¹² Predictably, a barrage of media reports soon followed, almost all of them expressing concern about the loosening of the boundaries of mental illness.⁴¹³ Moreover, the professional response included Frances' ominous warning that the proposals would amount to a "wholesale medical imperialization of normality [that] could potentially create tens of millions of innocent bystanders who would be mislabeled as having a mental disorder."⁴¹⁴ For example, individuals whose grief resembles a major depressive

"insensitive to the great risks of false positives, of medicalizing normality, and of trivializing the whole concept of psychiatric diagnosis." Frances & Spitzer, *supra* note 407; see Lisa Cosgrove & Harold J. Bursztajn, *Toward Credible Conflict of Interest Policies in Clinical Psychiatry*, *PSYCHIATRIC TIMES*, Jan. 1, 2009, available at <http://www.psychiatrictimes.com/display/article/10168/1364672> ("[D]iagnosis informs treatment decisions. Hence, pharmaceutical companies have a vested interest in the structure and content of *DSM*, and in how the symptomatology is revised. Even small changes in symptom criteria can have a significant impact on what new (or off-label) medications may be prescribed.").

⁴¹⁰ Paul Chodoff, *Proposed Diagnosis*, Letter to the Editor, *PSYCHIATRIC NEWS*, Jan. 21, 2005, <http://pn.psychiatryonline.org/content/40/2/56.2.full>.

⁴¹¹ *Id.*

⁴¹² Kate Kelland, *Mental Health Experts Ask: Will Anyone Be Normal?*, *REUTERS*, Jul. 28, 2010, <http://www.reuters.com/article/idUUSTRE66Q4BJ20100728>.

⁴¹³ See e.g., Benedict Carey, *Revising Book on Disorders of the Mind*, *N.Y. TIMES*, Feb. 10, 2010, A1, available at <http://www.nytimes.com/2010/02/10/health/10psych.html>.

⁴¹⁴ See e.g., Frances, *supra* note 317; Til Wykes & Felicity Callard, Editorial, *Diagnosis, Diagnosis, Diagnosis: Towards DSM-5*, 19 *J. MENTAL HEALTH* 301, 302 (2010) ("The current release for public consideration includes proposals for new diagnoses—including mixed anxiety depression, binge eating, psychosis risk syndrome and temper dysregulation disorder with dysphoria—where the symptoms are shared with the general population. It is also proposed that the threshold for inclusion for some existing disorders be lowered, and a few (but not many) diagnoses are scheduled for removal. Most of these changes imply a more inclusive system of diagnoses where the pool of 'normality' shrinks to a mere puddle.").

episode (e.g., two weeks of a depressed mood, loss of appetite, trouble concentrating, insomnia, and loss of interest in activities) immediately after the death of a spouse or child would be considered disordered. This would be a change to major depressive disorder that would increase the number of depression diagnoses and, according to critics, medicalize normal grief.⁴¹⁵ Another suggestion is mixed anxiety depression, a new disorder that involves three or four of the symptoms of major depression (rather than the five needed for a depression diagnosis) accompanied by anxious distress. The proposed criteria for mixed anxiety depression would lower the diagnostic threshold for both anxiety disorder and major depression, causing concern that the symptoms would “be difficult to distinguish from the emotional pains of everyday life.”⁴¹⁶ Although the “recklessly expansive suggestions go on and on,” the most controversial proposals reflect a move towards a spectrum model of mental illness.⁴¹⁷ This involves “the clustering of disorders into illness spectra (e.g., psychotic, bipolar, cognitive) and extension farther into the softer end of these spectra,” and, in some cases, signals the return of preventive psychiatry.⁴¹⁸ In other words, the proposals include “many new categories to capture the subthreshold (e.g., minor depression, mild cognitive disorder) or premorbid (e.g. prepsychotic) versions of the existing official disorders.”⁴¹⁹ In particular, temper dysregulation disorder with dysphoria, mild neurocognitive disorder, and psychosis risk syndrome are clear indications of the “spectralization” of mental illness.⁴²⁰

⁴¹⁵ Allen Frances, *Opening Pandora's Box: The 19 Worst Suggestions for DSM5*, PSYCHIATRIC TIMES, Feb. 11, 2010, <http://www.psychiatrictimes.com/dsm/content/article/10168/1522341>.

⁴¹⁶ See Frances, *supra* note 317; Wykes & Callard, *supra* note 414, at 302 (stating that the symptoms are shared with the general population, blurring the line between normality and abnormality).

⁴¹⁷ Frances, *supra* note 317; see Pierre, *supra* note 15, at 379 (discussing the spectral model and the more complex dimensional system that has been proposed for personality disorders).

⁴¹⁸ Pierre, *supra* note 15, at 379.

⁴¹⁹ Allen Frances, *A Warning Sign on the Road to DSM-5: Beware of its Unintended Consequences*, PSYCHIATRIC TIMES, June 26, 2009, available at <http://www.psychiatrictimes.com/dsm-5/content/article/10168/1425378>.

⁴²⁰ Pierre, *supra* note 15, at 379.

1. *Temper Dysregulation Disorder with Dysphoria*

Temper dysregulation disorder with dysphoria (TDD) is an attempt to provide a new diagnostic home for many of the children currently being misdiagnosed with bipolar disorder.⁴²¹ The symptoms of TDD include severe temper tantrums several times a week and a generally irritable mood on most days.⁴²² TDD has drawn a number of critics, many of whom agree with Frances' contention that TDD "is one of the most dangerous and poorly conceived suggestions for [DSM-V]—a misguided medicalization of temper outbursts."⁴²³ Their fear is that TDD will encourage the diagnosis of any child with a bad temper—which is not only a common trait, but a normal part of a child's development—and would ultimately result in even wider use of antipsychotics, antidepressants and mood stabilizers by children.⁴²⁴ Because of this, Frances warns that TDD will "create a new monster" rather than correcting the rampant overdiagnosis of childhood bipolar disorder.⁴²⁵

⁴²¹ Frances, *supra* note 415.

⁴²² Temper Dysregulation Disorder with Dysphoria, Proposed Revision, AM. PSYCHIATRIC ASS'N, <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=397>.

⁴²³ Frances, *supra* note 415. See Janet Albrechtsen, *Not Sick, Just Behaving Badly*, AUSTRALIAN, Mar. 3, 2010, available at <http://www.theaustralian.com.au/news/opinion/not-sick-just-behaving-badly/story-e6frg6zo-1225836275463>. Rob Stein, *Revision to the Bible of Psychiatry, DSM, Could Introduce New Mental Disorders*, WASH. POST, Feb. 10, 2010, available at <http://www.washingtonpost.com/wp-dyn/content/article/2010/02/10/AR2010021000009.html>; Will Anyone Be Normal?, J. MENTAL HEALTH, Jul. 27, 2010, available at <http://www.prnewswire.com/news-releases/will-anyone-be-normal-99301564.html> ("However, critics of this issue of DSM are concerned with the classification of novelty conditions as psychological disorders. In the new edition, temper tantrums among toddlers and heartache over a lost spouse could now be defined as mental health conditions . . ." (quoting Jerome Wakefield)).

⁴²⁴ Kirkey, *supra* note 386. JUSTIFICATION FOR TEMPER DYSREGULATION DISORDER WITH DYSPHORIA, DSM-5 CHILDHOOD AND ADOLESCENT DISORDERS WORK GROUP, 7 <http://www.dsm5.org/Proposed%20Revision%20Attachments/Justification%20for%20Temper%20Dysregulation%20Disorder%20with%20Dysphoria.pdf> ("That is, if TDD is a form of BD, first-line treatment would consist of atypical antipsychotic medication and/or mood stabilizers. On the other hand, if TDD is on a continuum with unipolar depressive disorders, anxiety disorders, and ADHD, first-line treatment would consist of serotonergic reuptake inhibitor antidepressants (SSRI's) and stimulants.").

⁴²⁵ Frances, *supra* note 415.

2. *Mild Neurocognitive Disorder*

Mild neurocognitive disorder (MND) is a dementia risk category involving a minor decline in memory that does not interfere with independence or meet the criteria for dementia.⁴²⁶ Opponents argue that MND is so broadly-defined that it risks medicalizing the predictable cognitive declines of aging.⁴²⁷ The concern is that the nonspecific symptoms are unavoidable for those over fifty years of age, creating the potential that millions of individuals, who will never develop dementia, will nonetheless be misdiagnosed with MND.⁴²⁸ Although diagnosis requires an objective cognitive assessment, this will do little to prevent false positives since the assessment is set to include up to 13.5% of the population; moreover, the requirement will likely be ignored altogether in primary care settings where most diagnoses will occur.⁴²⁹ Thus, critics charge that MND will lead to unnecessary and ineffective psychotropic drug treatments, as well as “quack folk remedies.”⁴³⁰ Others fear that long-term-care insurers will refuse to insure those diagnosed with MND.⁴³¹

3. *Psychosis Risk Syndrome*

Perhaps the most controversial proposal for DSM-V is psychosis risk syndrome (PRS), which has been recently renamed attenuated psychosis syndrome.⁴³² PRS is based on two fundamental

⁴²⁶ Mild Neurocognitive Disorder, Proposed Revision, AM. PSYCHIATRIC ASS'N (last updated Feb. 16, 2011), <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=420>.

⁴²⁷ Frances, *supra* note 415.

⁴²⁸ *Id.* (stating that the symptoms of mild neurocognitive disorder are “very common (perhaps almost ubiquitous) in people over fifty”).

⁴²⁹ *Id.*

⁴³⁰ *Id.*

⁴³¹ Stein, *supra* note 423.

⁴³² See Attenuated Psychotic Syndrome, Proposed Revision, AM. PSYCHIATRIC ASS'N (last updated Aug. 3, 2010), <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=412>; Allen Frances, *Psychosis Risk Syndrome: Just as Risky with a New Name*, PSYCHOL. TODAY (July 30, 2010), <http://www.psychologytoday.com/blog/dsm5-in-distress/201007/psychosis-risk->

assumptions: that it is possible to prospectively identify adolescents and young adults who are at risk for developing schizophrenia and other psychotic disorders; and, that intervening prior to the first episode of psychosis might ameliorate, delay, or prevent the onset of psychotic disorder in this population.⁴³³ The symptoms of PRS generally include delusions, hallucinations or disorganized speech in an attenuated form—the adolescent or young adult can still distinguish between reality and the symptoms—that occur once a week for a month and cause the patient or a parent to seek help.⁴³⁴ In terms of the benefits of inclusion, early identification of those destined for psychosis would reduce later misdiagnosis and unnecessary treatment, such as an ADHD diagnosis and stimulant treatment, which could exacerbate the attenuated positive symptoms.⁴³⁵ Moreover, a risk syndrome would bring psychiatry in line with other areas of medicine that use risk factors to begin preventive interventions.⁴³⁶ However, the direct benefit—improving outcomes and alleviating suffering—is largely hypothetical since it hinges on the unproven theory that it is possible to delay or prevent the onset of psychosis.⁴³⁷ Thus, laudable though the aim may be, the likely risks and uncertain benefits of recognizing PRS leaves many critics questioning whether the profession truly appreciates the potential harms associated with preventive psychiatry.⁴³⁸

syndrome-just-risky-new-name.

⁴³³ See Sally Satel, *Prescriptions for Psychiatric Trouble*, WALL ST. J. (Feb. 19, 2010), <http://online.wsj.com/article/SB10001424052748703525704575061851569968656.html>; Cheryl M. Corcoran et al., *The Psychosis Risk Syndrome and its Proposed Inclusion in the DSM-V: A Risk-Benefit Analysis*, 120 SCHIZOPHRENIA RES. 16, 16–17 (2010). At first, proponents of early identification of psychosis were focused on timely recognition and treatment of the first episode of psychosis, based on research suggesting that longer periods of untreated psychosis are associated with poorer outcomes in psychotic disorders. Patrick D. McGorry et al., *Intervention in Individuals at Ultra-High Risk for Psychosis: A Review and Future Directions*, 70 J. CLINICAL PSYCHIATRY 1206, 1206 (2009). Researchers later pushed the point of intervention back further, hoping to prevent or delay the onset of frank psychosis. *Id.* at 1207.

⁴³⁴ Attenuated Psychotic Syndrome, Proposed Revision, *supra* note 432.

⁴³⁵ Corcoran et al., *supra* note 433, at 17–18.

⁴³⁶ *Id.*

⁴³⁷ See Attenuated Psychotic Syndrome, Proposed Revision, *supra* note 432.

⁴³⁸ See Frances, *supra* note 398 (“[L]ike most experts, [those who developed PRS for DSM-V]

The most significant risk is the extraordinarily high rates of false positives (i.e., persons diagnosed as being at risk who will not later develop psychosis) that have been documented in several studies. The reason for the false positive problem, according to a recent study, is that PRS “remains poorly defined, with unclear validity, and limited specificity.”⁴³⁹ Two kinds of false positives are a concern. First, only a fraction of those who are correctly identified as at risk will ultimately develop psychotic disorder.⁴⁴⁰ In highly selected research settings with expert diagnosticians and patients referred by clinicians who suspect them of being at risk, studies report that between fifty percent and eighty-four percent of those identified as at risk do not become psychotic within two to three years.⁴⁴¹ Second, there is a significant risk of misdiagnosis when clinicians with less expertise apply the diagnostic criteria in community settings.⁴⁴² Studies suggest that in community settings, nearly half of those diagnosed as at risk may not even meet the criteria for risk syndrome.⁴⁴³ Although these rates are study-specific and cannot be generalized, the combined effects of both kinds of false positives would yield a total false-positive rate of ninety-one percent.⁴⁴⁴ In other words, nine young persons who are not destined for psychosis will be identified and unnecessarily treated for each young person who is destined for psychosis.⁴⁴⁵

The high false-positive rate is likely attributable to the substantial overlap between the attenuated positive symptoms and the normal spectrum of adolescent thoughts and behavior.⁴⁴⁶ Indeed, studies

have a blind spot when it comes to understanding the huge gulf between the real world and their rarified research experience. . . . It has been difficult for them to appreciate just how differently and destructively their pet suggestion would play were it to become prematurely official.”)

⁴³⁹ Corcoran et al., *supra* note 433, at 20.

⁴⁴⁰ *Id.* at 18.

⁴⁴¹ *Id.*

⁴⁴² *Id.* at 18–19.

⁴⁴³ *Id.* at 18–19.

⁴⁴⁴ *Id.* at 19.

⁴⁴⁵ *Id.*

⁴⁴⁶ See Corcoran et al., *supra* note 433, at 19.

have shown that around ten percent of the general public have psychosis-like hallucinations and delusions that are more intense than the average psychotic inpatient, but are usually able “to integrate [the experiences] into their lives without... becoming distressed or disabled.”⁴⁴⁷ Thus, a substantial number of people who can cope with positive symptoms on their own could be diagnosed with PRS. Moreover, the vague diagnostic criteria increase the likelihood of misdiagnosis, as illustrated by the proposed accompanying descriptive text for PRS.⁴⁴⁸ The text describes attenuated delusions as “unusual ideas” and “overvalued beliefs,” which include suspiciousness—“harbor[ing] notions that people are untrustworthy,” and grandiosity—“harbor[ing] “notions of being gifted, influential, or special.”⁴⁴⁹ Similarly, mild forms of disorganized communication can include a patient who “frequently gets into irrelevant topics but responds easily to occasional clarifying questions,” while mild attenuated hallucinations include “unformed” sounds and images, such as “shadows, trails, halos, murmurs, [or] rumbling.”⁴⁵⁰ According to critics, the requirement that these symptoms must be “beyond normal variation” and distressing enough to lead the patient or the patient’s parents to seek help does not provide a basis for distinguishing between normality and symptoms that are so widely distributed in the population.⁴⁵¹ Indeed, a recent study argues that “the offered alternative of being distressing to others opens the door to pathologizing eccentric or creative behavior that is not understood or appreciated by parents, teachers and others who may be more conventional or straight-laced based on transgenerational or cultural differences.”⁴⁵² Similarly, Robert Spitzer predicts that “[t]here will be adolescents who are a little odd and

⁴⁴⁷ See, e.g., Vaughan Bell et al., *The Cardiff Anomalous Perceptions Scale (CAPS): A New Validated Measure of Anomalous Perceptual Experience*, 32 SCHIZOPHRENIA BULL. 366, 374 (2006).

⁴⁴⁸ See Corcoran et al., *supra* note 433, at 19.

⁴⁴⁹ *Criteria for the Risk Syndrome for First Psychosis*, SCHIZOPHRENIA RES. F., <http://www.schizophreniaforum.org/images/livedisc/RiskSyndrome.pdf>.

⁴⁵⁰ Corcoran et al., *supra* note 433, at 19; *Criteria for the Risk Syndrome for First Psychosis*, *supra* note 451.

⁴⁵¹ See Corcoran et al., *supra* note 433, at 19.

⁴⁵² *Id.*

have funny ideas” who clinicians will label as “pre-psychotic” if PRS is included in its present form.⁴⁵³

In addition to the high rates of false positives, the APA admits that psychiatry lacks an “evidence-based intervention, which has demonstrated benefit in reducing conversion to psychosis.”⁴⁵⁴ Thus, it is also unclear that those who are destined for psychosis would benefit from early intervention. Nevertheless, clinicians—driven by parental pressure and preventive zeal, as well as the fear of liability—are likely to prescribe atypical antipsychotics and drug cocktails for young people identified as at risk, perhaps indefinitely, if PRS is included in DSM-V.⁴⁵⁵ As a result, all of those identified as at risk, including the many false positives, would bear the burden of the known iatrogenic harms associated with antipsychotics and other psychotropic drugs.⁴⁵⁶ There is also a substantial risk that identification will result in stigma. Apart from the negative stereotypes associated with serious mental illness, a PRS diagnosis may engender fear and anxiety about developing a severe mental illness such as schizophrenia and influence future education, career, and family plans.⁴⁵⁷ Considering the substantial false positive rate, diagnosis could have a devastating impact on the lives of many

⁴⁵³ Stein, *supra* note 423. See Edward Shorter, *Why Psychiatry Needs Therapy*, WALL ST. J. (Feb. 27, 2010), <http://online.wsj.com/article/SB10001424052748704188104575083700227601116.html> (“Even if you aren’t floridly psychotic with hallucinations and delusions, eccentric behavior can nonetheless awaken the suspicion that you might someday become psychotic. Let’s say you have ‘disorganized speech.’ This would apply to about half of my students. Pour on the Seroquel for ‘psychosis risk syndrome!’”).

⁴⁵⁴ Attenuated Psychotic Symptoms Syndrome, Proposed Revision, AM. PSYCHIATRIC ASS’N, <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=412#>.

⁴⁵⁵ See Corcoran et al., *supra* note 433, at 20; Pope et al., *supra* note 371, at 67; Colin A. Ross, *DSM-5 and the ‘Psychosis Risk Syndrome’: Eight Reasons to Reject It*, 2 PSYCHOSIS: PSYCHOL., SOC. & INTEGRATIVE APPROACHES 107 (2010).

⁴⁵⁶ The adverse effects associated with atypical antipsychotics include weight gain and movement disorders, such as tremor and akathisia. See Claire D. Advokat et al., *Side Effect Profiles of Atypical Antipsychotics, Typical Antipsychotics, or no Psychotropic Medications in Persons with Mental Retardation*, 21 RES. DEVELOPMENTAL DISABILITIES 75, 75-76 (2000); Correll et al., *supra* note 377, at 1765.

⁴⁵⁷ See Corcoran et al., *supra* note 433, at 19; Daniel Z. Buchman & Judy Illes, *Imaging Genetics For Our Neurogenetic Future*, 11 MINN. J. L. SCI. & TECH. 79, 91 (2010) (discussing the impact on the objective-self and the potential to alter personal identity).

adolescents and young adults who will never develop psychosis.

For critics, the unfavorable risk-benefit ratio and the high rates of false positives make the inclusion of PRS premature.⁴⁵⁸ Noting that “good intentions are not enough,” Frances argues that PRS fails to satisfy the “three fundamental pillars” of early intervention—the ability to diagnose the right people, to provide effective treatment, and to provide safe treatment—because of a “dangerous combination [of] wildly inaccurate identification [and] likely ineffective but definitely risky treatment.”⁴⁵⁹ As such, PRS is “clearly the prescription for an iatrogenic public health disaster.”⁴⁶⁰

Taken as a whole, the proposed revisions demonstrate that “therapeutic zeal” continues to take priority over all other considerations in defining the scope of mental illness, despite the perceived objectivity of modern psychiatry.⁴⁶¹ Both professional and lay critics claim the proposals for DSM-V will create millions of false positives. If DSM-V ultimately codifies these proposals, Frances writes, it will be “a bonanza for the pharmaceutical industry but at a huge cost to the new false-positive patients caught in the excessively wide DSM-V net.”⁴⁶² The potential for a significant number of false-positive children amplifies these concerns. Indeed, author Christopher Lane argues that psychiatry is “close to treating . . . children like guinea pigs” by continuing to lower the diagnostic threshold for childhood mental illness.⁴⁶³

IV. THE HIDDEN COSTS OF HEALTH CARE REFORM

Reformers maintain that mankind can conquer any social problem if the public will simply acquiesce in broad social

⁴⁵⁸ Corcoran et al., *supra* note 433, at 20.

⁴⁵⁹ Frances, *supra* note 400.

⁴⁶⁰ *Id.*

⁴⁶¹ See Frances, *supra* note 417 (arguing that “therapeutic zeal,” rather than conflicts of interest, “creates an enormous blind spot to the great risks that come with overdiagnosis and unnecessary treatment.”)

⁴⁶² Frances, *supra* note 400.

⁴⁶³ Stein, *supra* note 425.

interventions. With an unshakable faith in science and government, modern progressives insisted on broadening access to health care services and treatments, including mental health care, and accomplished what prior reformers had only hoped for—a national system of compulsory health insurance.⁴⁶⁴ A decade from now, most Americans will have comprehensive mental health coverage, including tens of millions who would otherwise be uninsured, and the federal government will be deeply involved in promoting mental health. This bold new direction in federal mental health policy represents an unambiguous endorsement of modern psychiatry and a sweeping commitment to the idea that mental illnesses are just as valid as other medical conditions. But equating the problems of mental illness and physical illness obscures the troubling policy mistakes of the past and the well-documented controversies that continue to bedevil psychiatry. As such, mental health care reform could be a very expensive way of undermining the nation's mental health.

History has not been kind to psychiatry or the mental health reform movement. In the past, a recurring atmosphere of hope, optimism, and euphoria within psychiatry following apparent advances in the understanding of mental illness or the introduction of new technologies, together with the fervor of reformers, has distorted mental health policy. For example, excitement about the possibility of preventing mental illness fueled the mental hygiene movement's misguided attempt to impose psychiatric beliefs and practices on our nation's schoolchildren. Ultimately, the movement did not improve the nation's mental health. Instead, it helped legitimize psychiatry's authority over abnormal psychological and emotional development in childhood, made mental health a priority for schools, and contributed to the medicalization of childhood, all of which remain controversial after a precipitous decline in children's

⁴⁶⁴ Progressive reformers have been advocating for a system of compulsory health insurance for almost a century. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 236 (1982). Cf. Jann Wenner, *Obama In Command: The Rolling Stone Interview*, ROLLING STONE, Oct. 15, 2010, available at <http://www.rollingstone.com/politics/news/obama-in-command-br-the-rolling-stone-interview-20100928> (quoting President Obama as describing his administration as "the most successful... in a generation in moving progressive agendas forward").

mental health.⁴⁶⁵ Similarly, deinstitutionalization was based, in part, on the belief that new psychotropic drugs were powerful enough to allow seriously mentally ill individuals to live essentially normal lives with minimal professional support outside of mental institutions. Ultimately, however, psychiatric medications and community mental health care were not panaceas for the problems of many of those suffering from severe and persistent mental illnesses. In contrast, psychiatry thrived after deinstitutionalization, as psychiatric practice moved into the community and shifted its focus from intractable mental illness to far less severe mental conditions. Free of institutions, the specialty could focus on the problems of everyday life, which ultimately became brain diseases requiring medical solutions. As the mental hygiene movement and deinstitutionalization illustrate, health policy stands or falls on the merits of its scientific basis. In the absence of a solid scientific foundation, optimism and “therapeutic fervor” distort mental health policy, creating a risk of far-reaching unintended consequences.⁴⁶⁶

Given this history, it is fitting that the new direction in federal mental health policy sits atop a shaky scientific foundation. Modern psychiatry owes much of its medical legitimacy to its purportedly objective diagnostic classification system, as well as the idea that mental disorders are brain-based diseases. The reality, however, is that the pathophysiology and etiology of mental disorders remains unknown, and psychiatry is stuck at the syndromal level, where there is a greater risk of arbitrary diagnoses, misclassification, overdiagnosis, and false positives. Moreover, there is no meaningful definition of mental disorder to restrain nosological and clinical decisions as to which conditions are disordered and which are not. Given these circumstances, the proliferation of diagnostic labels has been met with considerable unease within psychiatry. Most notably, psychiatrists have increasingly joined the ranks of vocal skeptics who

⁴⁶⁵ THERESA R. RICHARDSON, *THE CENTURY OF THE CHILD* 151, 191 (1989). (“The mental hygiene movement has effectively contributed to the transformation of the family, school context and family court in the United States and Canada over this century. Regardless of its reflection of the ‘truth’ of science, mental hygiene has become integrated into our cultures as common sense material, grounded in established authority structures.”).

⁴⁶⁶ Cohen, *supra* note 38, at 142 (describing the mental hygiene movement as “notoriously optimistic” and “swept up in a therapeutic fervor.”).

charge that modern psychiatry has medicalized normal human behavior and experience, suggesting the epidemic of mental illness includes millions of false positives. Without objective determinants of disease or even a meaningful definition of mental disorder, however, psychiatry has been unable to provide a principled explanation as to why individuals who share common features or properties are mentally ill.

Although this Article has primarily focused on diagnostic classification, psychotropic drugs are perhaps the most controversial aspect of modern psychiatry. During the psychodynamic era, the marginal status of psychiatry and the dominance of psychotherapy and psychoanalysis in psychiatric practice mitigated the risks associated with clinical diagnosis.⁴⁶⁷ In contrast, modern psychiatry relies almost exclusively on pharmaceutical treatments, a reflection of the unproven idea that mental disorders are brain diseases. Along with diagnostic expansion and public's insatiable appetite for pharmaceutical drugs, this shift has led to a massive spike in the number of Americans, from young children to the elderly, who are using psychotropic drugs, usually on a long-term basis.⁴⁶⁸ At the same time, pervasive conflicts of interest throughout psychiatry have led to fears that the pharmaceutical industry has been partially responsible for the expansion of DSM. There are also lingering doubts within psychiatry about the efficacy of psychotropic drugs.⁴⁶⁹

⁴⁶⁷ See Rosenberg, *supra* note 11, at 417 ("Even at the height of its influence (from the 1940s through the 1970s), psychodynamic explanations of behavior and emotions remained in an uneasy and even marginal relationship to much of mainstream medicine, despite the widespread influence of such ideas outside the profession.")

⁴⁶⁸ See Joanna Moncrieff, *Why is it so Difficult to Stop Psychiatric Drug Treatment? It May Be Nothing to do with the Original Problem*, 67 *MED. HYPOTHESES* 517, 517-18 (2006).

⁴⁶⁹ See Andrew A. Nierenberg, Editorial, *Distress: To Treat or Not to Treat*, 14 *CNS SPECTRUMS* 344, 344-345 (2009) (arguing that clinicians must understand that some "patients should experience their distress without pharmacologic treatment"); Linda M. Davies et al., *Cost-effectiveness of First- v. Second-generation Antipsychotic Drugs: Results from a Randomised Controlled Trial in Schizophrenia Responding Poorly to Previous Therapy*, 191 *BRIT. J. PSYCHIATRY* 14, 18 (2007) (reporting that schizophrenia patients using first-generation antipsychotics had a better quality of life than those taking newer atypical antipsychotics); Richard Turner & Richard Horton, *The Spurious Advance of Antipsychotic Drug Therapy*, 373 *LANCET* 4, 4 (2009) (claiming that atypical antipsychotics "are no more efficacious, do not improve specific symptoms, have no clearly different side-effect profiles than the first-generation antipsychotics, and are less cost effective."); Healy, *supra* note 377, at 0442-0443 (suggesting

Further, the problem of false positives suggests that a large number of children, adolescents, and adults diagnosed with mental illness have been unnecessarily exposed to the known risks of psychotropic drugs. A number of critics have even raised the specter of iatrogenic mental illness, arguing that psychotropic drugs trigger an insidious process that may cause patients to experience more severe and debilitating symptoms than those associated with the natural course of any underlying disease.⁴⁷⁰

Federal mental health policy implicitly rejects these concerns by seeking to expand access to mental health services and treatments. For the past forty years, the expansion of public and private insurance coverage has reduced out-of-pocket burden of treating mental disorders and broadened the use of psychotropic drugs.⁴⁷¹ As costs increased, private employers and public sector health insurance purchasers have used managed behavioral health care (MBHC) to control mental health care costs, particularly in response to benefit expansion under comprehensive parity.⁴⁷² MBHC has proven

that atypical antipsychotics may worsen the progression of bipolar disorder by increasing the risk of hospitalization, suicide, and other side effects); Jay C. Fournier et al., *Antidepressant Drug Effects and Depression Severity, A Patient-Level Meta-Analysis*, 303 JAMA 47, 47 (2010) (concluding that "[t]he magnitude of benefit of antidepressant medication compared with placebo increases with severity of depression symptoms and may be minimal or non-existent, on average, in patients with mild or moderate symptoms").

⁴⁷⁰ See WHITAKER, *supra* note 328, *passim* (offering a journalistic account of how most, if not all, psychiatric treatments may be behind the decline of the nation's mental health); Moncrieff, *supra* note 468, at 518 (arguing that "the problems that occur after withdrawal of psychiatric drugs may often be related to the process of withdrawal of that medication, rather than the natural course of the underlying condition," and "the recurrent nature of psychiatric disorders may be partially attributable to the iatrogenic effects of psychiatric drugs"); Guy Chouinard et al., *Neuroleptic-Induced Supersensitivity Psychosis*, 135 AM. J. PSYCHIATRY 1409, 1410 (1978) (proposing the "supersensitivity psychosis" hypothesis). Although this is a serious challenge to psychiatry's medical legitimacy, psychiatry cannot refute the hypothetical iatrogenic process because there have been no large studies of the long-term outcomes of medicated and nonmedicated patients. *Cf.* Moncrieff, *supra* note 468, at 522.

⁴⁷¹ See Richard G. Frank et al., *Mental Health Policy and Psychotropic Drugs*, 83 MILBANK Q. 271, 278 (2005).

⁴⁷² See D. RICHARD MAUERY ET AL., *MANAGED MENTAL HEALTH CARE: FINDINGS FROM THE LITERATURE, 1990–2005*, at 7 (2006). Under a popular approach, employers, plans, and states separate mental health benefits from general health benefits and delegate responsibility for administering mental health benefits to specialty managed behavioral health care organizations (MBHOs). See Alison Evans Cuellar & Deborah Haas-Wilson, *Competition and the Mental Health System*, 166 AM. J. PSYCHIATRY 278, 278 (2009); MECHANIC, *supra* note 209,

proficient in controlling expenditures while simultaneously maintaining or increasing access to mental health services, especially for those with milder conditions.⁴⁷³ However, because MBHC carve-out arrangements create an incentive to favor prescription drug treatments over other forms of mental health treatment, managed care has also been “a factor in the increasing uses of psychotropic medications among adults and children.”⁴⁷⁴ Given this past, the new direction in federal mental health policy is likely to dramatically increase the number of Americans diagnosed with mental illness and using psychotropic drugs. In the coming years, PPACA will expand comprehensive mental health coverage to tens of millions of previously uninsured individuals and reduce the financial burdens of treating mental disorders. As utilization increases, public and private insurance purchasers will have to rely on managed care to control use and spending. As a result, the number of individuals diagnosed with mental illness and treated with psychotropic drugs will

at 173. To control costs, behavioral health carve-outs conduct concurrent utilization review, and care managers evaluate clinical updates by reference to DSM diagnoses to substantiate medical necessity and the need for further care. William Goldman et al., *Costs and Use of Mental Health Services Before and After Managed Care*, 17 HEALTH AFF. 40, 44 (1998).

⁴⁷³ See Davina C. Ling et al., *Economic Incentives and Contracts: The Use of Psychotropic Medications*, 26 CONTEMP. ECON. POL’Y 49, 51 (2008); MAUERY ET AL., *supra* note 473, at 1 (“[I]t appears that managed mental health care improves access to care overall, primarily for persons whose mental health conditions are typically treated in ambulatory outpatient settings (e.g., mild to moderate depression or anxiety). However, a few small studies have found that utilization management techniques and reimbursement arrangements may restrict access to higher intensity services, particularly inpatient services needed by persons with severe and persistent mental illnesses.”)

⁴⁷⁴ Conrad, *supra* note 367, at 10. All carve-out contracts separate the financial risks for prescription drugs from the risks for other mental health care, so that the costs of prescription drugs are “off budget” for MBHOs. Ling et al., *supra* note 473, at 50. That is, drugs are not covered under carve-out contracts, and instead are covered under the patient’s medical benefit. Goldman et al., *supra* note 472, at 44. This creates powerful economic incentives for MBHOs “to shift treatment strategies to those that favor use of prescription drugs over other nondrug inputs (e.g., psychotherapy, inpatient care, and other psychosocial interventions. Ling et al., *supra* note 473, at 50. Thus, managed care is much more likely to pay for prescription drugs, which influences the prescribing practices of clinicians. Conrad, *supra* note 367, at 10. Managed care therefore responds to greater demand for mental health services by steering the delivery of mental health care towards drug interventions and away from psychotherapeutic interventions. Cf. Ling et. al, *supra* note 473, at 66 (finding “that behavioral health carve-outs raise the number of potential users for the newest antidepressants but do not do the same for the newest antipsychotics”).

skyrocket.

Though health care reform may benefit many of those suffering from serious mental illness,⁴⁷⁵ PPACA will only exacerbate the problems of overdiagnosis, false positives, and unnecessary treatment. Beyond the controversial status of many current mental disorders, the proposals for DSM-V indicate that psychiatry remains committed to lowering the threshold of mental illness further, even if it means creating millions of false positives. Under PPACA, these false positives will be just as entitled to treatment as someone suffering from a severe mental illness. As such, psychiatry's contempt for normality now enjoys the imprimatur of the federal government and whatever remains of normal human experience is up for grabs.

The primary concern raised by the problem of false positives is unnecessary treatment. In addition to the costs and risks associated with unnecessary treatment, medicalization may also have more abstract social consequences that deserve attention. The idea that psychiatry functions as an institution of social control, and psychiatric diagnosis allows behavioral control to masquerade as treatment, underlies much of the concern over medicalization.⁴⁷⁶ Indeed, psychiatry has proven susceptible to manipulation and abuse for political purposes, as evidenced by the medicalization of political dissent and non-conformity in the Soviet Union and China, as well as the more recent experience of minority spiritual movements in China.⁴⁷⁷ In the United States, the influence of market forces on

⁴⁷⁵ See MENTAL HEALTH AM., *supra* note 247 (discussing the expansion of the Medicaid program, new options for Medicaid enrollees with a serious mental health condition to designate a provider as a medical home, improved funding for community mental health centers, and a demonstration program to allow Medicaid coverage of private inpatient psychiatric facilities).

⁴⁷⁶ See, e.g., PETER CONRAD & JOSEPH W. SCHNEIDER, *DEVIANCE AND MEDICALIZATION: FROM BADNESS TO SICKNESS* 250 (expanded ed., Temple Univ. Press 1992) (1980) ("As is suggested from the discovery of hyperkinesis . . . , if a mechanism of medical social control seems useful then the deviant behavior it modifies will be given a medical label and diagnosis.").

⁴⁷⁷ Jablensky, *supra* note 10, at 139 ("Concepts about the nature and classification of psychiatric illness will always attract ideological and political attention that can translate into laws, policy, or other action with unforeseen consequences."). Outspoken critics and nonconformists in the former Soviet Union were routinely declared mentally ill and sent to mental institutions for "treatment." See CONRAD & SCHNEIDER, *supra* note 113, at 35, 70-71.

psychiatry and the exploitation of diagnosis for profit have been dominant concerns for a number of years.⁴⁷⁸ But fears are once again surfacing that American psychiatry is “a sophisticated form of social control that wraps itself in the banner of medicine [and] a discipline that uses medical technology and jargon to classify and control people.”⁴⁷⁹ From this perspective, medical diagnosis triggers an obligation to change and to regain a healthy state, a quid pro quo for relieving the patient of responsibility for normal obligations and other advantages of the sick role.⁴⁸⁰ This social response implies less respect and acceptance of psychiatric patients than even those with the most irritating normal variations of human traits.⁴⁸¹ Ordinarily, the pathway back to normal social status is psychiatric treatment targeting the brain, e.g., the ingestion of psychotropic drugs that have the potential to easily and quickly blunt emotional responses to the environment, alter personal identity, and change other characteristics of the self.⁴⁸² The fear is that mislabeling variants of normal human experience and behavior as disorder, coupled with this social response to diagnosis, “artificially constrain[s] the range of normal

See generally Daniel Beer, *Blueprints for Change: The Human Sciences and the Coercive Transformation of Deviants in Russia, 1890-1930*, 22 OSIRIS 26 (2007). Similarly, the Chinese government used psychiatry to repress political opposition during the Cultural Revolution and religious beliefs more recently. See Robin Munro, *On the Psychiatric Abuse of Falun Gong and Other Dissenters in China: A Reply to Stone, Hickling, Kleinman, and Lee*, 30 J. AM. ACAD. PSYCHIATRY & LAW 266, 267-73 (2002).

⁴⁷⁸ See Healy, *supra* note 377, at 0442-0443; Conrad, *supra* note 367 at 5-10.

⁴⁷⁹ Wakefield, *supra* note 19, at 10.

⁴⁸⁰ *Id.*, at 12.

⁴⁸¹ See *id.*

⁴⁸² See Christopher Lane, Excerpt, *Shyness: How Normal Behavior Became a Sickness*, WALL ST. J., Nov. 3, 2007, available at <http://online.wsj.com/article/SB119402985846180627.html> (“[S]ome doctors fear that antidepressants are causing widespread emotional blunting—altering the strength of our attachments, how well we can concentrate, and even how deeply we fall in love.”); Glannon, *supra* note 296, at 49-51; see also David Cohen, Professor, Sch. of Soc. Work, Coll. of Health & Urban Affairs, Fla. Int’l Univ., Needed: Critical Thinking About Psychiatric Medications, Keynote Address at the Fourth International Conference on Social Work in Health and Mental Health 9 (May 2004), available at <http://www.ahrp.org/about/CohenPsychMed0504.pdf> (suggesting the possibility that SSRIs “impair or blunt emotional responsiveness, social sensitivity, and judgment, as all sedatives and stimulants do”).

human emotions."⁴⁸³ What is more, diagnoses based on behavioral and emotional symptoms, with little consideration of the context in which symptoms develop, invalidates the once meaningful behaviors and mental states in question.⁴⁸⁴ This creates the risk of pathologizing normal human responses to adverse environmental conditions, thereby transforming social and political matters into individualized, brain-based problems.⁴⁸⁵ While psychiatric medications may relieve some amount of distress and discomfort, the environmental conditions remain. The medicalization of social and political problems therefore promotes the dominant social and institutional order by discouraging alternative, non-medical solutions that might open up the possibility for an even greater level of human happiness.⁴⁸⁶ In this way, the medicalization of normality is antithetical to the type of mental and emotional freedom that is necessary to sustain scrutiny of existing political and social institutions, including anxiety, fear, worry, distress, and the like.⁴⁸⁷ If

⁴⁸³ Wakefield, *supra* note 19, at 12; *see* Lane, *supra* note 483 ("The sad consequence is a vast, perhaps unrecoverable, loss of emotional range, an impoverishment of human experience.").

⁴⁸⁴ *See* David Ingleby, *Understanding Mental Illness*, in *CRITICAL PSYCHIATRY: THE POLITICS OF MENTAL HEALTH* (David Ingleby ed., Free Association Books, 2004) (1980), *available at* <http://www.critpsynet.freeuk.com/InglebyCritical.htm> ("[D]iagnosis of 'hyperkinesis' reifies and invalidates the rebellious actions whereby schoolchildren express their boredom and frustration with their allotted roles."; Scott, *supra* note 353, at 147 ("[S]hyness is not only socially unacceptable but also invalid as an emotional response, a betrayal of the rational self that we could, and should, become.").

⁴⁸⁵ *See* Wakefield, *supra* note 19, at 15–16; Joanna Moncrieff, *Psychiatric Diagnosis as a Political Device*, 8 *SOC. THEORY & HEALTH* 370, 380–81 (2010); CONRAD & SCHNEIDER, *supra* note 453, at 250.

⁴⁸⁶ CONRAD & SCHNEIDER, *supra* note 477, at 250 (By focusing on the symptoms and defining them as hyperkinesis, we ignore the possibility that the behavior is not an illness but an adaptation to a social situation. It diverts our attention from the family or school and from seriously entertaining the idea that the 'problem' could be in the structure or social system. By giving medications, we are essentially supporting the existing social and political arrangements in that it becomes a 'symptom' of the individual disease rather than a possible 'comment' on the nature of the present situation.").

⁴⁸⁷ *See* Wakefield, *supra* note 19, at 12, 16; *cf.* Benjamin Franklin, Letter from "Silence Dogood," *NEW ENGLAND COURANT*, July 9, 1722, in *RESPECTFULLY QUOTED: A DICTIONARY OF QUOTATIONS* 132–33 (Suzy Platt ed., 1993) ("Without freedom of thought there can be no such Thing as Wisdom; and no such Thing as publick Liberty without Freedom of Speech.").

government is a perpetual menace to liberty,⁴⁸⁸ the responsibility of the people to protect against tyranny and oppression, even that which proceeds incrementally and under the pretense of beneficence, demands that normality be broadly construed and that psychiatric diagnosis be based on the context in which mental and emotional conditions develop.⁴⁸⁹

Reducing human suffering and enhancing human potential are generally good for individuals or society. Indeed, some believe that psychiatry has legitimate functions beyond the treatment of disorder, including helping people cope with the distress and discomfort that is a normal part of every day life and enhancing human potential in ways that are socially and personally desirable.⁴⁹⁰ These additional functions help explain the proliferation of mental disorders and the medicalization of normality, as well as the apparent overlap between enhancement and treatment.⁴⁹¹ The idea that all mental disorders are brain diseases tends to exaggerate the benefits and trivialize the risks of psychiatric diagnosis and treatment, except in the case of serious

⁴⁸⁸ See Letter from Thomas Jefferson to Edward Carrington (May 27, 1788), in *THE QUOTABLE FOUNDING FATHERS* 117 (Buckner F. Melton Jr. ed., 2004) (“The natural progress of things is for liberty to yield and government to gain ground.”).

⁴⁸⁹ Compare James Madison, Proposed First Amendment to the United States Constitution, June 8, 1789, in *THE FOUNDERS’ CONSTITUTION* 481 (Philip B. Kurland & Ralph Lerner eds., 1987) (“That the people have an indubitable, unalienable, and inalienable right to reform or change their Government, whenever it be found adverse or inadequate to the purposes of its institution.”), available at http://press-pubs.uchicago.edu/founders/print_documents/v1ch14s50.html, with Letter from Thomas Jefferson to David Humphreys (Mar. 18, 1789), in *AMERICAN PHILOSOPHY* 55 (Barbara MacKinnon ed., 1985) (“There are rights which it is useless to surrender to the government, and which governments have yet always been found to invade. These are the rights of thinking, and publishing our thoughts by speaking or writing; the right of free commerce; the right of personal freedom.”), and Letter from Thomas Jefferson to Colonel W.S. Smith (Aug. 2, 1788), in *THE REAL THOMAS JEFFERSON* 430 (M. Richard Maxfield et al. eds., 6th prt. 2009) (“Our political machine is now pretty well wound up; but are the spirits of our people sufficiently wound down to let it work glibly? I trust it is too soon for that, and that we have many centuries to come yet before my countrymen cease to bear their government hard in hand.”).

⁴⁹⁰ See Wakefield, *supra* note 19, at 10.

⁴⁹¹ *Id.* at 11 (“[M]any clinician-theorists focus on appropriateness of treatment in judging disorder and are inclined to place various forms of non-disordered but treatable distress under the disorder category as a result.”).

mental illnesses.⁴⁹² This prevents individuals from making fully informed decisions about treatment and prevents society from fully understanding and acknowledging the ethical, social, and practical implications of the shrinking realm of normality. Indeed, approaching painful but normal parts of human existence in terms of disease encourages the relinquishment of normality in exchange for access to psychiatric treatments. Moreover, mandating that the nation accept and shoulder the costs associated with this view of mental illness further impedes the recognition of these important issues. At some point, however, increased spending will force the new mental health system to confront the problem of how to pay for the broadening spectrum of mental illness. However, the ties between government, the pharmaceutical industry, and psychiatry, as well as the public's insatiable appetite for psychiatric labels and medications, is likely to stand in the way of cost considerations leading to an open and honest discussion of the full range of issues that pertain to the loss of normality, thus, increasing the risk of an arbitrary solution that prioritizes minor discomfort over the suffering of the severely mentally ill.

V. CONCLUSION

The inverse relationship between psychiatric treatment and mental illness is not disputable. The more Americans submit to mental health care, the more mentally ill the nation becomes. The primary drivers of increases in mental health spending are psychotropic drugs, and increasing drug consumption is a function of supply (new drug treatments) as well as demand (the increasing number of people diagnosed as mentally ill).⁴⁹³ It is also attributable

⁴⁹² *Id.* at 11–12 (“It is true that even if one has no disorder, but merely intense normal emotions of anxiety or depression in response to one’s situation, one may conceivably benefit from treatment. However, studies show that once a clinician classifies a patient as disordered versus non-disordered, the kinds of thinking the clinician does about appropriate interventions and their prioritization as optimal or preferable changes. The potential benefits and costs of various interventions will be assessed differently.”).

⁴⁹³ See Barry et al., *supra* note 220, at 632–33.

to more generous insurance coverage.⁴⁹⁴ In light of the prior editions of DSM and the proposals for DSM-V, it is clear that psychiatry is stubbornly committed to increasing the prevalence of mental illness. Therefore, new federal entitlement to mental health coverage all but guarantees more diagnostic expansion, a larger drug market, and a surge in diagnoses and psychotropic drug use.

The best time for an open and honest discussion about psychiatry, psychotropic drugs, and mental health policy has passed. The reform that the nation truly needs requires a reevaluation of our faith that science and government can deliver us from the discomforts of life. Instead of mindlessly demanding scientific and political solutions, the public must take responsibility for its own mental health by embracing a healthy skepticism of psychiatry and mental illness. That begins with accepting that therapeutic zeal is an attribute shared by both psychiatry and reformers. Although they mean well, both appear willing to endanger the nation's mental health and financial resources on little more than hope and a prayer. It is incumbent on the public to demand that psychiatry, the drug industry, and the government engage in an open, honest discussion about the true nature of mental illness and the real risks and benefits of psychotropic drug treatments. We cannot afford to ignore the financial, physical, mental, social, and ethical risks associated with our declining mental health. At some point, mental illness really will be normal and it will be too late to do anything about it.

⁴⁹⁴ See *id.*