NOTES

THE NEURODIVERSITY PARADIGM AND ABOLITION OF PSYCHIATRIC INCARCERATION

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Against rising calls to expand carceral psychiatry and increasingly pervasive mischaracterizations of neurodivergence in law, this Note accurately introduces the neurodiversity paradigm to call for the abolition of psychiatric incarceration. This Note challenges empirical narratives that render Neurodivergent people incapable of producing knowledge and holding expertise on their own embodied experiences by rejecting dominant conceptions of "mental illness" as an incompetence-inducing pathology that impairs an underlying "normal cognitive function." Rather, by positioning neurodivergence as integral to and indistinguishable from the self, this Note corrects the longstanding removal of expertise on neurodivergence from Neurodivergent people and misplacement of that expertise within the intersection of medical and legal professions. By severing the assumed causal connection between "mental illness" and legal competence, this Note argues that all people, as the experts on their own self-concept, retain the final and unilateral legal authority to define the support they need in crisis and beyond.

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INTRODUCTION

All fifty states authorize psychiatric incarceration,[1] justifying the use of preventive detention based on the presumption of a causal relationship between "mental illness" and legal incompetence.[2] Statutes linking observably different cognition to irrationality, disease, and contamination pre-date the Founding of the United States.[3] Though there are ample critiques of psychiatric incarceration, within these critiques, the story of "mental illness" masquerades as biological fact.[4] Thus, the idea that observably different cognition is the result of an infection or an impairment to an underlying normal cognitive function has been widely and uncritically accepted in both medicine and law as nature-imposed reality rather than critiqued as a malleable normative framework.[5] Consequently, even psychiatric incarceration's most vocal critics have not been able to successfully advocate for its abolition.

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1. See infra section II.A. This Note does not refer to psychiatric incarceration as "civil commitment" because the accurate word for the exercise of state power to deprive someone of freedom of movement in its most basic form is "incarceration." This Note will not rely on euphemistic language to hide the reality of the legal mechanisms at work. Practically, there is little difference between being handcuffed, placed in the back of a police car, and then held involuntarily by threat of force at a hospital and being handcuffed, placed in the back of a police car, and then held involuntarily by threat of force at a jail.

2. For example, in November 2022, New York City Mayor Eric Adams "directed the police . . . to hospitalize people they deemed too mentally ill to care for themselves, even if they posed no threat to others." Andy Newman & Emma G. Fitzsimmons, New York City to Involuntarily Remove Mentally Ill People From Streets, N.Y. Times (Nov. 29, 2022), https://www.nytimes.com/2022/11/29/nyregion/nyc-mentally-ill-involuntary-custody.html (on file with the *Columbia Law Review*).

3. See Laura I. Appleman, Deviancy, Dependency, and Disability: The Forgotten History of Eugenics and Mass Incarceration, 68 Duke L.J. 417, 423 (2018) ("As 1676 legislation from Massachusetts addressing mental illness made very clear, the fear was that the mentally ill might contaminate other members of the community, sending them to damnation . . . ."); see also id. at 421 ("From the very beginning, European society has aimed to confine and isolate those suffering from various poorly understood disabilities. Anglo-Europeans began segregating and confining the mentally ill and cognitively disabled from approximately the twelfth century.").

4. See Liat Ben-Moshe, Decarcerating Disability: Deinstitutionalization and Prison Abolition 39 (2020) ("Psychiatrization . . . is not natural or God given; it is a specific discourse arising in a particular historical moment that [has] come to be seen as ahistorical and inevitable.").

5. See infra sections I.B, II.A.

When lawyers, legislators, psychiatrists, and mental health professionals rely on this pathological framing, debates surrounding treatment imposed by the force of law devolve into a cyclical battle between preferences for protecting the liberty interests of those who are competent and preserving the state's power to mandate treatment for people who are incompetent.[6] Generally, supporters of psychiatric incarceration argue that protecting the liberty interests of the "mentally ill" is no better than letting people die preventable deaths.[7] Critics typically respond that the error rate in the determination of "mental-illness"-induced incompetence is too high to justify the harms imposed by the erroneous deprivation of liberty.[8] But the cyclical battle between liberty and paternalism obscures the relevant—and not yet addressed—legal question of who is granted the expertise on divergent cognition and thus authority to decide when a person is legally incompetent.

This Note proposes a resolution to this debate found not in the balance between liberty and paternalism but in rejecting the dominant normative framework of divergent cognition as "mental illness." Rooted in a combination of Critical Autism Studies,[9] Mad studies,[10] and disability justice, this Note introduces the neurodiversity paradigm to reject the construction of "normal" cognition within law governing psychiatric incarceration.[11] Within the language of the neurodiversity paradigm,

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6. See infra text accompanying notes 119–124.

7. See infra text accompanying notes 125–130; see also infra text accompanying note 143.

8. See infra text accompanying notes 137–142.

9. Critical Autism Studies is a decentralized, cross-disciplinary body of scholarship that not only challenges deficit-based descriptions of autism but also critiques dominant cultural assumptions regarding interpersonal relationships and communication dynamics, thus disrupting traditional conceptions of intent, rhetoric, agency, and empathy.

10. Regarding the identity term Mad: Starting in the nineteenth century, "intellectual disabilities" and "mental illnesses" were conceptually distinguished as discrete kinds of categories. Ben-Moshe, supra note 4, at 41. Consequently, "Mad has been reclaimed as a socio-political identity for people who experience emotional distress and/or who have been labeled as 'mentally ill' . . . ." Definitions, Mad Network News, https://madnessnetworknews.com/definitions/ [https://perma.cc/X5FP-NB3V] (last visited Aug. 16, 2023). Because some psychiatric survivors are neurotypical, not all Mad people are Neurodivergent. Conversely, not all Neurodivergent people are Mad. See Derrick Quevedo (@drrckqvdo), Instagram (July 7, 2023), https://www.instagram.com/p/CuZaJxhAGnX/ (on file with the *Columbia Law Review*) ("One of the biggest misconceptions about Mad Pride is the belief that the Mad community is united by 'mental illness,' when we're more accurately united by the harm we've experienced from the mental health industrial complex.").

11. See Nick Walker, Throw Away the Master's Tools: Liberating Ourselves From the Pathology Paradigm [hereinafter Walker, Liberating Ourselves], *in* Neuroqueer Heresies: Notes on the Neurodiversity Paradigm, Autistic Empowerment, and Postnormal Possibilities 16, 19 (2021) [hereinafter Neuroqueer Heresies] ("Neurodiversity—the diversity among minds—is a natural, healthy, and valuable form of human diversity. . . . There is no 'normal' or 'right' style of human mind, any more than there is one 'normal' or 'right' ethnicity, gender, or culture.").

"Neurodivergent" is the identity term coined by activist Kassiane Asasumasu for a person who experiences any form of divergent cognition,[12] similar to how "Queer" is an umbrella term for a spectrum of different sexual and gender identities.[13] By contrast, "neurotypical" refers to people who conform with the construction of "normal" cognition.[14]

The neurodiversity paradigm positions neurodivergence as an integral component of the self rather than as a corrosive, autonomy-depriving, or incompetence-inducing agent to an underlying "normal." The paradigm thus severs the illusion of the causal relationship between divergent cognition and the determination of legal incompetence. In preserving the competence of Neurodivergent people, the neurodiversity paradigm permits all people to retain the final and unilateral legal authority to define the support they need in crisis and beyond. Thus, reframing the story told about divergent cognition allows policy discussions to step beyond the notion that the only effective interventions for people experiencing crisis are ones rooted in coercive applications of force that override potentially deadly exercises of autonomy. In reclaiming the expertise on neurodivergence for Neurodivergent people, this Note calls for the abolition of psychiatric incarceration in favor of an

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12. Nick Walker, Neurodivergence & Disability, *in* Neuroqueer Heresies, supra note 11, at 60, 69 [hereinafter Walker, Neurodivergence & Disability]. For example, at least autism, bipolar, schizophrenia, attention deficit hyperactivity "disorder" (ADHD), dyslexia, post-traumatic stress "disorder" (PTSD), dissociative identity "disorder" (DID), narcissistic personality "disorder" (NPD), borderline personality "disorder" (BPD), and complex post-traumatic stress "disorder" (cPTSD) are neurodivergences. Id. This Note, in advocating for the depathologization of neurodivergence and distress, avoids the use of the word "disorder" wherever possible. When such avoidance is not possible, the Note places "disorder" in quotes. This is a short-term fix and may change with time as the community works through the process of depathologizing neurodivergence. The word "Neurodistinct" has also been proposed as an alternative identity term. See Tim Goldstein, Neuro Cloud & Neurodistinct, Neurodiversity Refined, Neurodistinct (June 16, 2020), https://www.timgoldstein.com/blog/neurodiversityrefined [https://perma.cc/6RGH-U8N8] ("Instead of the negative, separating, divisive term [Neurodivergent], I coined Neurodistinct."). This Note, however, elects to use the word "Neurodivergent" to preserve the recognition that cognition can and does diverge from neuronormativity.

13. See Sonny Jane Wise (@livedexperienceeducator), Instagram (Nov. 22, 2022), https://www.instagram.com/livedexperienceeducator (on file with the *Columbia Law Review*) ("[N]eurodivergent and queer are similar terms because they are both identities . . . about diverging; one is about diverging from neuronormativity while the other is about diverging from cisnormativity and heteronormativity."). It is more than a superficial comparison; Critical Autism Studies and Queer Theory are deeply intertwined. See Nick Walker, A Horizon of Possibility: Some Notes on Neuroqueer Theory, *in* Neuroqueer Heresies, supra note 11, at 168, 170–72 ("The more I reflected on the process by which I was pushed into the ill-fitting confines of heteronormative gender performance and the process by which I was pushed into the ill-fitting confines of neuronormative performance, the more it became clear that the two processes weren't merely similar or parallel . . . but [were] a single multifaceted process.").

14. Walker, Liberating Ourselves, supra note 11, at 27 ("In the pathology paradigm, the neurotypical mind is enthroned as the 'normal' ideal against which all other types of minds are measured.").

understanding of care designed by Indigenous, Black, Mad, Neurodivergent, and Disabled survivors of carceral psychiatry.[15]

Part I introduces the pathology paradigm. It explains how an outdated conceptualization of statistics within psychiatry permitted the construction of the false dichotomy between normal and abnormal cognition. It then details how disability studies absorbed the construction of abnormal cognition within biological impairment. Part II maps the pervasive and uncritical acceptance of the pathology paradigm into statutes authorizing psychiatric incarceration and policy debates regarding the practice's normative and ethical dimensions. Part III introduces the neurodiversity paradigm as developed in Critical Autism Studies and aligned with modern statistics. It then calls for the abolition of psychiatric incarceration in favor of an understanding of care and support currently being implemented by grassroots organizations that aim to catch society's most marginalized without resorting to handcuffs, body slams, or bullets.[16]

I. DEFINING THE PATHOLOGY PARADIGM

To understand how "mental illness" is a normative framework masquerading as empirical fact, section I.A first explains how normative reasoning and empirical inquiry are not distinct processes but rather are intrinsically intertwined. Section II.B then demonstrates how the normative commitment to biological essentialism in the concurrent development of statistics and psychiatry permitted the construction of "normal" and "abnormal" categories masquerading as empirically

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15. This Note uses identity-first language. If a nondisabled person needs a reminder that a Disabled person is a person, then the nondisabled person already sees the Disabled person as something less. This will be the only comment on identity-first language use in this Note.

Carceral psychiatry names spaces where psychiatrically labeled people are incarcerated as an extension of the carceral state. See Ben-Moshe, supra note 4, at 16; Rafik Wahbi & Leo Beletsky, Involuntary Commitment as "Carceral-Health Service": From Healthcare-to-Prison Pipeline to a Public Health Abolition Praxis, 50 J.L. Med. & Ethics 23, 26 (2022). For a more extensive background on the similarities between psychiatric hospitals and prisons, see generally Erving Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (1961) (defining "total institutions," including both prisons and mental hospitals, and the socialization process inmates in total institutions undergo).

16. See Judith Prieve, Family, Friends Call for Police Reform on Anniversary of East Bay Man's Shooting Death, E. Bay Times (June 3, 2020), https://www.eastbaytimes.com/2020/06/03/family-friends-call-for-police-reform-on-anniversary-of-east-bay-mans-shooting-death/ (on file with the *Columbia Law Review*) ("Miles Hall suffered a breakdown, and so did the system, [Hall's mother] said. 'We called them, they came with guns, they didn't come with compassion—and now our son is dead, dead at the hands of law enforcement because it is a broken system.'"); Special Books by Special Kids, Visiting My Schizoaffective Friend After His Forced Psychiatric Stay, YouTube, at 20:45 (Oct. 26, 2020), https://www.youtube.com/watch?v=xc1tbETJpX4 (on file with the *Columbia Law Review*) ("I was falling over [a bridge] and then it was body-slam time where [police officers] slammed me onto the ground and handcuffed me . . . . There have got to be better ways . . . . I didn't call for help . . . [because] I was afraid of exactly what would happen.").

cognizable classes.[17] Finally, section I.C demonstrates how the pathology paradigm was absorbed into disability studies under the concept of "impairment," which obscures the historical co-construction of and thus intersection between ableism and anti-Black racism.

A. *The Necessary Subjectivity of Empiricism*

Critiques of psychiatry often characterize the discipline as the consequence of bad or biased science.[18] Science, however, is characterized by subjective, value-laden choices made at every step of the process, from data collection to experimental design and result interpretation.[19] Thus, it

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17. This Note defines "biological essentialism" similarly to how Angela Harris defines "gender essentialism" as "the notion that a unitary, 'essential' women's experience can be isolated and described independently of race, class, sexual orientation, and other realities of experience" and "racial essentialism" as "the belief that there is a monolithic 'Black Experience.'" Angela P. Harris, Race and Essentialism in Feminist Legal Theory, 42 Stan. L. Rev. 581, 585–88 (1990). Specifically, this Note understands biological essentialism as the notion that there is essential human bodymind that can be isolated and described under a value-neutral empirical analysis. "[B]odymind refers to the inextricable nature of body and mind, insisting that one impacts the other and that they cannot be understood or theorized as separate." Sami Schalk, Black Disability Politics 15 (2022). The term "bodymind" was first coined by Margaret Price and expanded upon by Sami Schalk. Id. This Note uses "bodymind" because "the separation of the body and the mind, also referred to as the *Cartesian dualism*, has been used against people of color and women to claim that we are primarily or exclusively controlled (and therefore limited) by our bodies." Id. Bodymind is conceptually integral not only to disability justice broadly speaking but also to critical autism studies. See Nick Walker, Defining Neurodiversity, *in* Neuroqueer Heresies, supra note 11, at 53, 55 ("But *neuro-* doesn't mean *brain*, it means *nerve*. . . . [Thus] the *neuro-* in *neurodiversity* is . . . referring . . . to the entire nervous system—and, by extension, to the full complexity of human cognition and the central role the nervous system plays in the embodied dance of consciousness.").

18. See generally Thomas Szaz, The Myth of Mental Illness (1961) (arguing by relying upon a strict separation of mind and body that mental illnesses are not comparable to physical illness); Robert Whitaker, Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill (2002) (describing the history and pseudoscience of the treatment of the mentally ill in the United States). For more such critiques of psychiatry, see Nick Walker & Dora M. Raymaker, Toward a Neuroqueer Future: An Interview With Nick Walker, 3 Autism in Adulthood 5, 7 (2021) ("First, [we] need to be absolutely clear—in our own minds and in our written and spoken discourse—that [the pathological conception of Autism] is nothing more than institutionalized bigotry masquerading as science . . . ."); Benedict Cary, Dr. Thomas Szasz, Psychiatrist Who Led Movement Against His Field, Dies at 92, N.Y. Times (Sept. 11, 2012), https://www.nytimes.com/2012/09/12/health/dr-thomas-szasz-psychiatrist-who-led-movement-against-his-field-dies-at-92.html (on file with the *Columbia Law Review*) ("Dr. Szasz saw psychiatry's medical foundation as shaky at best, and his book hammered away, placing the discipline 'in the company of alchemy and astrology.'").

19. See Heather Douglas, Inductive Risk and Values in Science, 67 Phil. Sci. 559, 563–64 (2000) ("First, values (both epistemic and non-epistemic) play important roles in the selection of problems to pursue. Second, the direct use to which scientific knowledge is put in society requires the consideration of non-epistemic values. . . . Third, non-epistemic values place limitations on methodological options . . . ."); see also Michael Strevens, The Knowledge Machine: How Irrationality Created Modern Science 79 (2020) ("Science is

is not that a researcher's normative commitments can influence the research process but rather that a researcher cannot engage in the scientific method without relying on their normative commitments.[20] It is often the clarity of hindsight that allows the retrospective acknowledgement of how normative commitments informed the creation of dehumanizing hypotheses.[21] Once disproved, the sanctity of empirical objectivity is preserved by dismissing these hypotheses as pseudoscientific. This weaponization of pseudoscience thus allows for the continued conceptualization of science as an objective method of inquiry that must be protected from the erroneous and avoidable importation of bias.[22]

In other words, medical racism was not pseudoscience. Medical racism was the predictable consequence of letting people in positions of power tell stories about marginalized experiences under the veneer of scientific objectivity. Subjective hypotheses made by powerful groups about the legally subordinated, politically excluded, and socially ostracized other predictably lead to horrific abuses of power obscured behind notions of objectivity and perpetuated under the guise of evidence-based medicine, policy, and care. Psychiatry is not pseudoscience, but the stories told about Neurodivergent people are dehumanizing nonetheless.

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driven onward by arguments between people who have made up their minds and want to convert or at least to confute their rivals. Opinion that runs hot-blooded ahead of established fact is the life force of scientific inquiry.").

20. See Sandra Harding, Whose Science? Whose Knowledge? 81 (1991) ("[M]odern science has been constructed by and within power relations in society, not apart from them. . . . Even though there are no complete, whole humans visible as overt objects of study in astronomy, physics, and chemistry, one cannot assume that no social values, no human hopes and aspirations, are present in human thought about nature."); see also id. at 83–86 (refuting the conception of scientific fact and method as consisting only of formal statements and symbols that therefore do not absorb social values); Strevens, supra note 19, at 68 ("Scientists seeking to make sense of the evidence cannot be neutral. They must take a stand on whether the instrument is relaying the truth, on whether the theoretical assumptions hold. . . . They must resort to educated guesswork, and that makes scientific reasoning irreducibly, unavoidably . . . subjective."); Chris Wiggins & Matthew L. Jones, How Data Happened: A History from the Age of Reason to the Age of Algorithms 21 (2023) ("The critics of numerical statistics at the end of the Enlightenment well understood that data is profoundly artificial. . . . '[R]aw data is an oxymoron,' as all data collection comes through human choice about what to collect, how to classify, who to include and to exclude . . . ."); see also Stephen John, Why Science Isn't Objective, IAI News (July 26, 2021), https://iai.tv/articles/why-science-isnt-objective-auid-1846 [https://perma.cc/9UND-HM4C] ("There is no way at all of doing science which doesn't somehow prejudge or assume some ethical or political or economic viewpoint.").

21. See Medical Racism, Harv. Libr., https://library.harvard.edu/confronting-anti-black-racism/scientific-racism [https://perma.cc/Z63L-HAGE] (last visited Aug. 15, 2023) ("[P]romoters of anti-Black racism and white supremacy have co-opted the authority of science to justify racial inequality. A history of pseudoscientific methods 'proving' white biological superiority and flawed social studies used to show 'inherent' racial characteristics still influence society today.").

22. See Jonathan Metzl, The Protest Psychosis: How Schizophrenia Became a Black Disease, at xi–xvii (2010) (critiquing the influence of racial bias in the psychiatric definition schizophrenia while reinforcing its pathological conceptualization).

Though these theories may be refuted, how many people will we sacrifice between now and then when we continue to let the powerful dictate the "objective" narrative about those who they have made powerless?

B. *The Pathology Paradigm in Psychiatry*

Psychiatry relies on clinical observation of distress to statistically generate classes of cognitive impairments, thereby defining by negation the bounds of normal cognition.[23] This process, however, relies on a confounding normative commitment to biological essentialism, which provides a referential comparison group against which abnormal cognitive processes can be measured. To construct biological abnormality, psychiatry first asserts a meaningful distinction between rational and irrational distress[24] and second assumes that irrational distress can define the bounds of biologically abnormal cognitive processes.[25]

In other words, psychiatry assumes that society does not cause distress in biologically normal people, who are considered biologically normal at least in part because they are economically productive.[26] This assumption

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23. The DSM-V (that is, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)) does not define "normality." Rather, it defines a mental disorder as:

> [A] syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or development processes underlying mental functioning. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual as described above.

Dan J. Stein, Andrea C. Palk & Kenneth S. Kendler, What Is a Mental Disorder? An Exemplar-Focused Approach, 51 Psych. Med. 894, 895 tbl.3 (2021) (internal quotation marks omitted) (quoting Diagnostic and Statistical Manual of Mental Disorders 20 (5th ed. 2013))).

24. See id. (articulating that culturally approved distress is not a mental disorder).

25. See Stein et al., supra note 23, at 895 (defining "mental disorder" as a disturbance in cognition that reflects dysfunctional biological processes).

26. See Bruce M.Z. Cohen, Psychiatric Hegemony 80 (2016) ("[T]he [DSM-V] . . . states that '[t]he symptoms are associated with clinically significant distress or interference with work, school, or social activities, or relationships with others (e.g., avoidance of social activities; *decreased productivity and efficiency* at work, school, or home).'" (alteration in original) (quoting Diagnostic and Statistical Manual of Mental Disorders 172 (5th ed. 2013)). Thus, according to Cohen, "the prevailing ideological values of our time—for instance, to be productive and efficient in all aspects of our lives—[are] conceived through psychiatric discourse as a common sense mental health message." Id. See also Micha Frazer-Carroll, Mad World 86–87 (2023) ("Under Capitalism, being able to sell our labour is the *definition* of mental health, with 'work' being referenced almost 400 times in the DSM-5. . . . [T]he common denominator between almost all experiences categorized as Mental Illness is that they . . . diminish our productivity in work."). Though conceptions of "mental illness" are often associated with self-shame and suffering, journalist Micha Frazer-Carroll notes that "[w]hile suffering is often a *component* of Madness/Mental Illness, it is not a precursor. Even

permits the conclusion that if a person is distressed to the point of unproductivity, it is because that person—not society—is abnormal.[27] Thus, psychiatry's commitment to biological essentialism not only masks the role of the constructed sociopolitical environment in creating distress but depoliticizes it by characterizing that allegedly irrational distress as induced by biological abnormality.[28]

Biological normality, however, is a nebulous concept in the face of the chaotic uniqueness of biological organisms.[29] Regardless of its fiction, medicine routinely applies statistical analysis to observations of distress to construct its "objective" bounds.[30] Yet the words "normal," "normality," and "normalcy" only entered the English language in the 1840s,[31] coinciding with Adolphe Quetelet's 1844 importation of astronomical error law to the study of human characteristics at a population level.[32] Thus, normality is not as inevitable as many believe it to be.

In astronomy, error law was a mathematical technique applied to a series of biased measurements to establish the underlying true value of what was being measured.[33] Thus, when Quetelet applied error law to human physical characteristics, he similarly understood the normal value

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when people with particular mental experiences are not actually in distress – for example, someone who hears voices and sees it as a spiritual experience – their bodymind may still be categorized as 'ill', because these experiences often limit a person's ability to labour under capitalism." Id. at 86–87.

27. See Jennifer Helfand, Childhood Gaslighting: When Difference Receives a Diagnosis, Mad in Am. (Oct. 29, 2021), https://www.madinamerica.com/2021/10/childhood-gaslighting-when-difference-receives-diagnosis/ [https://perma.cc/8UL3-A4YW] ("At age twenty-five, therapy officially began with a psychiatrist who told me outright: 'Society is fine. You're the one with the problems.'").

28. Cohen, supra note 26, at 87 ("[T]he psychiatric discourse seeks to both depoliticize the fundamental inequalities and structural failings of capitalism as individual coping problems . . . .").

29. See Ernst Mayr, The Growth of Biological Thought 46 (1982) ("This uniqueness is true not only for individuals but even for stages in the life cycle of any individual, and for aggregations of individuals whether they be demes, species, or plant and animal associations.").

30. See Darrel A. Regier, Emily A. Kuhl & David J. Kupfer, The DSM-5: Classification and Criteria Changes, 12 World Psychiatry 92, 94 (2013) ("Throughout general medicine, conditions are frequently conceptualized on a continuum from 'normal' to pathological . . . .").

31. Lennard J. Davis, Enforcing Normalcy: Disability, Deafness, and the Body 24 (1995) ("The word 'normal' as 'constituting, conforming to, not deviating or differing from, the common type or standard, regular, usual' only enters the English language around 1840. (Previously, the word had meant 'perpendicular'; the carpenter's square, called a 'norm,' provided the root meaning.)"); see also Jenifer L. Barclay, The Mark of Slavery: Disability, Race, and Gender in Antebellum America 9 (2021) ("'[N]ormality,' 'norm,' and 'normalcy' entered the English language []in 1840, 1849, and 1857, respectively[].").

32. See Theodore M. Porter, The Rise of Statistical Thinking, 1820–1900, at 100 (1986) ("Quetelet announced in 1844 that the astronomer's error law applied also to the distribution of human features such as height and girth . . . .").

33. Id. at 95–96 (explaining the development of the normal distribution between 1755 and 1837).

to reveal the essential human type, the unmarred human form, or *l'homme moyen*.[34] Both Quetelet's early application of error law to human populations and his imported concept of *l'homme moyen* were widely influential. This influence extended to Francis Galton,[35] the founder of eugenics,[36] who applied error law concepts to cognition.[37]

Galton's logic followed a specific pattern. First, he identified a human characteristic that presumptively can be measured linearly.[38] Second, he measured a subset of the individuals within the population and used error law to generate the distribution of the relevant characteristic over the population, thus identifying the normal value in the distribution.[39] Third, he labeled the statistical average as the true *l'homme moyen* value for that characteristic, understood to represent the underlying essential type.[40] Fourth, deviance from the *l'homme moyen* value was seen as error: literally a flawed expression of the essential type.[41] The logical jump made in Galtonian reasoning is that deviation from normal represents error from the underlying essential type. This permits abnormality to be understood as disordered or dysfunctional rather than a less probable expression of the measured characteristic. The derivation of normality and abnormality from statistical analysis thus rests upon the essentialist conceptualization of *l'homme moyen*.[42]

Yet modern statistical thinking rejects this essentialist understanding of normality. For example, in statistical thermodynamics, normal values do not correspond to a real or true underlying quantity but instead represent

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34. Id. at 108 ("Quetelet's identification of live individuals with copies of statutes conveys . . . the way he viewed human diversity. . . . [The] conformity [of the soldiers' measurements] to the error curve was interpreted as implying that the distribution was a genuine product of error. The soldiers had been designed according to a uniform pattern, that of the average man.").

35. Id. at 139.

36. Id. at 129.

37. Id. at 141 ("[I]f the error curve expresses the distribution of [physical] stature, 'then it will be true as regards to every other physical feature—as circumference of head, size of brain, weight of grey matter, number of brain fibres, and [thus] . . . mental capacity.'" (quoting Francis Galton, Hereditary Genius: An Inquiry Into Its Laws and Consequences 31–32 (London, MacMillan & Co. 1869))).

38. Id. at 287 ("Given Galton's experience as a meteorologist and his readiness to perceive linear relationships, it is unsurprising that he should have begun by trying a linear formula.").

39. Id. at 144 ("The presumptive applicability of the error law implied that only two pieces of information need be known in order to characterize the distribution.").

40. Id. at 139 ("Despite his enthusiasm for the exceptional, Galton often used the error curve precisely in the fashion developed by Quetelet . . . , as a definition of type.").

41. Id. at 130 ("[Galton] firmly believed that men are not 'of equal value, as social units, equally capable of voting, and the rest.'" (quoting Francis Galton, Hereditary Improvement, Fraser's Mag., Jan. 1873, at 116, 127)).

42. Language indicating that there is no "hard cut off" between normality and abnormality similarly reflects Galton's line of reasoning, in which distribution of a characteristic is continuous, not discontinuous.

the most probable state of the measured characteristic.[43] Thus, the use of statistics to define ranges of "normal biological function" is logically consistent only within the Galtonian regime. Under modern statistical thinking, the statistically calculated normal cannot define abnormality, disorder, or dysfunction.[44] Just because a certain cognitive function *is* common in a population does not mean that all human cognition *ought* to function that way. Further, the statistical construction of normality is empirically inconsistent with modern biology.[45] For example, the key conceptual advance in evolution was the rejection of biological essentialism,[46] including essential type in species, in favor of acknowledging the complete uniqueness of biological organisms.[47]

The psychiatric designation of "classes" of symptomatology that designate distinct disordered pathologies characterizes the statistically generated type as a real psychopathology rather than a manmade abstraction.[48] Only in accepting Galtonian reasoning can a psychiatrist name a statistically generated abnormality as a pathology subject to diagnosis and cure.[49]

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43. Porter, supra note 32, at 128 ("The second law of thermodynamics was equivalent to a tendency for a system of molecular velocities to approach its most probable state, the Maxwell-Boltzmann distribution . . . .").

44. Id.

45. Mayr, supra note 29, at 47 ("For instance, [a person] who does not understand the uniqueness of individuals is unable to understand the working of natural selection."). However, not only is the notion that there is a human type that is "fit" and thus closer to the human ideal blatantly racist, sexist, and ableist—it also requires the inaccurate presumption that the environment is static, constant, or unchanging.

46. Id. Regardless, even today essentialism remains a dominant, widespread, confounding framework. See id. at 38 (noting how historians of ideas have yet to appreciate the full extent to which essentialism dominated Western thinking "with its emphasis on discontinuity, constancy, and typical values"); see also Harris, supra note 17, at 589 ("Why, in the face of challenges from 'different' women . . . is feminist essentialism so persistent and pervasive?").

47. Mayr, supra note 29, at 46.

48. Id. at 47 ("[D]ifferences between biological individuals are real, while the mean values which we may calculate in the comparison of groups of individuals . . . are manmade inferences.").

49. DSM is fundamentally a statistical project with origins in data collected from the federal census. Gerald N. Grob, Origins of DSM-I: A Study in Appearance and Reality, 148 Am. J. Psychiatry 421, 424 (1991). It is more than just data aggregation, however; these statistical analyses influenced the development of distinct identifiable mental illnesses:

> Toward the close of the [nineteenth] century . . . interest in psychiatric nosology reawakened. . . . Emil Kraepelin in particular singled out groups of signs as evidencing specific disease entities . . . . Studying thousands of patients at his clinic in Heidelberg, Kraepelin identified the disease entity in terms of its eventual outcome. Dealing with a large mass of data, he sorted out everything that individuals had in common, omitting what he regarded as purely personal data. In this respect he diverted attention away from the unique circumstances of individuals toward more general and presumably universal disease entities. In so doing, he was simply emulating a distinct trend in medical thinking in general.

Regardless, psychiatry relies on statistical distributions in conjunction with economic-functioning expectations to establish the bounds of what constitutes abnormality.[50] When observable difference in cognitive function conflicts with economic-functioning expectations, that difference is conceptualized by way of metaphor to pathology, nosology, or disease such that it is understood as a pathological abnormality that corrupts or infects the underlying "normal" cognitive function, or the *l'homme moyen* of thinking.[51] The conceptualization of difference as disorder and of divergent cognition as psychopathology is the conceptual framework of the pathology paradigm.[52]

Empirical reasoning within the pathology paradigm leads to a positive feedback loop due to the effect of pathological framing. Specifically, external observers begin research expecting to find abnormality, then measure differences in structure or function, which they then presumptively interpret as abnormal or pathological.[53] However, observation of difference neither implies nor necessitates the orientation of differences into states of normality and abnormality.

C. *The Pathology Paradigm in Disability Law*

Traditionally, disability is conceptualized under different models, including the medical model of disability and the social model of disability.[54] A simple way to understand the need for a model of disability

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Id. at 423 (footnote omitted).

50. Id. at 422 ("Nineteenth-century American psychiatrists were deeply committed to the collection and analysis of such [quantitative] data. In their eyes, statistical inquiry could shed light on recovery rates, uncover the laws governing health and disease, . . . and enhance the legitimacy of both their specialty and their hospitals . . . .").

51. See Regier et al., supra note 30, at 97 ("By continuing collaboration with the [World Health Organization] in future editions of the DSM, we can assure a more comparable international statistical classification of mental disorders and move closer to a truly unified nosology and approach to diagnosis.").

52. The term "pathology paradigm" was first coined by psychology professor Nick Walker. See Walker, Liberating Ourselves, supra note 11, at 16. Walker defined the pathology paradigm as including two fundamental assumptions:

> There is one "right," "normal," or "healthy" way for human brains and human minds to be configured and to function . . . , [and second that if] your neurological configuration and functioning (and, as a result, your ways of thinking and behaving) diverge substantially from the dominant standard of "normal," then there is Something Wrong With You.

Id. at 18.

53. See Stein et al., supra note 23, at 898 ("In the case of Gender Dysphoria, there is some preliminary evidence of neuroanatomical differences between transgender and cisgender persons which may arguably indicate underlying dysfunction.").

54. See generally Routledge Handbook of Disability Law and Human Rights (Peter Blanck & Eilionóir Flynn eds., 1st ed. 2016) (detailing different models of disability and their conceptual development).

is to reframe discussions on disability using the active voice.[55] "I am disabled" becomes "something disables me," in which the model of disability identifies the disabling agent.[56] For example, the medical model identifies abnormal biology as the disabling agent,[57] whereas the social model identifies exclusionary design of physical, economic, and social landscapes as the disabling agents.[58] Thus, the medical model characterizes disability as individual and biologically inevitable, whereas the social model characterizes disability as socially constructed and malleable.

Because many Neurodivergent people are Disabled,[59] it may appear that the pathology paradigm is rooted within the medical model of disability. Within this reasoning, rejecting the medical model of disability in favor of the social model would appear to effectively reject the pathologization of bodymind nonnormativity.[60] But even though the social model places the cause of exclusion within the landscape rather than within the bodymind, it does not reject the statistical construction of a biological "normal."[61] Without rejecting the statistical construction of the Galtonian normal, the social model of disability is of little use to Neurodivergent people,[62] including in the context of psychiatric

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55. Marta Rose (@divergent_design_studios), Instagram (June 23, 2020), https://www.instagram.com/p/CBx0W5sBJtN/?img_index=1 (on file with the *Columbia Law Review*) ("We can re-diagram the sentence [we are disabled] to include implied actors i.e. those doing the disabling. Of course, that raises the complicated question of who [is] responsible for our disability.").

56. Id.

57. See Jamelia N. Morgan, Policing Under Disability Law, 73 Stan. L. Rev. 1401, 1406 (2021) ("The medical model of disability frames disability as an 'individual medical problem'—a succinct description I adopt from Elizabeth Emens. Michael Ashley Stein writes that the medical model 'views a disabled person's limitations as naturally (and thus, properly) excluding [them] from the mainstream.'" (footnotes omitted) (first quoting Elizabeth F. Emens, Framing Disability, 2012 U. Ill. L. Rev. 1383, 1401; then quoting Michael Ashley Stein, Same Struggle, Different Difference: ADA Accommodations as Antidiscrimination, 153 U. Pa. L. Rev. 579, 599 (2004))).

58. See Elizabeth F. Emens, Framing Disability, 2012 U. Ill. L. Rev. 1383, 1401 ("[T]he social model understands disability to inhere in the interaction between an individual's impairment and the surrounding social context.").

59. However, not all Neurodivergent people are Disabled, such as synesthetes. Walker, Neurodivergence & Disability, supra note 12, at 70.

60. See Morgan, supra note 57, at 1401 ("Rather, I maintain that rejecting the medical model requires rejecting a view of disability focused on curing, controlling, or containing individuals in mental crisis—those with minds labeled as non-normative, deviant, disordered, or pathological.").

61. See Emens, supra note 58, at 1401 ("The social model does not necessarily reject the idea of biological impairment—in the sense of variations from a value-neutral idea of . . . normal functioning . . . . Even if one accepts some impairments as inherently undesirable, the social model shifts the focus . . . to the ways that the environment renders that variation disabling.").

62. Therí Alyce Pickens articulates the ineffectiveness of the social model without reverting to or reaffirming bioessentialist medical models:

incarceration.[63] Critiquing the social model of disability, however, does not require abandoning the social construction of both disability and impairment.[64]

Absent the full rejection of biological essentialism, both medical and social models of disability prevent full recognition of the historical co-construction of disability and race.[65] In the dichotomous construction of

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> The social model privileges a particular kind of mental agility and cognitive processing to combat the stigma and material consequences that arise as a result of ableism. In turn, the model dismisses madness as a viable subject position, ensuring that those counted as such—either by communal consensus or psy-disciplines—remain excluded from conversations about disability because they cannot logically engage.

Therí Alyce Pickens, Black Madness :: Mad Blackness 32 (2019).

63. See Essya M. Nabbali, A "Mad" Critique of the Social Model of Disability, 9 Int'l J. Diversity Orgs. Cmtys. & Nations, no. 4, 2009, at 1, 7 ("[The social model] is pallid, even empty, when addressing the convoluted systems of risk management which culminate in the forced deprivation of liberty occasioned by civil commitment and mandatory outpatient treatment[,] . . . [and] it fails to offer a well-founded stance against the said need[]of psychiatric intervention.").

64. Harding, supra note 20, at 134 (articulating that "the world as an object of knowledge is and will always remain socially constructed," where the socially constructed world includes the bodymind and conceptions of impairment and disorder applied to the bodymind). Further, conceptualizing disability as socially constructed does not mean that a person cannot be limited by their bodymind. It merely reflects the observation that there is no correct way to be, exist, or function. A person can be limited by their bodymind without saying that their bodymind is wrong for working in a way it does not currently work. Further, the constructed nature of disability does not mean that disability, suffering, or limitation is "not real" or that under the correct circumstances suffering, limitation, or difference would be eliminated.

65. Pickens grapples with the interstices of disability and race in the following illustrative quote:

> Historically speaking, the creating of disability, race, and gender occurs at the same time. The strands of what would become modern medicine worked to differentiate bodies from each other, specifically normal bodies from abnormal ones, where abnormal was constituted in gendered, raced and abled terms. These fantasies of identification found their justification in what [Ellen] Samuels terms 'biocertification," a process that further links the construction of abnormality (and with it the construction of Blackness and disability) to objective science, aspiring to some semblance of truth. What becomes clear is not just that one cannot read race without disability nor disability without race, but that their entanglement requires a robust critical armature that grapples with them both.

Pickens, supra note 62, at 25 (footnote omitted) (quoting Ellen Samuels, Fantasies of Identification: Disability, Gender, Race 9 (2014)); see also Ben-Moshe, supra note 4, at 25 ("Race is coded in disability, and vice versa. It's impossible to untangle antiblack racism from processes of pathologization, ableism, and sanism. . . . [W]omen of color are already understood as mentally unstable."); id. at 28 ("[A]ntiblack racism is composed of pathologization and dangerousness, which lead to processes of criminalization and disablement, for instance, constructing people as Other or as deranged, crazy illogical, unfathomable, or scary."). Pickens further complicates a linear or comparative construction, rejecting conceptualizations where Blackness is characterized as analogous to or indistinguishable from Madness. Id. at 3 ("I theorize that [M]adness (broadly defined) and

race, "Whiteness exists not only as the opposite of non-Whiteness, but as the superior opposite . . . [such that] [f]or each negative characteristic ascribed to people of color, an equal but opposite and positive characteristic is attributed to Whites."[66] However, the orientation of difference into states of superiority and inferiority is accomplished by invoking stigmatizing disability imagery,[67] in which "[B]lackness [is tethered] to disability, defectiveness, and dependency and whiteness to normality, wholeness, vitality, and rationality."[68] Failure to recognize the constructed nature of the Galtonian normal can hide the Disabled social identity behind the illusion of factually immutable biological impairment, obscuring the role of ableism in perpetuating anti-Black racism and of racism in perpetuating ableism.[69]

By contrast, in recognizing disability as entirely socially constructed, lawyer Talila Lewis captures the intertwined nature of ableism and racism:

> [Ableism is] [a] system that places value on people's bodies and minds based on societally constructed ideas of normality, intelligence, excellence, desirability, and productivity. These constructed ideas are deeply rooted in anti-Blackness, eugenics, misogyny, colonialism, imperialism and capitalism.
>
> This form of systemic oppression leads to people and society determining who is valuable and worthy based on a person's language, appearance, religion and/or their ability to satisfactorily [re]produce, excel and "behave."
>
> You do not have to be disabled to experience ableism.[70]

Failure to reject the pathology paradigm obscures knowledge held in Black disabled voices like Lewis's.[71] Further, anything less than the rejection of normality and the associated metaphor of psychopathology

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Blackness have a complex constellation of relationships. These relationships between Blackness and [M]adness (and race and disability more generally) are constituted within the fissures, breaks, and gaps . . . .").

66. Ian F. Haney López, White by Law: The Legal Construction of Race 28 (1996) (emphasis omitted).

67. Barclay, supra note 31, at 9 ("Disability's power to stigmatize [is] derived from its . . . ability to rationalize inequality based on one's real or imagined proximity to [biologically "objective" abnormality].").

68. Id. at 1.

69. See id. at 8 ("[M]any of the most deeply offensive racial stereotypes and caricatures involve obvious associations with physical or mental disabilities[.]"); Imani Barbarin (@crutches_and_spice), Instagram (Nov. 17, 2022), https://www.instagram.com/p/ClEklZmDmjc/ (on file with the *Columbia Law Review*) ("A lot of you let your ableism fly free, because it allows you the chance to be racist with no consequences.").

70. Talila A. Lewis, January 2021 Working Definition of Ableism, TL's Blog (Jan. 1, 2021), https://www.talilalewis.com/blog/january-2021-working-definition-of-ableism [https://perma.cc/2HH9-RWBV] (last alteration in original).

71. See Lauren Melissa Ellzey (@autienelle), Instagram (Sept. 13, 2021), https://www.instagram.com/p/CTw_OiAAtju/?hl= (on file with the *Columbia Law Review*) ("The ableism present in BIPOC spaces and the racism that pervades autistic spaces rests upon the false separation of disability and race. The intersection of race and disability must be named and incorporated in order for there to be disability and/or racial justice.").

permits the perpetuation of at least systemic racism, ableism, sexism, antisemitism, and cisheteronormativity. These systems of oppression are not discrete but instead weave together to create an interlocking web of power dynamics.[72] Within this web, failing to recognize any form of oppression or power, including the socially constructed nature of disability, confounds meaningful progress in totality.

II. THE PATHOLOGY PARADIGM IN LAW GOVERNING PSYCHIATRIC INCARCERATION

To demonstrate the pervasive legal acceptance of the pathology paradigm, section II.A first defines the causal relationship between the pathology paradigm and legal competence and then maps this causal relationship in statutes authorizing psychiatric incarceration. Section II.B then explores the human costs of statutory reliance on the pathology paradigm at different intersecting oppressions in carceral psychiatry. Finally, section II.C demonstrates how the pathology paradigm acts as a restrictive framework in legal and policy discussions surrounding the scope of psychiatric incarceration and its associated ethical and normative dimensions.

A. *Statutory Reliance on the Pathology Paradigm*

> *"I also know I am not free. I have a note on my medical records that makes me less free. If freedom is a real thing, I am less free because I cannot get angry, sad, or frustrated. I cannot call out anyone with power over me or be myself for fear of retribution in the form of incarceration in a psychiatric institution."*
>
> — Karin Jervert.[73]

All fifty states and the District of Columbia have statutes authorizing psychiatric incarceration that pervasively, uncritically, and unquestionably

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72. Harris, supra note 17, at 587 ("Feminists have adopted the notion of multiple consciousness as appropriate to describe a world in which people are not oppressed only or primarily on the basis of gender, but on the bases of race, class, sexual orientation, and other categories in inextricable webs."); see also Tiffany Hammond (@fidgets.and.fries), Instagram (Jan. 8, 2023), https://www.instagram.com/p/CnKHE_6uLNI/?utm_source=ig_web_copy_link&igshid=MzRlODBiNWFlZA== (on file with the *Columbia Law Review*) ("White advocates will often treat Intersectionality as if it were the hoarding of oppressed identities and not the exploration of how these experiences are interconnected . . . . It is about asking . . . questions . . . that will lead to the revealing of how discrimination operates within the experience that overlapping identities create.").

73. Karin Jervert & Marnie Wedlake, Loss, Grief, and Betrayal: Psychiatric Survivors Reflect on the Impact of New Serotonin Study, Mad in Am. (Aug. 9, 2022), https://www.madinamerica.com/2022/08/psychiatric-survivors-reflect-serotonin-study/ [https://perma.cc/C7KX-WNSU].

absorb the pathology paradigm.[74] Each statute falls into one of three categories. Thirty-one states justify carceral treatment and psychiatric incarceration based on mental-illness-impaired judgment, reason, or perception of reality and on dangerousness to the self or others.[75] Six states justify only outpatient carceral treatment based on mental-illness-impaired judgment, reason, or perception of reality and on dangerousness.[76] These six states justify inpatient psychiatric incarceration based on dangerousness alone.[77] The remaining thirteen states and the District of Columbia do not explicitly reference mental-illness-impaired judgment, reason, or perception of reality, justifying psychiatric incarceration and outpatient carceral treatment based only on dangerousness.[78]

Statutes that justify carceral treatment or psychiatric incarceration based on mental-illness-induced irrationality proceed in the following

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74. See Treatment Advoc. Ctr., State Standards for Civil Commitment (2020), https://www.treatmentadvocacycenter.org/storage/documents/state-standards/state-standards-for-civil-commitment.pdf [https://perma.cc/94KD-2ZLP].

75. Alabama, Alaska, Arkansas, Colorado, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Texas, Utah, Vermont, and Wisconsin. See Ala. Code §§ 22-52-10.1 to -10.2 (2022); Alaska Stat. § 47.30.915(17) (2022); Ark. Code Ann. § 20-47-207(c) (2009); Colo. Rev. Stat. § 27-65-101 (2022); Del. Code tit. 16, § 5011(a) (2014); Fla. Stat. Ann. § 394.4655(2) (West 2016); Idaho Code § 66-317(11)–(12) (2023); 405 Ill. Comp. Stat. Ann. 5/1-119(3)(ii), -119.1 (West 2023); Ind. Code Ann. §§ 12-26-7-5(a), -7-2-96(2) (West 2023); Iowa Code §§ 229.1(21), .13(1) (2023); Kan. Stat. Ann. § 59-2946(f)(1)–(2) (West 2023); La. Stat. Ann. § 28:2(13) (2023); Mich. Comp. Laws Ann. § 330.1401(1)(a)–(c) (West 2023); Minn. Stat. § 253B.02(17)(a) (2022); Miss. Code Ann. § 41-21-61(f) (2023); Mo. Ann. Stat. § 632.005(10)(a)-(b) (West 2023); Mont. Code Ann. § 53-21-102(9)(a) (West 2021); Neb. Rev. Stat. §§ 71-907, -925 (2023); Nev. Rev. Stat. Ann. § 433A.0175(1)(b) (West 2023); N.H. Rev. Stat. Ann. § 135-C:2(X) (2023); N.J. Stat. Ann. § 30:4-27.2(r) (West 2023); N.C. Gen. Stat. § 122C-3(11)(a)(1)(I)–(II) (2023); N.D. Cent. Code § 25-03.1-02(12) (2023); Ohio Rev. Code Ann. §§ 5122.01(A), .10(A)(1) (2023); Okla. Stat. tit. 43A, § 1-103(13)(a) (2023); 40.1 R.I. Gen. Laws § 40.1-5-2(7) (2023); S.C. Code Ann. §§ 44-17-580(A)(1), -23-10(7) (2023); Tex. Health & Safety Code Ann. §§ 574.034(a)(2)(C)(iii), .0345(a)(2)(D)(ii) (West 2023); Utah Code §§ 26B-5-332(16)(a)(iii), -351(14)(c)(i) (2023); Vt. Stat. Ann. tit. 18, § 7101(17) (2023); Wis. Stat. & Ann. § 51.20(2)(c) (2023).

76. Georgia, Hawaii, Kentucky, Oregon, Virginia, and Wyoming. See Ga. Code Ann. § 37-3-1(12.1) (2022); Haw. Rev. Stat. Ann. § 334-121(2) (West 2023); Ky Rev. Stat. Ann. § 202A.0815(3)(b) (West 2023); Or. Rev. Stat. § 426.133(2) (West 2023); Va. Code Ann. § 37.2-817.01(B) (2023); Wyo. Stat. Ann. § 25-10-110.1(b)(2023).

77. Ga. Code Ann. § 37-3-1(9.1); Haw. Rev. Stat. Ann. § 334-60.2; Ky. Rev. Stat. Ann. § 202A.026; Or. Rev. Stat. §§ 426.005(1)(f), .130(1); Va. Code Ann. § 37.2-817(C); Wyo. Stat. Ann. § 25-10-101(a).

78. California, District of Columbia, Georgia, Maine, Maryland, Massachusetts, New Mexico, New York, Ohio, Pennsylvania, South Dakota, Tennessee, Washington, and West Virginia. See Cal. Welf. & Inst. Code § 5250 (2023); D.C. Code § 21-545(b)(2) (2023); Me. Rev. Stat. Ann. tit. 34-B, § 3864(6)(A)(1) (West 2023); Md. Code Ann., Health–Gen. § 10-632(e)(2) (West 2023); Mass. Gen. Laws Ann. ch. 123, § 8(a) (West 2023); N.M. Stat. Ann. §§ 43-1-11(E), 43-1B-3 (2023); N.Y. Mental Hyg. Law §§ 9.37, .60 (McKinney 2023); 50 Pa. Stat. & Cons. Stat. Ann. § 7304(a)(1) (West 2023); S.D. Codified Laws § 27A-1-2 (2023); Tenn. Code Ann. § 33-6-502 (2023); Wash. Rev. Code Ann. § 71.05.153(1) (West 2023).

manner. First, these statutes establish a state of abnormality—mental illness. Second, they attach the abnormality to an undesirable outcome—suicide, homicide, or grave poverty—such that the way to resolve the poor outcome is to return the abnormal to a state of normality. Third, they create a causal link between the abnormality and rationality so as to attribute any rejection of offered treatment to the abnormality rather than to the expression of reasoned preference. Through this structure, these statutes justify a coercive override of autonomy under the guise of rational care.

In Alabama, for example, the statute permitting psychiatric incarceration establishes the state of abnormality by requiring that "the respondent has a mental illness."[79] The statute then attributes suicide, homicide, or grave poverty to the abnormality: "[*A*]*s a result of* the mental illness, the respondent poses a real and present threat of substantial harm to self or others."[80] Additionally, it asks whether "the respondent . . . [will] continue to experience deterioration of the ability to function independently."[81] Finally, it causally links the presence of abnormality to irrationality: "The respondent *is unable to make a rational and informed decision* as to whether or not treatment for mental illness would be desirable."[82]

Statutes that authorize either inpatient psychiatric incarceration or outpatient carceral treatment rely on a variety of phrasings to link abnormality to irrationality. Many states focus on impaired capacity to reason, such that "mental illness" causes an individual to be "incapable of making informed decisions,"[83] "unable to engage in a rational decision-making process,"[84] or "unable to make a rational and informed decision."[85] Other statutes link abnormality to the individual's cognitive capacity, dictating that an individual may be subject to psychiatric incarceration if the individual "lacks sufficient insight or capacity to make responsible decisions,"[86] if there is an "obvious deterioration of that individual's judgment, reasoning, or behavior,"[87] or if the individual "is unable to determine for himself or herself whether services are necessary."[88] Similarly, the abnormality may be conceptualized as limiting or negating a person's "capacity to exercise self-control, judgment and

79. Ala. Code § 22-52-10.4(a)(1).
80. Id. § 22-52-10.4(a)(2) (emphasis added).
81. Id. § 22-52-10.4(a)(3).
82. Id. § 22-52-10.4(a)(4) (emphasis added).
83. Colo. Rev. Stat. § 27-65-102(17) (2023).
84. Kan. Stat. Ann. § 59-2946(f)(2) (West 2023).
85. Tex. Health & Safety Code Ann. § 574.034(a)(2)(C)(iii) (West 2023).
86. S.C. Code Ann. § 44-17-580(A)(1) (2023).
87. Ind. Code Ann. § 12-7-2-96(2) (West 2023).
88. Fla. Stat. Ann. § 394.4655(2)(f) (West 2023).

discretion"[89] or impeding a "mentally ill" person's "capacity to knowingly and voluntarily consent."[90]

In other states, the reference to rationality is more brazen, where statutes connect "mental illness" directly to the recognition and perception of reality. For example, a person may be subject to psychiatric incarceration when mental illness "grossly impairs judgment, behavior, or capacity to recognize and adapt to reality,"[91] "grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand,"[92] or "significantly impairs judgment, capacity to control behavior, or capacity to recognize reality."[93] Other states permit psychiatric incarceration when mental illnesses cause "grossly disturbed behavior or faulty perceptions"[94] or confound "the ability to perceive reality or to reason . . . [and cause] extremely abnormal behavior or extremely faulty perceptions."[95]

In Arizona, the consequence of the connection between abnormality and irrationality becomes apparent. The relevant statute dictates that "a person who has a mental disorder" may be subject to psychiatric incarceration when "the[ir] judgment . . . is so impaired that the person is unable to understand the person's need for treatment."[96] The decision about the individual's need for treatment has already been made, and abnormality will be found regardless in order to justify psychiatric incarceration.[97] To reject handcuffed "care" is to be irrational, and once labeled abnormal, the only path to restore autonomy is near-total compliance.[98] Thus, under these state statutes, the illusion of voluntary treatment hides the reality that there was never a choice at all. In practice, however, the illusion of choice is laced with the threat of violence, in which "many so-called 'voluntary' patients will consent to things only because

89. Nev. Rev. Stat. Ann. §433A-0175.1(b) (West 2023).

90. Del Code tit. 16, § 5011(a)(4) (2023).

91. Idaho Code § 66-317(11) (2023).

92. Minn. Stat. § 253B.02.17(1) (2023); see also Miss. Code Ann. § 41-21-61(f) (2023) (using the same definition of mental illness as Minnesota).

93. N.J. Stat. Ann. § 30:4-27.2.r (West 2023).

94. Miss. Code Ann. § 41-21-61(f).

95. N.H. Rev. Stat. Ann. § 135-C:2(X) (2023).

96. Ariz. Rev. Stat. Ann. § 36-501.8 (2023).

97. William M. Brooks, The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process, 86 N.D. L. Rev. 259, 278–79 (2010) ("The psychiatrist who wishes to pay lip service to the law . . . can always assert enough symptoms of mental illness or factors relating to harm-causing behavior . . . knowing the court system will rarely second guess [their] determination.").

98. See Palter v. City of Garden Grove, 237 F. App'x 170, 172 (9th Cir. 2007) (demonstrating how once abnormality is presumed, there is nothing a person can do to effectively counter that accusation without submitting to a coercive psychiatric examination).

they know that if they don't, they could be labeled 'noncompliant' and face even worse abuse."[99]

In states with outpatient carceral treatment or inpatient psychiatric incarceration statutes that do not reference rationality, judgment, or reason, coercive care is justified solely on dangerousness to the self or others. However, no matter how many times a person injures themselves downhill mountain biking, they may continue to ride at the detriment to their health without state intervention. Thus, even in the states that do not justify psychiatric incarceration on "mental-illness"-induced irrationality, the pathology paradigm's causal link between abnormality, irrationality, and dangerousness remains quite damning.

As soon as a person receives a psychiatric label, their freedom to reject treatment, direct treatment course, and change treatment providers all vanish. By comparison, absent a psychiatric label, the presence of an illness or injury does not result in surveillance or restriction of freedom of movement regardless of consequence.[100] For example, if a person has cancer, they remain free to completely reject treatment, even if doing so directly results in death. Thus, even if the black letter of the statute does not explicitly articulate that "mental illness" confounds a person's capacity to reason, there remains a strong implicit presumption of irrationality that justifies an autonomy-overriding paternalistic intervention.

B. *The Human Costs of Legal Reliance on the Pathology Paradigm*

There is perhaps not a place more evident of the presumption of irrationality and thus discrepancy between care received under a psychiatric label and care for other diseases, illnesses, or injuries than in Leah Ashe's story, which she documents in *From Iatrogenic Harm to Iatrogenic Violence: Corruption and the End of Medicine*. Published posthumously, Ashe's article documents the events that occurred upon the transmutation of a Crohn's disease diagnosis to that of an eating disorder.[101] After being admitted to a hospital for a chronic illness, a single medical note made by nurses who confused "explosions of diarrhea for an episode of bulimic vomiting" transformed the course of Ashe's treatment.[102] Despite Ashe's begging for real food, doctors declared she

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99. Maggie (@thebooksmartbimbo), Instagram (June 23, 2022), https://www.instagram.com/p/CfKsS8cM_2A/?utm_source=ig_web_copy_link&igshid=MzRlODBiNWFlZA== (on file with the *Columbia Law Review*); see also Eric Garcia, We're Not Broken: Changing the Autism Conversation 85 (2021) ("They stood behind me with guns and said, 'We can do this the easy way or the hard way.' And I cheerfully signed myself in voluntarily.").

100. Developments in the Law, Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1194 (1974) ("Equally important, . . . a physically ill individual is ordinarily permitted to choose whether to seek medical attention and is protected in this right by common law tort doctrines . . . .").

101. Leah M. Ashe, From Iatrogenic Harm to Iatrogenic Violence: Corruption and the End of Medicine, 28 Anthro. & Med. 255, 258 (2021).

102. Id. at 260.

be force fed, all while denying her treatment for her chronic illness.[103] While psychiatrically incarcerated, Ashe experienced sepsis, hospital-acquired pneumonia, and cardiac arrest.[104] Once psychiatrically labeled, her care transformed from treatment to punishment, cooperative to combative, and healing to harming. Here, the bifurcation of carceral and noncarceral care demonstrates how, in psychiatry, "care" is merely punishment rebranded.

Medical professionals, however, are not the only people whose testimony overrides the credibility of a psychiatrically labeled person. As writer, mental health advocate, and Depressed While Black founder Imadé Nibokun describes, when Cards Against Humanity writer Nicholas Carter questioned his white coworkers' inclusion of the n-word in the card game, they interpreted his antiracist advocacy as mental instability.[105] Carter was subject to psychiatric incarceration on the basis that his "co-workers' account of his mental state was considered 'more reliable collateral' than Carter's own perspective as a Black man."[106]

Racialized people, queer people, transgender people, Autistic people, and people who hold multiple marginalized identities are particularly susceptible to erroneous psychiatric labeling. For example, attorney Gabriel Arkles describes the experience of a Black transgender client subject to psychiatric incarceration in which "his gender identity was treated like a delusion and his fear and distrust of police was treated like

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103. Id. at 263.

104. Id. at 261.

105. Imadé Nibokun, "Cards Against Humanity" Writer Says He Was Forced Into a Psych Ward After Speaking Up About Racism, The Mighty (July 8, 2020), https://themighty.com/topic/mental-health/cards-against-humanity-writer-psych-ward [https://perma.cc/8XJF-CBRS]; see also Nicholas Carter, How to Know You Are Not Insane (And How a Cards Against Humanity Staff Writer Was Fired), Medium (June 25, 2020), https://medium.com/@nicolas.j.carter/how-to-know-youre-not-insane-and-how-a-cards-against-humanity-staff-writer-was-fired-40fe07fbbfe4 [https://perma.cc/MX4P-JL9R]. There is a "deeply troubling history of pitting the categories of disability and race against one another." Barclay, supra note 31, at 8. This Note does not follow in that tradition. Rather, the Note invites all nondisabled people to reflect on how their privileged nondisabled identity interoperates with their other privileged and marginalized identities.

106. Naming how psychiatric incarceration of Black people mimics historical patterns of racism, Nibokun articulates:

> He should not have been told that living freely as a Black man is a mental illness over a hundred years after white southern physicians did the same. We need a mental health system where Carter can be treated as the expert of his own experiences. If we look beyond psychiatric jails and policing, we'll discover that what heals Black people is within Black people.

Nibokun, supra note 105. Further, the weaponization of psychiatric labels to silence, incarcerate, and debilitate Black men is no new occurrence. Black men are four times more likely to receive a schizophrenia diagnosis than their white counterparts; the backlash to the Civil Rights Movement transformed the conceptualization of the diagnosis. See Metzl, supra note 22, at xv. Before the Civil Rights Movement, schizophrenia was associated not with violence but rather with docile white femininity. Id.

paranoia."[107] Here, the institution of psychiatry relied on the veneer of a "biologically objective" disability status to perpetuate racism and transphobia. Gloria Oladipo, breaking news writer for the *Guardian*,[108] describes her experience as a Black woman seeking mental health care as "betrayal."[109] Despite knowing she was struggling with OCD and an eating disorder, mental health professionals construed her eating disorder as bipolar "disorder" and construed her distress due to changing circumstances as paranoid personality "disorder."[110] Oladipo, the expert on her own experiences, identified what professionals did not, in large part because "[m]ental health professionals don't know how to diagnose Black people."[111] The institution of psychiatry, marred by a long and still-present history of racism, remains ill equipped to stand in as an authority on the experiences of Black people.

Built on the bedrock of ableism and sanism,[112] psychiatry is similarly ill equipped to stand in as an authority on the experiences of Neurodivergent people. For example, Autistic people also receive a litany of misdiagnoses because of a pervasive misunderstanding of how masked autism presents in adults, especially in psychiatric settings.[113] Carrie Beckwith-Fellows remained unsupported within various mental health

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107. Gabriel Arkles, Gun Control, Mental Illness, and Black Trans and Lesbian Survival, 42 Sw. L. Rev. 855, 893 (2013) ("The police perceived him as an emotionally disturbed Black butch lesbian, cuffed him, and took him to a psychiatric emergency room. Once committed, he experienced pathologization, in that his gender identity was treated like a delusion and his fear and distrust of police was treated like paranoia.").

108. Gloria Olapido, The Guardian, https://www.theguardian.com/profile/gloria-oladipo [https://perma.cc/E3DW-BKF2] (last visited Aug. 17, 2023).

109. Gloria Olapido, Black People Like Me Are Being Failed by the Mental Health System. Here's How, Healthline (July 2, 2019), https://www.healthline.com/health/racism-mental-health-diagnoses [https://perma.cc/8YX6-766K].

110. Recounting her own experiences, Olapido articulates:

> My eating disorder was diagnosed as adjustment disorder. My moodiness, a direct result of malnutrition, was mistaken for a serious chemical imbalance—bipolar disorder—and a reaction to a stressful life change.
>
> My OCD . . . became paranoid personality disorder.
>
> I'd opened up about some of the greatest secrets in my life only to be called "paranoid" and "maladjusted."

Id.

111. Id.

112. This Note defines "sanism" as the subordination, exclusion, and dismissal of people and knowledge deemed irrational, unreasonable, or unquantifiable. For example, epistemic violence and psychiatric incarceration are both forms of sanism. See Ben-Moshe, supra note 4, at 16–17 ("[S]anism is oppression faced due to the imperative to be sane, rational, and non-mad/crazy/mentally ill/psychiatrically disabled.").

113. Devon Price, Unmasking Autism 110 (2022) ("Even many mental health professionals are unaware that these 'disorders' and self-destructive behaviors are highly comorbid with Autism. The stereotype that Autistic people are withdrawn 'losers' who just sit at home on the computer all day runs very deep . . . .").

settings for ten years, erroneously labeled with a litany of "disorders."[114] Only after Beckwith-Fellows voluntarily withdrew from treatment did she identify her own autism.[115]

Ableism and sanism also impact survivors of childhood abuse and intimate partner violence. Specifically, survivors can be coercively and erroneously bestowed with psychiatric labels that fail to address a history of trauma.[116] As ex-patient and now-psychotherapist Marnie Wedlake has described, "[I]t felt as though no one genuinely wanted to know . . . about why I was so distressed. References to trauma and adversity were stuffed behind the diagnoses. . . . [S]o, like many, I internalized the belief that . . . *I was the problem*."[117] But coercively imposing psychiatric labels—such as personality "disorders"—on a person experiencing discrimination and ostracization due to one or more marginalized identities does not just

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114. While presenting a TEDx talk, Beckworth-Fellows recounted her own experiences:

> As I grew up into my teens, my early twenties, my [a]utism fought back. It was tired of hiding, and it was tired of being masked, and so it showed itself in the only way it could: I developed an eating disorder, I began to self-harm and I tried to end my life repeatedly. My Autistic self was screaming to be heard, but the louder it shouted, the more incorrect labels I was given: bipolar disorder, borderline personality disorder, depression, mixed anxiety disorder. . . . I spent ten years in the mental health system bouncing from one inpatient stay to another until finally I was left blind for two whole years because of psychiatric drugs I should not have been on.

TEDx Talks, Invisible Diversity: A Story of Undiagnosed Autism, Carrie Beckwith-Fellows, YouTube, at 13:40 (July 6, 2017), https://www.youtube.com/watch?v=cF2dhWWUyQ4 (on file with the *Columbia Law Review*).

115. Id. at 14:49 ("Enough was enough: I withdrew from the mental health system. . . . I referred myself to an autistic-diagnostic team and they confirmed my suspicion: I was Autistic.").

116. As Rebecca Donaldson explains her own experiences in the mental health industrial complex as a trauma survivor:

> [C]linicians are trained to label feelings like suicidality, restricting food, self-injury, crying, and feeling sad as 'problem behaviors' and are taught to engage in irreverent responses to clients who exhibit them. Talking about trauma is often shunned, and any of the aforementioned 'behaviors' are commonly viewed as attention-seeking. Despite [a majority] of individuals diagnosed with 'borderline personality disorder' reporting histories of childhood trauma, these individuals are merely viewed through the [Dialectical Behavioral Therapy] lens as people with problems that need to change.

Rebecca Donaldson, Trauma Survivors Speak Out Against Dialectical Behavioral Therapy (DBT), Mad in Am. (Aug. 12, 2022), https://www.madinamerica.com/2022/08/trauma-survivors-speak-out-against-dialectical-behavioral-therapy-dbt/ [https://perma.cc/J2YM-UYX4].

117. Jervert & Wedlake, supra note 73; see also Donaldson, supra note 116 ("DBT infuriated [me] because it was basically telling me, 'learn to be passively okay with outrageous unhappiness at what's been done to you.' . . . [Y]ou're basically treating us like car alarms you want to . . . smash . . . with a hammer, so you don't have to pay attention to it." (first alteration in original) (internal quotation marks omitted) (quoting an anonymous comment)).

refuse to address a history of trauma—it actively depoliticizes distress stemming from systemic oppression.[118]

In these stories, the human cost of the legal reliance on the pathology paradigm begins to emerge: The political presumption that some people are broken and must be fixed is itself what traps many people in their sociopolitical distress. This is not to say that input from a medical professional is not valuable. Having an external perspective is a powerful way to help make meaning of an internal experience.[119] Erroneous psychiatric labeling, however, is not a consequence of a biologically inevitable error rate of an imprecise science. Rather, the error that disproportionately burdens othered bodyminds arises only when, based on the normative presumption of abnormality-induced irrationality, expertise on an internal experience is removed from the only person who has access to it.

C. *The Restrictive Effect of Pathological Framing in Legal and Policy Debates*

Though statutes rely on a presumption of irrationality arising from acceptance of the pathology paradigm, legal and policy discussions surrounding psychiatric incarceration are typically more nuanced. Many scholars recognize that the presence of "mental illness" does not necessarily imply that a person is legally incompetent.[120] Thus, scholars discussing psychiatric incarceration rely on a variety of normative frameworks to decide when, if at all, paternalistic intervention is justified. But despite the relative nuance, these debates remain constrained by acceptance of the pathology paradigm as biological fact and the limits this framework imposes.

Specifically, the pathology paradigm forces the normative balancing of two types of error associated with the coercive psychiatric labeling

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118. See Devin S. Turk, Mad Thought: "Personality Disorders", Medium (Sept. 23, 2022), https://medium.com/@devinsturk/mad-thoughts-personality-disorders-9213e786be87 [https://perma.cc/WKB5-HM5V] ("As someone who was misdiagnosed with a 'disordered personality,' and someone who is also Autistic and trans, being told to Cognitive Behavioral Therapy my way out of 'mental illness' that was born out of a response to an ableist and transphobic society . . . does nothing but perpetuate cycles of harm.").

119. Without realizing there is an alternative, many people accept the pathological understanding of neurodivergence and distress. This Note does not argue that we should dismiss the internal experiences of those who self-pathologize. Rather, the Note argues that psychiatry and the pathology paradigm should not be the legally mandated default understanding of suffering and difference. People should remain free to consume psychiatric services autonomously rather than being mandated to do so under the force of law.

120. See Candice T. Player, Involuntary Outpatient Commitment: The Limits of Prevention, 26 Stan. L. & Pol'y Rev. 159, 212 (2015) ("[N]ot all people with mental illnesses are incompetent to make treatment decisions."); Elyn R. Saks, Competency to Refuse Medication: Revisiting the Role of Denial of Mental Illness in Capacity Determinations, 22 S. Cal. Rev. L. & Soc. Just. 167, 169–70 (2013) (detailing the current standards for assessing capacity to refuse treatment).

process.[121] If law protects against harms inflicted by coercive restrictions on liberty, that law must tolerate false negatives and thus fail to incarcerate people who would experience harm due to a nonidentified pathology-induced incompetence.[122] Conversely, if a law protects against harms inflicted by untreated psychopathology, that law must tolerate false positives and thus subject people without incapacitating pathology to unnecessary, coercive, and traumatic treatment.[123] Further, because these two types of error are inversely related and thus cannot be reduced simultaneously, their balance is neither empirical nor value neutral.[124] Literature tackling psychiatric incarceration thus remains stuck within a cyclical battle between preferences for either liberty or paternalism. Within this literature, there is a spectrum of arguments about the correct balance between these two kinds of error.[125]

Effectively, these debates may be distilled to a particular pattern of reasoning. Arguments in favor of preserving or expanding psychiatric incarceration first observe that a person is different and struggling such that the observed difference is presumed to be the cause of the observed suffering.[126] This leads to the conclusion that relief of difference is relief of suffering. Never once is suffering conceptualized as an expected response to an economic, social, and political landscape that marginalizes difference at every turn. By contrast, arguments in favor of abolishing or severely limiting psychiatric incarceration follow the same logic but take issue with what is characterized as an unacceptable rate of error in distinguishing between people who do not need "treatment" and people who could be correctly subjected to involuntary "treatment."[127] Yet critics

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121. Player, supra note 120, at 220–21 ("[S]ettling on an appropriate competence standard is not simply a matter of settling on the correct test, but rather a process of balancing competing values and guarding against two kinds of error [i.e., false negatives and false positives].").

122. See id. at 220 ("The first error (Type I or false positive) results from choosing a standard of competence that is too low and failing to protect the person from the harmful consequences of his or her decisions when those decisions stem from serious defects in the capacity to decide.").

123. See id. at 220–21 ("The second error (Type II or false negative) results when we choose a threshold for competence that is too high and fail to allow a person to make her own choices when she is able to do so.").

124. See Douglas, supra note 19, at 566 ("For any given experimental test, one cannot lower both [false positive error and false negative error]; one can only make trade-offs from one to the other.").

125. Compare Stephen J. Morse, A Preference for Liberty: The Case Against Involuntary Commitments of the Mentally Disordered, 70 Calif. L. Rev. 54, 57 (1982) (accepting the harms that flow from false negatives in defense of a policy argument that would not tolerate false positives), with Dora W. Klein, When Coercion Lacks Care: Competency to Make Medical Treatment Decisions and Parens Patriae Civil Commitment, 45 U. Mich. J.L. Reform 561, 565 (2012) (accepting the perpetuation of harms that flow from false positives to guard against the harms that flow from false negatives).

126. See infra notes 129–132 and accompanying text.

127. See infra notes 141–145 and accompanying text.

and supporters alike fail to realize the false dichotomy within which they are stranded. This leads to the appearance of an unresolvable disagreement about which of two poor solutions is marginally preferable. Supporters of psychiatric incarceration argue that mandating carceral care to change the person to fit the landscape is better than the position of critics, who argue that if a person rejects carceral care, it is acceptable to leave that person without any support at all.[128] Not once do critics or supporters recognize that care need not be carceral or consider that perhaps it is not the person who needs fixing.

Scholars that argue in favor of maintaining or increasing the reach of psychiatric incarceration justify tolerance of false positive error by positioning the consequences of the untreated pathology as worse than the consequences of erroneous deprivation of liberty.[129] For example, some commentators connect untreated pathology to the disproportionate representation of "mentally ill" people in jails, prisons, and within unhoused populations.[130] Based on this connection, the solution to the disproportionate criminalization or impoverishment of the "mentally ill" appears obvious: Coercively treat the abnormal pathology. This permits the characterization of carceral treatment as the lesser of two evils when compared to the dangers of poverty or a criminal legal system that is unprepared to accommodate Disabled people.[131]

When neurodivergence is understood as "mental illness," poor outcomes are associated with and blamed on the state of abnormality, effectively internalizing—within individual biology—systemic drivers of inequity. Thus, the framework of "mental illness" masks the structural issues that leave multiply marginalized people most vulnerable to interpersonal and state-sanctioned violence that results in social, political, and economic exclusion. But the sanist idea that external expressions of neurodivergence should be understood as an eradicable illness is exactly what demands this framing.

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128. See infra notes 133–139 and accompanying text.

129. See Player, supra note 120, at 218 ("[T]he good associated with outpatient commitment outweighs the harms associated with infringing personal autonomy and the right to refuse treatment. . . . The harms to be avoided are grave—chronic homelessness, violent crime, violent victimization, incarceration, and suicide.").

130. See Sara Gordon, The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People With Serious Mental Illnesses, 66 Case W. Rsrv. L. Rev. 657, 698 (2016) ("In many cases, this heightened [commitment] standard has resulted in the marginalization of people with serious mental illness into poverty and homelessness."); Collin Mickle, Safety of Freedom: Permissiveness vs. Paternalism in Involuntary Commitment Law, 36 Law & Psych. Rev. 297, 301 (2012) ("Thousands of other mentally ill individuals are homeless[,] . . . [facing] increased risks of illness, violence, and substance abuse, and consequently have much lower life expectancies than those with reliable shelter.").

131. See Mickle, supra note 130, at 301 ("The presence of large numbers of mentally ill inmates in ill-equipped and ill-prepared corrections facilities increases the risk of conflict in those facilities.").

In a related but alternative line of reasoning, advocates for paternalistic intervention also dispute the characterization of carceral treatment as deprivation of autonomy. Here, the pathology is characterized as the autonomy-depriving agent, such that return to "normal" cognitive function by way of carceral treatment is presented as restoring autonomy.[132] However, loss of autonomy based on the presence of pathology is again coherent only if neurodivergence is conceptualized as a destructive agent that corrodes an underlying "normal" cognitive process.[133]

In *Involuntary Outpatient Commitment: The Limits of Prevention*, Candice Player combines these two approaches when she suggests a soft paternalist theory of intervention regarding outpatient psychiatric "care."[134] For Player, "interventions into self-regarding harm are justified when, and only when, the actions or choices of the person concerned are substantially

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132. See M. Carmela Epright, Coercing Future Freedom: Consent and Capacities for Autonomous Choice, 38 J.L. Med. & Ethics 799, 804 (2010) ("Thus, if our purpose is to uphold patient autonomy, then coercing treatment in the short term might well be the best means of providing protection for the patient's capacities for rational choice, and thus promoting genuine autonomy for that patient."); Klein, supra note 125, at 566 ("Requiring that people who have been civilly committed because of dangerousness to self have a rational understanding of the consequences of refusing treatment furthers the ultimate goal of promoting autonomous decisions . . . ."); Player, supra note 120, at 203 ("If one's thoughts and behavior are driven by a disease process of the brain over which one has no control, is this truly liberty? . . . 'Medication can free victims from their illnesses . . . and restore their dignity, their free will, and the meaningful exercise of their liberties.'" (internal quotation marks omitted) (quoting E. Fuller Torrey & Mary Zdanowicz, Outpatient Commitment: What, Why, and for Whom, 52 Psychiatric Servs. 337, 340 (2001))).

133. Further, pathological framing that assumes an underlying essential "normal" often biases the interpretation of observed differences:

> Do psychotic diseases negatively impact these areas of the brain [necessary for exercise of autonomy and rational thought]? The general consensus is yes. Although the data is limited and preliminary, multiple neuroimaging studies have documented structural abnormalities in the prefrontal and dorsal lateral cortexes of persons with untreated bipolar and other mood disorders, including cortical thinning, the reduction of gray matter in these regions, and the various cell pathologies including alterations in neuronal and glial density. Neuroimaging studies of untreated [Schizophrenic people] show similar defects . . . .

Epright, supra note 132, at 804 (footnotes omitted). All the while, differences in structure and function can go unnoticed altogether when they do not conflict with economic functioning expectations:

> In an article entitled 'Is Your Brain Really Necessary?' Roger Lewin describes a university student . . . who has an IQ measured at 126, a normal social life, and 'virtually no brain.' . . . The student was functionally indistinguishable from his colleagues, but had no more than 10% of the average person's brain tissue.

See Ron Amundson, Against Normal Function, 31 Stud. Hist. Phil. Biological & Biomedical Sci. 33, 40 (2000).

134. Player, supra note 120, at 211.

nonvoluntary."[135] Thus, even though Player may be fairly characterized as protective of liberty interests of the psychiatrically labeled,[136] she argues that those liberty interests are permissibly curtailed when exercise of a pathology-influenced autonomy leads to sufficiently adverse outcomes.[137] Here, the pathological story of neurodivergence strips the psychiatrically labeled of their credibility by classifying certain embodied expressions of neurodivergence as "biological motions" rather than "symbolic actions," thereby degrading the rhetorical intentionality behind them.[138]

By contrast, critics who prefer tolerance of false negative error rely on a myriad of arguments that center on the legal inability to create substantive and procedural mechanisms that guard against unwarranted psychiatric incarceration. Some critics argue that if the state relies on poor outcomes to justify forced treatment, then this paternalistic override of autonomy should apply to all medical interventions, not just treatment of "mental illness."[139] Other critics argue that it is the imprecision of psychiatry or the lack of scientific character of psychiatric labels that guarantees an intolerable number of false positives.[140] Some critics argue that absent this scientific character, psychiatric incarceration is used predominantly as a mechanism to control noncriminal social deviance.[141]

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135. Id.

136. See id. at 221 ("I argue that an emphasis on appreciation or insight as a measure of competence is misplaced. Indeed 'appreciation,' the legal correlate of insight, should have no role to play in our thinking about competence." (footnote omitted)).

137. Id. at 228 ("Exposure to extreme weather conditions, untreated medical illnesses, infection, and insufficient nutrition . . . increase the risk of death. . . . [W]here the risks are sufficiently grave—and a person's capacity to make rational choices is sufficiently in question—a reasonable court might risk a [false negative] error . . . .").

138. Melanie Yergeau, Authoring Autism: On Rhetoric and Neurological Queerness 10 (2018).

139. See Samantha Godwin, Bad Science Makes Bad Law: How the Deference Afforded to Psychiatry Undermines Civil Liberties, 10 Seattle J. for Soc. Just. 647, 686 (2012) ("The argument that mentally ill people would benefit from needed medical treatment, and that this benefit outweighs their right to refuse and therefore justifies commitment, would apply equally to *anyone* who refuses needed medical treatment."); Morse, supra note 125, at 66 ("There would thus seem to be little support for an involuntary commitment system that is imposed only on the mentally disordered.").

140. See Godwin, supra note 139, at 648 ("I challenge the assumption that psychiatry provides reliable and scientific facts by demonstrating that the evidence available to psychiatrists is typically insufficient to support many of the claims they make about mental illness."); Morse, supra note 125, at 68 ("Another factor that increases the likelihood of improper overcommitment is the difficulty attending proper conceptualization and diagnosis of mental disorder.").

141. See Morse, supra 125, at 67 ("One factor that is likely to lead to the overuse of civil commitment is the use of commitment as a mechanism for the control of 'overflow' deviance. As a social control system, involuntary commitment provides a solution to the problems caused by troublesome, annoying, scary, and weird persons."); William Hoffman Pincus, Note, Civil Commitment and the "Great Confinement" Revisited: Straightjacketing Individual Rights, Stifling Culture, 36 Wm. & Mary L. Rev. 1769, 1814 (1995) ("The State has committed a woman for exercising independent religious thought and a man for practicing vegetarianism. It was not until 1972 that homosexuality ceased to be classified as

Other critics focus on the practical realities of the legal processes surrounding psychiatric incarceration, arguing that an intolerable number of false positives is at least in part a result of the opportunity for pretext during the psychiatric designation of dangerousness[142] or the performative nature of judicial procedures.[143] In effect, critics favoring tolerance of false negatives focus in some way on the rate of error inherent to an external observer's process in determining the presence or absence of a competence-impairing pathology.[144]

These critiques often fall flat because they fail to effectively respond to the paternalistic criticism that protecting liberty interests of the psychiatrically labeled is no different than letting people die preventable deaths.[145] Within these debates, however, there is no discussion of who is claiming expertise and authority on neurodivergence. The focus on the correct balance between preferences for liberty or paternalism obscures the fact that an entire industry of neurotypical people claim expertise on an embodied way of being they have never and may never experience.

III. THE NEURODIVERSITY PARADIGM AND NONCARCERAL CARE

As a solution to the restrictive and carceral influence of the pathology paradigm, section III.A introduces the neurodiversity paradigm as an alternative normative framework to understand divergent cognition. Section III.B then introduces relational autonomy to bridge a neurodiversity-informed vision of noncarceral care and legal discussions surrounding provision of support to people in crisis. Part III concludes with a call to shift from the pathology paradigm to the neurodiversity paradigm not only in law but also in broader discussions surrounding mental health, abolition, and social justice.

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mental illness and, hence, potential grounds for commitment . . . . On what primitive grounds do we justify commitment today?" (footnotes omitted)).

142. See Brooks, supra note 97, at 278–79 ("The psychiatrist who wishes to pay lip service to the law . . . can always assert enough symptoms of mental illness or other factors relating to harm-causing behaviors, . . . knowing [that] the court system will rarely second guess [their] determination.").

143. See Michael L. Perlin, "Who Will Judge the Many When the Game Is Through?": Considering the Profound Differences Between Mental Health Courts and "Traditional" Involuntary Civil Commitment Courts, 41 Seattle U. L. Rev. 937, 937 (2018) ("[T]he Supreme Court noted, in *Parham v. J.R.*, that the average length of a civil commitment hearing ranged from 3.8 to 9.2 minutes . . . .").

144. See Morse, supra note 125, at 74 ("[The] number of wrongly committed 'false positives' is completely unjustified in a society that values liberty.").

145. See Paul S. Appelbaum & Thomas G. Gutheil, "Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients, 7 Bull. Am. Acad. Psychiatry L. 306, 311–15 (1979) (describing a "small study" in which the majority of legal arguments in support of the right to refuse medication were found not to fit the clinical reality).

A. *The Neurodiversity Paradigm*

"Mental illness" is not the only normative framework that can be used to understand divergent cognition. Beginning in tandem with both the Disability Rights movement and the rise of early versions of the internet in the 1990s, Autistic adults started questioning pathological descriptions of autism.[146] This Autistic-led critical approach gave way to the concept of neurodiversity, in which autism, dyslexia, and ADHD were characterized as natural and necessary forms of neurocognitive variation rather than abnormalities in need of eradication or cure.[147] In 2012, Critical Autism Studies scholar Nick Walker named and defined the neurodiversity paradigm.[148] Under the neurodiversity paradigm, Walker both explicitly broadened the concept of neurodiversity to all nonnormative neurocognitive variation and rejected the broad normative commitment to "normal" cognitive function.[149]

However, when Walker rejected the Galtonian normal to acknowledge that "differences between biological individuals are real" and "the mean values which we may calculate in the comparison of groups . . . are man-made inferences," she aligned the neurodiversity paradigm, perhaps inadvertently, with the modern, nonessentialist conceptualization of statistics.[150] Thus, where the social model of disability distinguishes between "value-neutral" biological impairment and socially constructed disability,[151] the neurodiversity paradigm rejects the notion that Neurodivergent people are impaired. The neurodiversity paradigm is thus aligned with disability justice, which rejects impairment broadly when arguing that there is no right or wrong way to have a bodymind.[152] While

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146. As sociologist Judy Singer recounts:

> By the 1990s, the idea of autism as a spectrum . . . was gathering momentum . . . . The new paradigm was spreading fast thanks to the advent of the internet, which I described in my thesis as "the prosthetic device that binds isolated . . . autistics into a collective social organism capable of having a public 'voice.'"

Judy Singer, NeuroDiversity 11 (2016).

147. Walker, Liberating Ourselves, supra note 11, at 38.

148. Awais Aftab, The Neurodiversity Paradigm in Psychiatry: Robert Chapman, PhD, Psychiatric Times (Sept. 24, 2021), https://www.psychiatrictimes.com/view/neurodiversity-paradigm-psychiatry [https://perma.cc/Y2R8-XP6Z] ("The term *neurodiversity paradigm* was proposed a bit later, in 2012, by [A]utistic scholar Nick Walker, PhD (she/her) . . . .").

149. Walker, Liberating Ourselves, supra note 11, at 19. Walker coined the term so that she could explore "the philosophical implications of this broader application of [neurodiversity] . . . and how it challenged theoretical assumptions and cultural and scientific practices." Aftab, supra note 148.

150. Mayr, supra note 29, at 47 ("[D]ifferences between biological individuals are real, while the mean values which we may calculate in the comparison of groups of individuals . . . are man-made inferences.").

151. See Emens, supra note 58, at 1401.

152. See Leah Lakshmi Piepzna-Samarasinha, Harm Reduction Is Disability Justice: It's Not Out There, It's in Here, *in* Saving Our Own Lives: A Liberatory Practice of Harm Reduction 182, 184 (Shira Hassan ed., 2022) ("One of the primary offerings of Disability

it rejects normality, the neurodiversity paradigm does not reject all data collected under the pathology paradigm.[153] Rather, it argues that when neurotypical researchers rely—often implicitly—on a pathological framing, they analyze that data through a dehumanizing lens, thereby generating limited and often outright inaccurate theories about a politically, socially, and economically subordinated group of people.[154]

Rejection of the Galtonian normal allows difference to be understood as a natural, even if less common, way of being, not as disease to be eradicated or disorder to be cured. Consequently, difference is not presumptively alien to or corrosive to the neurocognitive *l'homme moyen*—instead, neurodivergence may be experienced as integral to and indistinguishable from the self. As schizophrenia and psychosis advocate Rose Parker explains:

> Schizophrenia is so much more than hearing Voices. Schizophrenia affects every aspect of how we perceive[], interact with, experience, and are received by the world. I do not view my Schizophrenia as a 'Disorder' or 'Illness' . . . because even though it is Disabling, it is so fundamental to my life and to my Neurology that I would not be who I am without it – literally, it dictates how I experience my sense of Self. I am Schizophrenic and I do not believe there is anything wrong with that.[155]

Similarly, Autistic people describe their neurotype as an entirely different way of being, with cognition dominated by monotropic, grid-like thinking in contrast with the associative, spiral-like, curvilinear thinking characteristic of ADHD.[156] The neurodiversity paradigm frames borderline

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Justice is that there is no right or wrong way to have a body or mind."). As both a critical and a rhetorical question: Who gains power when a bodymind can be declared right or wrong?

153. Walker, Liberating Ourselves, supra note 11, at 28 ("A paradigm shift . . . requires that all data be *reinterpreted* through the lens of the new paradigm."); see also Frazer-Carroll, supra note 26, at 51 ("Questioning the way that we 'know' mental health doesn't involve rejecting all current knowledge, or resisting the pursuit of knowledge in the first place. Rather, it is about finding new ways to orient ourselves toward knowledge.").

154. See supra note 58 and accompanying text; supra note 119.

155. Rose Parker, Embodiment, The Self, and Schizophrenia, Medium (Apr. 12, 2022), https://medium.com/@psychosispsositivity/embodiment-the-self-schizophrenia-6e2b6932e360 [https://perma.cc/PM4A-ZBCZ].

156. Photograph of Tweet by Barisan Hantu (@barisanhantu), *in* Devon Price (@drdevonprice), Instagram (Aug. 14, 2021), https://www.instagram.com/p/CSj1NjnLd65 (on file with the *Columbia Law Review*) [hereinafter Price, Instagram Post] ("ADHD is associative and curvilinear in thinking [while] [a]utism is monotropic and tends to have repetitive patterns . . . ."); Photograph of Tweet by Lydian (@Marvin_humanoid), *in* Price, Instagram Post, supra (When you are both, it[']s really hard if not impossible to give a clear distinction between [autism and ADHD]. It[']s almost like you are in a [third] group . . . [a]n outsider amongst the outsiders."). Like Rose Parker understands being Schizophrenic, Nick Walker describes Autistic cognition as inextricably linked to conceptions of the self:

> It isn't a disease, like a tumor or a virus. You can't cut an autism out of a person and preserve it in a bottle. You can't isolate autism in a laboratory and have a little test tube or petri dish full of autism. Being autistic informs

personality "disorder" (BPD) and dissociative identity "disorder" (DID) as incredible adaptations to unacceptable circumstances rather than states of biological brokenness or moral failure.[157] However, in line with the rejection of biological essentialism, there is also no essential, monolithic, or universal experience of any given neurotype.

When Neurodivergent people are the authority on neurodivergence, they identify nuances between neurodivergences that are not readily made based on external expressions alone. Specifically, Neurodivergent people readily distinguish between neurodivergence and distress. For example, under the neurodiversity paradigm, anxiety and depression are often expressions of distress that arise predictably in response to the society we have constructed.[158] Further, eating disorders, substance use, self-harm,

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> every facet of a person's development, embodiment, cognition, and experience, in ways that are pervasive and inseparable from the person's overall being.

Nick Walker, Person-First Language Is the Language of Autistiphobic Bigots, *in* Neuroqueer Heresies, supra note 11, at 91, 95.

157. See Candice Alaska (@understandingbpd), Instagram (Jan. 13, 2023), https://www.instagram.com/p/CnXt1snvuxI (on file with the *Columbia Law Review*) ("What if we saw people with BPD as incredible instead of 'broken'? What if we admired people with BPD for the ways that they have survived often unbearable things?"); Gianu System (@gianusystem), Instagram, at 00:30 (Oct. 10, 2022), https://www.instagram.com/gianusystem (on file with the *Columbia Law Review*) ("[W]hat I wished people knew is that . . . the experiencing of a fragmented consciousness is not what is . . . distressing about DID. It's the dissociation and the PTSD symptoms."). Even though some Neurodivergent people reclaim and depathologize BPD, it is important to note how psychiatry weaponizes BPD against those gendered as female, survivors of childhood sexual abuse, and Autistic people. BPD is a heavily stigmatized psychiatric label. Cohen, supra note 26, at 163 ("[T]here is no other diagnosis currently in use that has the intense pejorative connotations that have been attached to the [BPD] diagnosis." (internal quotation marks omitted) (quoting Dana Becker, Through the Looking Glass: Women and Borderline Personality Disorder, at xv (1997))). It is also heavily gendered. See id. at 162 ("[BPD is] a label which has been increasingly applied to women, with around 75 per cent of all cases estimated to be female . . . ."). Many of those labelled with BPD are survivors of childhood sexual abuse. Id. at 163. Autistic people gendered as female by others are frequently misdiagnosed with BPD. See, e.g., Lisa Rayner, Abused by Psychiatrists After a BPD Misdiagnosis, Mad in Am. (Apr. 7, 2023), https://www.madinamerica.com/2023/04/abused-psychiatrists-bpd-misdiagnosis/ [https://perma.cc/GY8S-YUFJ] ("Like most older female-bodied autists, I was soon misdiagnosed with borderline personality disorder, which has significant overlapping symptoms with autism, like self-injury, meltdowns misinterpreted as tantrums, and an inability to form solid, emotionally healthy relationships with allistic and neuronormative people."). BPD is thus the label psychiatry uses most flexibly to depoliticize trauma derivative of and dismiss dissent against systemic marginalization.

158. See Sonny Jane Wise (@livedexperienceeducator), Instagram (Sept. 25, 2022), https://www.instagram.com/p/Ci8_jqPP94Q (on file with the *Columbia Law Review*) ("[P]erhaps depression and anxiety are human responses rather than disordered responses."). How people experience neurodivergence, however, is complicated, such that some people may see fit to reclaim anxiety and depression as neurodivergences. See Frazer-Carroll, supra note 26, at 52 ("To argue that Madness/Mental Illness is only caused by social factors also discounts the embodied experiences of many people. Sometimes suffering may

and other compulsive or impulsive behaviors are understood as coping mechanisms that help regulate distress.[159] Psychiatry—limited to observation of external expressions of behavior filtered through the neurotypical lens of the clinician—fails to capture these meaningful differences. Thus, removing credibility from Neurodivergent people not only obscures recognition of violence imposed by ableism and sanism on Neurodivergent bodyminds but also confounds development of effective support for all people. By contrast, under the pathology paradigm, distress created in response to the marginalization of neurodivergence is uncritically characterized as yet another expression of pathological abnormality.[160]

Though the neurodiversity paradigm rejects the pathological understanding of difference, it is not antimedicine. Rather, medicine, therapy, and other "treatments" are understood as forms of accommodation. When understood as accommodations, the authority to define the supports needed remains within the bodyminds that need them. Further, because unsupported neurodivergence itself is often traumatizing, medication can be an empowering tool to navigate the intersection of neurodivergence and trauma.[161]

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feel more 'bodily', internal, random, messy, spontaneous, or unknowable – in ways that we cannot always neatly trace to social triggers.").

159. Jenara Nerenberg, Divergent Mind: Thriving in a World that Wasn't Designed For You 137 (2020) ("[A]wareness of trauma and how it affects people's lives [is] fundamental and important, but . . . attribut[ing] *everything* to trauma, as though some kind of 'normal' exists that everyone would return to if they just resolved all their trauma . . . [risks] replicating the simplicity of past theoretical frameworks.").

160. Under the pathology paradigm, high rates of suicidal ideation and attempts in Autistic people are attributed to Autistic "deficits" or "comorbid" psychiatric conditions such as depression rather than the repeated trauma of being othered—bullying, exclusion, and ostracization—based on neurotype. See M. South, J.S. Beck, R. Lundwall, M. Christensen, E.A. Cutrer, T.P. Gabrielsen, J.C. Cox & R.A. Lundwall, Unrelenting Depression and Suicidality in Women With Autistic Traits, 50 J. Autism & Developmental Disorders 3606, 3613 (2020) ("[T]he construct of *flexibility* . . . added unique additional explanation for variance in S[uicidal] T[houghts and] B[ehaviors]. . . . [T]he flexibility [scores] . . . capture a desire for concrete, rather than abstract experience . . . and an associated preference for predictable environments and behavior."). The pathology paradigm thus depoliticizes the role of at least ableism in elevated suicide rates in Autistic people.

161. Karin Jervert explains how a person can rely on psychiatric medication without ascribing to the pathology paradigm:

> In another world, another culture, another life, I may have gotten the language, the stories, and the support I needed to deal with [hearing voices] and altered states before I collapsed into the isolation, chaos, and confusion that led me to psychiatry. Perhaps I could have lived without psychiatric medication. But as I write this today, it seems not in this life, not in this culture, not in this world. Although, that may change as I further build the architecture of support and wisdom in my life.

Karin Jervert, The Song of Psychiatry: The Impact of Language, Mad in Am. (Apr. 20, 2022), https://www.madinamerica.com/2022/04/song-psychiatry-language/ [https://perma.cc/3JM8-C9PL].

In other words, in conceptualizing neurodivergence as indistinguishable from the self and distress as a predictable response to both interpersonal and sociopolitical trauma, the neurodiversity paradigm preserves the credibility of Neurodivergent people and allows them to tell their own story. The Mad who experience altered states or multiple consciousness are not broken or irrational but are our story tellers, our creative thinkers, and our meaning makers. The Autistic are not wrong in how they take up space or connect but are our innovators, our social-construct critics, and our niche-theory historians. Those who experience extreme emotional states are not wrong for their intensity of feeling but are our connectors, our beauty holders, and our emotive translators. Under the neurodiversity paradigm, society respects how Neurodivergent people contribute to their communities without needing to dull the part of them that colors everything they touch.

The introduction of the neurodiversity paradigm to law governing psychiatric incarceration reclaims the authority on neurodivergence for Neurodivergent people, correcting the longstanding removal of that authority and its misplacement within medical and legal professions. Under the neurodiversity paradigm, people who experience altered states are best situated to detail, define, and explore the kinds of support provided to people who experience altered states. Similarly, chronically suicidal people are the best situated to detail, define, and explore the support provided to suicidal people. To quote Mad and Disabled writer Devin Turk:

> My history [as a survivor of psychiatric coercion] is an unfortunate kind of qualification: I do not have a degree in medicine or in treating "psychopathology" but I know viscerally what this system can do to those it consumes.
>
> Psychiatry . . . has done and continues to do irrevocable harm to generations of marginalized populations.
>
> I've been waiting for this knowledge . . . [that] so many people with stories like mine have embodied for hundreds of years[]to finally take up its proper space in modern discussions of so-called mental health. . . . I'm still waiting.[162]

Under a neurodiversity-informed conception of law, Mad people are the experts on madness, Neurodivergent people are the experts on neurodivergence, Disabled people are the experts on disability, and psychiatric survivors are the experts on the institution of psychiatry.[163] Ultimately, the neurodiversity paradigm champions the idea that any

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162. Devin S. Turk (@devinisautistic), Instagram (Oct. 10, 2022), https://www.instagram.com/p/Cji0OgPPeeh/ (on file with the *Columbia Law Review*) (emphasis added).

163. Similarly, formerly incarcerated people are the experts on the criminal legal system, and survivors of the family regulation system are the experts on that system.

individual person is the expert on their own internal narrative.[164] Yet this lifesaving expertise is so often dismissed, obscured, and discarded because of the power whole industries can claim when they pretend to speak on behalf of the very people they have rendered voiceless. So who dies when we continue to strip credibility from those with the knowledge we need to create lifesaving systems of noncarceral support?

B. *Relational Autonomy and Neurodiversity-Informed Noncarceral Care*

"The autonomy over my own identity was stolen from me within the fleeting moments of receiving my first diagnostic label."

— Rose Yesha.[165]

Definitions of "autonomy" as self-governance, self-determination, independence, and control confound the capacity of people who have not survived carceral psychiatry to understand the harms that arise from the deprivation of autonomy by way of legal force. Specifically, autonomy as self-governance leaves no space for the idea that a person needs support, but not carceral support. There are no words that a person can use to effectively communicate a need for support that does not start from the presumption that, because they are in distress, who they are is wrong, abnormal, disordered, or irrational. Rejection of the pathological story told about neurodivergence is often interpreted as rejecting observable distress, which is then used to support a determination of legal incompetence.[166] In other words, for a person to accept support under the pathology paradigm, they must accept that it is them—not society—who is wrong.

For example, in *The Limits of Prevention*, Player incorporates legal philosopher Joel Feinberg's understanding of autonomy in her analysis,[167] which defines autonomy as "the capacity for self-government and the

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164. The abolition of psychiatric incarceration based on the neurodiversity paradigm calls into question the validity of the insanity defense in the criminal context. Because the neurodiversity paradigm argues that Neurodivergent people are competent, there exists an argument that this Note does not explore that determinations of competence—including insanity—based on the haphazard construction of divergent cognition filtered through the lens of neurotypicality in the criminal context, are dehumanizing, if not outright discriminatory. This Note, however, takes an abolitionist position in totality, where harm is better reconciled through noncarceral processes, not through the criminal legal system.

165. Rose Yesha, Breaking With Disorder: The Invisible Flames of Mental Illness Labels, Mad in Am. (Sept. 10, 2021), https://www.madinamerica.com/2021/09/invisible-flames-mental-illness-labels/ [https://perma.cc/9XB2-A2RK].

166. See Saks, supra note 120, at 174–75 ("[T]here is more consensus around, and acceptance of, mental illness as a medical illness . . . . [S]ome mental illnesses are now being characterized as 'brain disorders' . . . . Therefore, today denial of mental illness is not as easily dismissed as a basis for incompetency [to make treatment decisions].").

167. Player, supra note 120, at 203–10 ("I argue that Joel Feinberg's theory of autonomy has sufficient room to accommodate people with mental illnesses.").

actual condition of self-government."[168] Here, Player and Feinberg explicitly connect dependence to a lack of full exercise of autonomy even if an individual would otherwise be capable of acting autonomously. Thus, they implicitly conceptualize independence as an integral component of autonomy's full exercise. Further, Player articulates that "Feinberg's account privileges authenticity as an element of autonomy. 'To the degree to which a person is autonomous he is not merely the mouthpiece of other persons or forces' . . . . [A]uthenticity arises through a process of self-creation and 'self-*re*-creation.'"[169] Thus, for Player, autonomy is individual self-governance that involves self-creation and re-creation. Yet Player's understanding of autonomy masks the underlying choice a distressed person seeking mental health support must make: seek support and thus reject one's autonomy to define and re-define one's own internal experiences, or retain the capacity to define and redefine one's own internal experiences and be left without support.

Thus, the combination of autonomy as authentic self-governance and the pathology paradigm obscures the current trade-off between support and autonomy, missing a viable solution held in their decoupling. We can have our cake and eat it too, but only by rejecting the pathology paradigm and reconceptualizing what it means to be autonomous.

In *Law's Relations: A Relational Theory of Self, Autonomy, and Law*, Professor Jennifer Nedelsky rejects self-governance, self-determination, independence, and control as defining features of autonomy.[170] Nedelsky instead defines autonomy as "the core of a capacity to engage in the ongoing, interactive creation of . . . our relational selves . . . that are constituted, yet not determined, by the web of nested relations within which we live[,] . . . to reshape, re-create, both the relationships and ourselves."[171] In focusing on the inherent interdependence of the human condition, "[a] relational conception of autonomy turns our attention to the kinds of relations that undermine or enhance autonomy."[172] Thus, for

168. Id. at 204 ("In Feinberg's view, a person might possess the capacity for self-government—insofar as he has the capacity to make rational choices—but be less than fully autonomous because he does not actually govern himself[including because of poverty-induced dependence]." (discussing 3 Joel Feinberg, The Moral Limits of Criminal Law 27–51 (1986))).

169. Id. at 205–06 (quoting 3 Joel Feinberg, The Moral Limits of Criminal Law 32, 35 (1986)).

170. Jennifer Nedelsky, Law's Relations: A Relational Theory of Self, Autonomy, and Law 118 (2011) ("My central argument here is that autonomy is not to be equated with independence."); id. at 46 ("I also reject another commonplace synonym for autonomy: control . . . ."); id. at 167 ("[I]t is more helpful to refer to an ongoing capacity for interactive 'self-creation' than to 'self-determination.'").

171. Id. at 45. Relational autonomy does not necessarily contradict the understanding of autonomy furthered by Player. Rather, each has different views on how autonomy is engaged. For Player, a person must elect into the act of exercising autonomy, whereas for Nedelsky, to be human is to be relationally autonomous.

172. Id. at 119.

Nedelsky, exercise of autonomy is a core function of what it means to be human,[173] which can be supported or corroded based on the relationships within which the person is positioned.[174]

Under a relational conceptualization, the interplay between autonomy and liberty in the context of psychiatric incarceration takes on a new valence. When we seek to help someone in crisis, we need not conceptualize the only effective crisis intervention as one rooted in surveillance that overrides a potentially deadly exercise of autonomy. Rather, through a relational lens, we can provide care through a relationship that supports a person's capacity to navigate their own inner world, even in a state of immense distress or existential exhaustion. This sits in stark contrast with our current system of support that is not only physically violent and even outright deadly for Neurodivergent Black men[175] but that also requires traumatic abandonment of the authority to create and re-create one's own internal narrative. Further, in the context of psychiatric incarceration, deprivation of relational autonomy is not merely deprivation of the authority to self-govern but is itself deprivation of the core human capacity to understand oneself, such that psychiatric incarceration violates a person's humanity. Thus, relational autonomy explains why trauma incurred during psychiatric incarceration is often so profound.

Suicide also takes on a new valence when viewed through the lens of relational autonomy. When a person experiences discrete or continuous trauma in which they are denied the autonomy necessary to alleviate or make meaning of that trauma, suicide can be a final reclamation of the autonomy they were long denied.[176] Placement in yet another autonomy-degrading relationship, however, only reinforces a sense of powerlessness. This is why, especially in the context of suicidal ideation, the preservation of autonomy must be so staunchly protected. Care that helps a person in

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173. Id. at 159 ("[A]utonomy is . . . a key component of a core human value: the capacity for creative interaction.").

174. Id. at 169 ("[T]he context of creative interaction highlights both the genuinely creative and inevitably interactive dimensions of all our exercises of autonomy. It thus directs our attention to the constraining as well as enabling dimensions of circumstance without underplaying the core capacity for creation.").

175. See e.g., Prieve, supra note 16.

176. As Leah Lakshmi Piepzna-Samarasinha explains:

> When I've wanted to kill myself—when it's hit strong and knocked me to my knees familiar—there's this thing. It's felt like, in that moment, I can feel all the ways I really have been without agency in my life. And in that moment of feeling the deep grief and sadness over the impact of oppression, killing myself has felt like one clear way I can have agency. I can have total control.

Leah Lakshmi Piepzna-Samarasinha, Suicidal Ideation 2.0: Queer Community Leadership, and Staying Alive Anyway, *in* Care Work: Dreaming Disability Justice 173, 177–78 (2018).

crisis reclaim autonomy is itself lifesaving, while treatment that further restricts autonomy can cause the suicide it intended to prevent.[177]

The imposition of medical jargon on an individual's internal understanding of themselves in exchange for access to health care, however, is no new occurrence. As Professor Dean Spade articulated in 2003, the pathologization of gender dysphoria made seeking gender-affirming care "dehumanizing, traumatic, or impossible to complete" for many transgender people.[178] The trauma of abandoning nonpathologizing language within autonomy-degrading relationships helps explain why many reject carceral support.

Absent a relational understanding of autonomy, rejection of support—especially by unhoused people—is used as evidence for the legal need of carceral "treatment." This dynamic is particularly apparent in Oakland Mayor Libby Shaaf's comment in support of California's Community Assistance, Recovery and Empowerment (CARE) Act:[179]

> [Shaaf] lost her composure as she shooed a rat off of a sleeping woman, she said. She later learned that the woman had spent three years living in that same spot, feeding rats because they were her "chosen company" and refusing services. "She had been offered care, shelter, housing countless times but had been left to freeze on the pavement of our city."[180]

Here, Shaaf degrades the rhetorical intentionality behind the rejection of carceral care by characterizing it as the consequence of impaired biology. By degrading this person's rhetorical intentionality, Shaaf both justifies legislation that disappears nonnormative bodyminds under the guise of benevolent compassion that mitigates her own discomfort and avoids the idea that cold sidewalks indeed offer more comfort than the cold dismissal of autonomy-corroding relationships she offers as care.[181] No person who wields political power asks why this woman decides to turn down services. Thus, the autonomy-corroding and

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177. See Alberto Forte, Andrea Buscajoni, Andrea Fiorillo, Maurizio Pompili & Ross J. Baldessarini, Suicidal Risk Following Hospital Discharge: A Review, 27 Harv. Rev. Psychiatry 209 (2019) ("The present findings support the proposal that patients recently discharged from psychiatric hospitalization have rates of suicide deaths and attempts that are many times higher than that in the general population . . . [and] in unselected clinical samples of similar patients.").

178. Dean Spade, Resisting Medicine, Re/modeling Gender, 18 Berkeley Women's L.J. 15, 28–29 (2003).

179. See generally Janie Har & Adam Beam, California Governor OKs Mental Health Courts for Homeless, AP News (Sept. 14, 2022), https://apnews.com/article/health-california-san-francisco-gavin-newsom-mental-0e68288d97959f9ceeb5c5683afa092b [https://perma.cc/WMS8-FG44] ("Gov. Gavin Newsom signed a first-of-its kind law . . . that could force [unhoused people] into treatment.").

180. Jocelyn Wiener, Newsom's 'New Strategy' Would Force Some Homeless, Mentally Ill Californians Into Treatment, CalMatters (March 3, 2022), https://calmatters.org/health/2022/03/newsom-california-mental-illness-treatment/ [https://perma.cc/9EV6-EFSH].

181. Id.

dehumanizing nature of the services offered remains unexamined. Instead, the imagery of physical squalor masks the reality that society treats unhoused people with so much disdain that rats may genuinely provide more compassionate, life-sustaining, and autonomy-supporting relationships than people, all the while denying the rhetorical act of asserting the veracity of such reality. Further, conditioning support on acceptance of the medical narrative of irrational distress and near-total compliance with treatment built on the assumption that it is the individual who is wrong can mimic and thus recreate the trauma that brought them to psychiatry in the first place.[182] Perhaps even worse, this carceral treatment fails to strike at the systems that both create the initial trauma and render people disempowered within their own distress.

Though this Note names the harm perpetuated by psychiatric incarceration, it recognizes that harm does not imply that psychiatry has not saved anyone. For many, violent intervention in crisis was the ghost-thin line between life and death. This Note, however, does not universalize the experiences of those who psychiatry saved. Rather, the Note argues that to build an infrastructure of care that does not perpetuate the harm it seeks to remedy, we must start by heeding the expertise of those who have been most violently harmed by the system as it stands. In reclaiming the authority to detail and define the support needed by the person who needs it, the neurodiversity paradigm displaces the need for psychiatric incarceration altogether. But abolishing psychiatric incarceration is not a call to leave Neurodivergent people unsupported. Rather, the call to abolish psychiatric incarceration is a call to reimage the contours of care that center the knowledge held by the most marginalized bodyminds.

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182. Indigo Daya describes how, in her experiences, psychiatric abuse is indistinguishable from other forms of abuse she has experienced in the following powerful quote:

> My abuser said no-one would believe me. Psychiatry . . . said I was lacking insight and capacity, so I couldn't be believed.
>
> My abuser controlled me with substances[.] Psychiatry controlled me with sedating drugs and shock treatment[.] My abuser put painful, unwanted things into my body. Psychiatry put painful, unwanted things into my body.
>
> My abuser told me to submit. Consent was impossible and irrelevant in the face of his total control. Psychiatry . . . said I must be compliant with what they wanted to do to my body and mind. They said if I didn't agree they could force me. Then they did.
>
> My abuser watched me. Told me others were watching too, I had to be careful. Psychiatry security guards watched me. Nurses did constant observations. . . .
>
> My abuser took off my clothes[.] Psychiatry strip searched me[.]
>
> Again and again, mental health services recreated the very experiences that led me to that state of extreme distress and altered states. To me, psychiatry became just one more perpetrator.

Indigo Daya (@indigo.mad.art), Instagram (Jan. 5, 2023), https://www.instagram.com/p/CnD0LEapU7s/ (on file with the *Columbia Law Review*) (emphasis omitted).

Indigenous, Black, Mad, Neurodivergent, Queer, and Disabled people have already begun the work of constructing networks of noncarceral care that could replace the violent and carceral medical–legal institution in place today.[183] From these people fighting for a world that leaves no one behind, we learn at least two critical ideas. First, focusing on preventing behavior labeled "dangerous" or "high risk" obscures how we force people to survive systems of immense violence.[184] Second, the presumption of singularity built into the pathology paradigm prevents recognition of the kaleidoscopic nature of crisis.[185] Thus, a call for psychiatric abolition recognizes that self-harm is a kind of quiet survival against all odds and the way out of crisis is a path only the person in crisis is capable of discerning.[186] Preserving the credibility of even those in their most distressed state so that they may determine what tools are necessary for their own survival is critical for crafting ecosystems where relational autonomy, dignity, and interdependence are universal.[187]

CONCLUSION

Abolishing psychiatric incarceration in favor of a noncarceral, neurodiversity-informed infrastructure of care is not about letting people die. Rather, rejecting the pathology paradigm is about removing carceral

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183. See generally Cara Page & Erica Woodland, Healing Justice Lineages: Dreaming at the Crossroads of Liberation, Collective Care, and Safety (2023) (formulating a political framework that embraces community- and survivor-led care networks, practices, and strategies that center the knowledge generated within disability, reproductive, environmental, and transformative justice movements).

184. Shira Hassan, Understanding Harm Reduction, *in* Saving Our Own Lives, supra note 152, at 114, 123 ("'High-risk behavior' is a stigmatized way of talking about the gorgeous and varied coping strategies we reach for when we are trying to heal from or just survive day to day.").

185. Stefanie Lyn Kaufman-Mthimkhulu describes the different forms of care needs they have seen in their time providing anticarceral care:

> Sometimes when someone reaches out in crisis they need $100 to fill their medication prescription before they go into withdrawal. . . . Or they need alternative housing for the night or the week. Sometimes, they need to be on the phone with someone for 3 hours to share their story. Sometimes intervention is needed in the form of de-escalating a crisis or mediating a conversation or offering a group the ability to process something traumatic. Sometimes someone feels unsafe and wants a person to stay in their home with them until the feeling passes.

Stefanie Lyn Kaufman-Mthimkhulu, Visions for a Liberated Anti-Carceral Crisis Response: From a Mad Crip Care Worker and Psychiatric Survivor, Medium (Sept. 3, 2022), https://medium.com/@stefkaufman/visions-for-a-liberated-anti-carceral-crisis-response-c81791459a99 [https://perma.cc/7U5U-9KT6].

186. Id. ("There is no one program that will solve the problem of distress. We are forced to endure a society that is deeply out of balance with our needs as humans. This will manifest inside of our individual bodies, but it doesn't mean the problem is individual.").

187. Hassan, supra note 184, at 212 ("Liberatory Harm Reduction gives us the rare opportunity to feel accepted, witnessed, and not judged for what the world sees as morally wrong behaviors, and we can learn to care for ourselves in complex and beautiful ways.").

logic from "care" and reframing who is the final authority on the internal experiences of those who are distressed, Neurodivergent, or both. Rejecting the pathology paradigm is about dismantling systems that corrode mental health rather than convincing those deemed other that it is them who are wrong. Neurodiversity-informed, noncarceral care is about liberatory harm reduction, including creating therapies that help all bodyminds move through trauma, acknowledging pain without pathologizing it, celebrating rather than shaming survival, and helping people identify the support they need without depriving them of full informed consent.

This paradigm shift demands that the best noncarceral care gets to the communities who need it most based on what those communities themselves have decided is necessary for their own healing and wellness and that we dismantle the systems that disproportionately burden othered bodyminds to envision a world where healthcare is more than merely biomedical. The abolition of psychiatric incarceration is about demanding we focus on the community relations that sustain us rather than strengthening a myopic focus on fixing what we perceive is broken only after we think we see it break.