

“HIGH FUNCTIONING”: SUCCESSFUL PROFESSIONALS WITH SEVERE MENTAL ILLNESS

BY JAMES T. R. JONES†

I. INTRODUCTION

Major depressive disorder. Bipolar disorder. Schizophrenia. Borderline personality disorder. Mental illness¹ is a serious international health concern. As of 2012, an estimated 18.6 percent of American adults—that is, 43.7 million people—suffer from a mental disorder in any given year.² The principal burden

Copyright © James T. R. Jones.

† Professor of Law, Louis D. Brandeis School of Law at the University of Louisville. B.A., University of Virginia; J.D., Duke University School of Law. The author is particularly interested in this topic because, as noted *infra*, he has suffered from the severe mental illness bipolar disorder, mostly in silence due to fear of stigma and discrimination, for much of his life. He has attempted suicide and has been hospitalized five times for this disease for periods ranging from a few days to over six months; he has lost one job and over a year and a half of his working life to severe manifestations of mental illness. In 2008, he became only the second law professor in the United States publicly to acknowledge living with a serious mental illness. Since 2008 he has written and spoken extensively about successful professionals who are so afflicted, and has won multiple awards for his mental health advocacy efforts. In 2011 he published his memoir, *A Hidden Madness*.

1. Many terms, often pejorative in nature, are used to describe people who live with mental illness—“crazy,” “insane,” “nuts,” “cracked,” “lunatic,” and “mentally ill” are some of them. Among those so afflicted, the preferred term is “mad,” and “madness” is the preferred term for mental illness. See, e.g., PATTY DUKE & GLORIA HOCHMAN, *A BRILLIANT MADNESS: LIVING WITH MANIC-DEPRESSIVE ILLNESS* (1992) (recounting actress Patty Duke’s experience living with manic depressive disorder); KAY REDFIELD JAMISON, *AN UNQUIET MIND: A MEMOIR OF MOODS AND MADNESS* (1995) [hereinafter JAMISON, *AN UNQUIET MIND*] (examining bipolar disorder from the dual perspective of a healer and the healed); JAMES T. R. JONES, *A HIDDEN MADNESS* (2011) (recounting the experience of the author of this Article as a professional forced to deal with his madness largely in silence because of the stigma of mental illness in the legal profession); ELYN R. SAKS, *THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS* (2007) (telling the story of Professor Elyn R. Saks, the Orrin B. Evans Professor of Law, Psychology, Psychiatry, and Behavioral Sciences at the University of Southern California Gould School of Law, and her struggles with schizophrenia); Gregory M. Duhl, *Over the Borderline*, 44 *LOY. U. CHI. L.J.* 771, 771-72 (2013) (reviewing MARGARET PRICE, *MAD AT SCHOOL: RHETORICS OF MENTAL DISABILITY AND ACADEMIC LIFE* (2011), a study of how our education practices might change if we understood disability to incorporate the disabled mind, including one with borderline personality disorder).

2. Nat’l Inst. Mental Health, *Prevalence of Any Mental Illness (AMI) Among Adults*, NAT’L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml> (last visited Apr. 10, 2015). These estimates do not include substance-abuse disorders. *Id.* They assume a total U.S. adult population of 235 million. *Id.* Like the National Institute of Mental Health, this article does not discuss individuals with substance-abuse issues. See

of mental illness is concentrated in those with serious mental illnesses. Serious mental illnesses include major depressive disorder, which touches roughly 6.9 percent of American adults (16 million people);³ bipolar disorder, which affects about 2.6 percent of American adults (6.1 million people);⁴ schizophrenia, which afflicts an estimated 1.1 percent of American adults (2.6 million people);⁵ and borderline personality disorder, which strikes an estimated 1.6 percent of American adults (3.75 million people).⁶ Twice as many live with schizophrenia as with HIV/AIDS.⁷

Mental illness is the leading cause of disability for Americans between ages fifteen and forty-four, and accounts for over 15 percent of the total U.S. disease burden—more than the burden of all cancers.⁸ In 2006, it is estimated that among American adults, 31.6 million people paid a total of \$48.6 billion for mental-health services.⁹ This means the average expenditure per person with a mental illness was \$1,537. Mental illness can have grave impact on individuals' quality of life, often leading to disability and, in extreme cases, suicide.¹⁰

Mental illness can strike anyone, regardless of age, race, sex or occupation.

Yuri N. Walker, *Protecting the Public: The Impact of the Americans with Disabilities Act on Licensure Considerations Involving Mentally Impaired Medical and Legal Professionals*, 25 J. LEGAL MED. 441, 441–42 (2004) (noting that the article's focus on mental impairment did not include substance abuse).

3. Nat'l Inst. Mental Health, *Major Depression Among Adults*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml> (last visited Apr. 10, 2015).

4. Nat'l Inst. of Mental Health, *Bipolar Disorder Among Adults*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/bipolar-disorder-among-adults.shtml> (last visited Apr. 10, 2015).

5. Nat'l Inst. of Mental Health, *Schizophrenia*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/schizophrenia.shtml> (last visited Apr. 10, 2015).

6. Nat'l Inst. of Mental Health, *Borderline Personality Disorder*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/borderline-personality-disorder.shtml> (last visited Apr. 10, 2015).

7. Logan Parker, *Access to Medicaid for the Mentally Ill: PPACA's Effect on Payment of Mental Health Services*, 21 ANNALS HEALTH L. ADVANCE DIRECTIVE 100, 100 (2011).

8. James T. R. Jones, *Walking the Tightrope of Bipolar Disorder: The Secret Life of a Law Professor*, 57 J. LEGAL EDUC. 349, 351–52 & n.10 (2007).

9. Nat'l Inst. Mental Health, *Mental Healthcare Cost Data for All Americans (2006)*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/cost/mental-healthcare-cost-data-for-all-americans-2006.shtml> (last visited Apr. 10, 2015).

10. Suicide is a serious problem. Every forty seconds someone in the world dies by suicide. WORLD HEALTH ORG., PREVENTING SUICIDE: A GLOBAL IMPERATIVE 3 (2014), *available at* http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1&ua=1. The world saw 804,000 reported suicides in 2012, and the actual number may be far greater than the reported total given stigma concerns for the victims' loved ones. *Id.* at 7. Globally, 56 percent of all violent deaths are by suicide, and 81 percent in high-income nations. *Id.* at 22. There were 43,361 completed suicides in the United States in 2012. *Id.* at 87. The gravity of this situation is driven home by the 2014 death by suicide of popular Vermont Law School Professor Cheryl Hanna. *Vermont Law Professor Death Ruled a Suicide*, THE NAT'L JURIST (Aug. 6, 2014), *available at* <http://www.nationaljurist.com/content/vermont-law-professor-death-ruled-suicide> [hereinafter *Vermont Law Professor*]. See *infra* notes 87–88 and accompanying text (discussing Professor Hanna's struggle with mental illness and her death by suicide).

Legal and medical¹¹ professionals¹² and students are not immune from its various manifestations; indeed, these groups have some of the highest rates of these disorders. No one knows exactly how many legal and medical professionals and students are so afflicted because they often keep their illnesses secret. They do this because they fear stigma if they are open to others. Perhaps one of the best (or worst) examples of stigma among professional communities is the situation in many states where medical and bar licensing agencies ask applicants intrusive and inquisitional questions about any history of mental-health conditions or treatment. Students, who fear they will not be approved for a license if they answer “yes” to these inquiries, will forego the mental-health care they desperately need in order to be able to avoid having to report diagnosis of, or treatment for, mental illness. This choice to go untreated can gravely affect them. Thus, stigma has terrible consequences for professionals.

Despite stigma concerns, some “high functioning”¹³ professionals go public with their mental health diagnoses to try to reduce stigma by showing that some prominent people have severe mental illnesses. Various professionals have achieved prominence despite suffering from the aforementioned severe mental illnesses, including major depression, bipolar disorder, schizophrenia, and borderline personality disorder.

11. This article discusses medical and mental health professionals under the “medical” umbrella.

12. Successful professionals in many other fields have gone public with their severe mental illnesses, including astronaut Colonel Edwin E. “Buzz” Aldrin, Marc Lee, *Buzz Aldrin: the dark times that followed that historic flight*, THE TELEGRAPH (July 8, 2009), available at <http://www.telegraph.co.uk/news/science/space/5779145/Buzz-Aldrin-the-dark-times-that-followed-that-historic-flight.html>; authors William Styron and Art Buchwald, Sarah Brown, *Celebrating the Dark and Bright Days of the Blues Brothers*, VINEYARD GAZETTE (Aug. 16, 2012), available at <http://vineyardgazette.com/news/2012/08/16/celebrating-dark-and-bright-days-blues-brothers?k=v5527d481e9c24&r=1>; journalists Mike Wallace and Jane Pauley, Michael Shally-Jensen, *Mental Healthcare Issues in America: An Encyclopedia* 441–42 (2013); professional athlete Alonzo Spellman, Greg Garber, *Spellman returns to football after addressing disorder*, ESPN (June 13, 2006), <http://sports.espn.go.com/nfl/news/story?id=2474007>; and actors Patty Duke, Richard Dreyfuss, Roseanne Barr, Brooke Shields, and Catherine Zeta-Jones, *Famous People Who Struggled With Mental Illness*, BIO., <http://www.biography.com/people/groups/mental-illness> (last visited Apr. 10, 2015). Unlike some other mental diseases such as bipolar disorder, e.g., LANA R. CASTLE, *BIPOLAR DISORDER DEMYSTIFIED: MASTERING THE TIGHTROPE OF MANIC DEPRESSION* 285–89 (2003); KAY REDFIELD JAMISON, *TOUCHED WITH FIRE: MANIC-DEPRESSIVE ILLNESS AND THE ARTISTIC TEMPERAMENT* (1993) [hereinafter JAMISON, *TOUCHED WITH FIRE*], only a few artists or famous and creative people who had schizophrenia have been reported. E. FULLER TORREY, *SURVIVING SCHIZOPHRENIA: A MANUAL FOR FAMILIES, PATIENTS, AND PROVIDERS* 389–94 (5th ed. 2006). This article focuses on those in the legal and medical professions.

13. Both the author’s psychiatrist and therapist frequently refer to him as “high-functioning.” Jones, *supra* note 8, at 367 n.68, 369 n.73 (noting that psychiatrist Dr. Deborah Quinton calls the author high-functioning); see Duhl, *supra* note 1, at 774 (stating that a law professor with borderline personality disorder is high functioning). When pressed for a definition, neither can point to a scientific one. They say that calling the author “high functioning” means that, despite suffering from an often debilitating disease, he works at the highest possible level. Allegedly, the world’s most famous consulting detective was a high-functioning sociopath. E.g., *Sherlock Holmes: High-Functioning Sociopath?*, SOCIOPATH WORLD (Aug. 6, 2010), <http://www.sociopathworld.com/2010/08/sherlock-holmes-high-functioning.html>; see MARGARET PRICE, *MAD AT SCHOOL: RHETORICS OF MENTAL DISABILITY AND ACADEMIC LIFE* 2 (2011) (suggesting that Sherlock Holmes had Asperger’s syndrome).

Serious mental illness profoundly affects an afflicted professional. It impairs cognitive abilities essential to functioning as a professional, especially practicing and teaching law or medicine. Imagine the despair that must be endured when one's mind, which has so far been the key to one's professional success, suddenly becomes one's worst enemy. The situation is brought home by the story of Nobel laureate John Forbes Nash, Jr., as portrayed in the book and motion picture *A Beautiful Mind*.¹⁴ As a result of severe mental illness, some successful professionals have been hospitalized numerous times, attempted suicide, and lost jobs and years of their working lives.¹⁵ Still, they soldier on, with no alternatives other than disability or suicide. Neither is an attractive option.

This Article will proceed in four parts. Part I discusses severe mental illness in the United States among legal and medical students and professionals. Part II looks at stigma, and why it keeps most of those with mental illness in the shadows. In particular, it will focus on the issue of professional licensure. Part III will give examples of successful medical and legal professionals who have gone public with their disease and discuss how they are able to function at the highest levels of their profession notwithstanding the special challenges they face every day. In Part IV, this Article concludes by discussing how these examples show that potentially tragic circumstances can have a positive effect on professionals' lives through hard work, good medical care, and a modicum of luck.

II. INCIDENCE OF SEVERE MENTAL ILLNESS IN MEDICAL AND LAW STUDENTS AND PROFESSIONALS

A. Medical Students and Physicians

Numerous sources attest to the high incidence of mental illness in the medical profession. Medical students see their mental health start to decline almost as soon as they start medical school,¹⁶ and it continues downhill from there.¹⁷ One study shows that at the end of their first year, 57 percent of medical students have moderate to severe symptoms of anxiety and 27 percent have moderate to severe symptoms of depression.¹⁸ Overall, a substantial percentage of medical students suffer from significant depression;¹⁹ these depressed

14. SYLVIA NASAR, *A BEAUTIFUL MIND* (1998); *A BEAUTIFUL MIND* (Universal Pictures 2001).

15. See *infra* notes 162–307 and accompanying text.

16. Stuart J. Slavin et al., *Medical Student Mental Health 3.0: Improving Student Wellness Through Curricular Changes*, 89 *ACAD. MED.* 573, 576 (2014).

17. Thomas L. Schwenk et al., *Depression, Stigma, and Suicidal Ideation in Medical Students*, 304 *JAMA* 1181, 1181 (2010).

18. Slavin et al., *supra* note 16, at 574.

19. See Claudia Center et al., *Confronting Depression and Suicide in Physicians: A Consensus Statement*, 289 *JAMA* 3161, 3162 (2003) (highlighting that cross-sectional rates of depression among medical students are 15 to 30 percent); Liselotte N. Dyrbye et al., *Burnout and Suicidal Ideation among U.S. Medical Students*, 149 *ANNALS OF INTERNAL MED.* 334, 336 (2008) [hereinafter Dyrbye, et al., *Burnout and Suicidal Ideation among U.S. Medical Students*] (finding that 46.5 percent screen positive for depression); Laura Weiss Roberts, *Understanding Depression and Distress Among Medical Students*, 304 *JAMA* 1231, 1231 (2010) (noting that a cross-sectional study at the University of Michigan found from

students are more likely than their peers to seriously consider suicide.²⁰ Immediately prior to graduation, as many as 38 percent of medical students may be depressed.²¹ A startling 11.2 percent have suicidal ideation,²² which is a well-established predictor of suicidal planning and attempted suicide.²³ Female medical students have significantly higher levels of depression, anxiety, and psychological distress than their male peers,²⁴ and single students have higher depression rates than married students.²⁵ As many as 80 percent of students have significant distress.²⁶ Medical students in other nations exhibit similar symptoms.²⁷

Sadly, only 22 percent of depressed medical students and 42 percent of those with suicidal ideation use mental-health services.²⁸ Medical students are less likely to seek mental-health care than the general population even though they have better access to it.²⁹

The seeds of mental illness planted in medical school often bear fruit after medical students become practicing physicians.³⁰ Medical residents have problems with distress and burnout.³¹ Many physicians feel social isolation, and do not take proper care of themselves;³² some follow dangerous approaches to

14 to 33 percent of medical students had symptoms consistent with moderate to severe depression).

20. Roberts, *supra* note 19, at 1231.

21. Liselotte N. Dyrbye et al., *The Problems Program Directors Inherit: Medical Student Distress at the Time of Graduation*, 33 MED. TCHR. 756, 756 (2011) [hereinafter Dyrbye, et al., *The Problems Program Directors Inherit*].

22. Slavin et al., *supra* note 16, at 573. See also Dyrbye et al., *Burnout and Suicidal Ideation among U.S. Medical Students*, *supra* note 19, at 334 (noting that some studies have found between 3 and 15 percent of medical students have suicidal ideation during medical school training); *id.* at 339 (noting that the study authors found a suicidal ideation rate of 11.2 percent among medical school students); Dyrbye et al., *The Problems Program Directors Inherit*, *supra* note 21, at 756 (noting that from 12.9 to 14.1 percent of fourth year students have suicidal ideation).

23. Dyrbye et al., *Burnout and Suicidal Ideation among U.S. Medical Students*, *supra* note 19, at 334 (“34% of individuals . . . with suicidal ideation develop a suicide plan and, of those who plan, more than 70% will attempt suicide”).

24. Liselotte N. Dyrbye et al., *Systematic Review of Depression, Anxiety, and Other Indicators of Psychological Distress Among U.S. and Canadian Medical Students*, 81 ACAD. MED. 354, 358 (2006) [hereinafter Dyrbye et al., *Systematic Review*]; Dyrbye et al., *The Problems Program Directors Inherit*, *supra* note 21, at 757; Schwenk et al., *supra* note 17, at 1189.

25. Dyrbye et al., *Systematic Review*, *supra* note 24, at 359; Dyrbye et al., *The Problems Program Directors Inherit*, *supra* note 21, at 757.

26. Liselotte N. Dyrbye et al., *Patterns of Distress in US Medical Students*, 33 MED. TCHR. 834, 837 (2011). Levels of distress correlate with suicidal ideation. *Id.*

27. See, e.g., Dyrbye et al., *Burnout and Suicidal Ideation among U.S. Medical Students*, *supra* note 19, at 340 (noting that 14 percent of graduating medical students in Norway have suicidal ideation); Dyrbye et al., *Systematic Review*, *supra* note 24, at 361 (noting that medical students in Turkey, Sweden, Norway, and the United Kingdom have serious problems with distress, depression, and suicidal ideation).

28. Center et al., *supra* note 19, at 3163. See Dyrbye et al., *Systematic Review*, *supra* note 24, at 360 (noting that only 22 to 27 percent seek counseling).

29. Schwenk et al., *supra* note 17, at 1181.

30. Slavin et al., *supra* note 16, at 576.

31. Dyrbye et al., *The Problems Program Directors Inherit*, *supra* note 21, at 756.

32. Eva Schernhammer, *Taking Their Own Lives – The High Rate of Physician Suicide*, 352 NEW ENG. J. MED. 2473, 2474 (2005).

care such as self-prescribing antidepressants.³³ As a result, they are often more susceptible to depression.³⁴ As early as 1858, English physicians observed that physicians die by suicide at a higher rate than the general population.³⁵

Today, the numbers are frightening: the suicide rate among male physicians is 40 percent higher than for men in the general population, and that for female physicians is a staggering 130 percent greater than for women in the general population.³⁶ Every year three-hundred to four-hundred physicians and medical students die by suicide, a number equal to several medical-school classes.³⁷

Why do so many more female physicians die by suicide than male ones? Scholars posit several reasons. First, women in medicine face sexual harassment, especially in male-dominated fields like surgery and emergency medicine.³⁸ Moreover, they are more likely to be single and childless, both of which are linked to a higher suicide rate.³⁹ Female physicians complete suicide at a much higher rate than do women in the general population—physicians complete it more than half the time, while women in the general population do so only in 7 to 10 percent of cases.⁴⁰ At least some of this difference is attributable to ready access to drugs in female physicians' offices and laboratories, and to their medical knowledge.⁴¹

In sum, medical students and practicing physicians face many psychiatric issues. They have high rates of anxiety and depression. Suicidal ideation is also a major problem. They attempt, and complete, suicide at appalling rates. It is very troubling that those whom society has tasked with taking care of others do not take care of themselves.

B. Law Students and Lawyers

As bad as things are for medical students and physicians, law students and lawyers have it worse. Law students suffer from more mental illness than any other category of graduate and professional students.⁴² Their average level of

33. Schwenk et al., *supra* note 17, at 1181.

34. Schernhammer, *supra* note 32, at 2474; Slavin et al., *supra* note 16, at 576.

35. Center et al., *supra* note 19, at 3161.

36. Dyrbye et al., *Burnout and Suicidal Ideation among U.S. Medical Students*, *supra* note 19, at 334; Schernhammer, *supra* note 32, at 2474.

37. JAMISON, AN UNQUIET MIND, *supra* note 1, at 208; Kay Redfield Jamison, *Stigma of Manic Depression: A Psychologist's Experience*, 352 THE LANCET 1053, 1053 (1998) [hereinafter Jamison, *Stigma of Manic Depression*]; Christine Moutier et al., *The Suicide Prevention and Depression Awareness Program at the University of California, San Diego School of Medicine*, 87 ACAD. MED. 1, 1 (2012). See also Rupinder K. Legha, *A History of Physician Suicide in America*, 33 J. MED. HUMANITIES 219 (2012) (providing a fascinating 2012 history of suicide among American physicians).

38. Schernhammer, *supra* note 32, at 2474-75.

39. *Id.* at 2474.

40. *Id.* at 2475.

41. *Id.* at 2476.

42. Jennifer Jolly-Ryan, *The Last Taboo: Breaking Law Students with Mental Illnesses and Disabilities Out of the Stigma Straitjacket*, 79 UMKC L. REV. 123, 131 (2010) [hereinafter Jolly-Ryan, *The Last Taboo*]. The same is true in Australia. Wendy Larcombe et al., *Does an Improved Experience of Law School Protect Students against Depression, Anxiety and Stress? An Empirical Study of Wellbeing and the Law School Experience of LLB and JD Students*, 35 SYDNEY L. REV. 407, 408 (2013).

stress is much higher than that of medical students.⁴³ They also have a much higher level of depression than do medical students.⁴⁴ Law school is less nurturing of its students than is medical school.⁴⁵ And law students are much less likely to seek psychological counseling than are medical students.⁴⁶

When students enter law school they are no different psychologically than their age group in the general population.⁴⁷ Things quickly change.⁴⁸ By the end of their first year, 32 percent of law students are depressed, and by graduation 40 percent are so afflicted.⁴⁹ Some blame increasing rates of depression among law students on issues like class ranking of first-year students, awareness that large firms generally hire only from the top 10 percent of the class, peer-to-peer stigmatization, and professor feedback.⁵⁰ Competition for grades is fierce and generates a heavy workload among the competitors.⁵¹ In short, law school is injurious to good mental health.⁵²

But competition for top grades is not the whole story. Perhaps surprisingly (or not), the top students at elite law schools—those large firms want to hire—also have widespread depression.⁵³ This Article’s author, for example, ranked in

43. Jennifer Jolly-Ryan, *Promoting Mental Health in Law School: What Law Schools Can Do for Law Students to Help Them Become Happy, Mentally Healthy Lawyers*, 48 U. LOUISVILLE L. REV. 95, 97 (2009) [hereinafter Jolly-Ryan, *Promoting Mental Health in Law School*]; Todd David Peterson & Elizabeth Waters Peterson, *Stemming the Tide of Law Student Depression: What Law Schools Need to Learn from the Science of Positive Psychology*, 9 YALE J. HEALTH POL’Y L. & ETHICS 357, 359 (2009).

44. Dyrbye et al., *Systematic Review*, *supra* note 24, at 358; Peterson & Peterson, *supra* note 43, at 366, 368.

45. Peterson & Peterson, *supra* note 43, at 366 n.55.

46. *Id.* at 373. According to a recent study, while 41.8 percent of responding law students thought they needed help for emotional or mental-health problems in the past year, only 24.3 percent actually received counseling from a mental-health professional. Jerry Organ et al., 2014 Survey of Law Student Well-Being 15 (Sept. 19, 2014) (unpublished manuscript) (on file with author).

47. Peterson & Peterson, *supra* note 43, at 369–70. Accord Larcombe et al., *supra* note 42, at 408.

48. Corie Rosen Felder, *The Accidental Optimist*, 21 VA. J. SOC. POL’Y & L. 63, 67, 72 (2014).

49. Jolly-Ryan, *Promoting Mental Health in Law School*, *supra* note 43, at 99–100; Jolly-Ryan, *The Last Taboo*, *supra* note 42, at 135; Michael Serota, *A Personal Constitution*, 105 NW. U. L. REV. COLLOQUY 149, 151–52 (2010). In Australia, over 30 percent of students have significant depression and anxiety by the end of their first year. Larcombe et al., *supra* note 42, at 416. This decline starts early in students’ second semester. *Id.* at 423.

50. Corie Rosen, *The Method and the Message*, 12 NEV. L.J. 160, 176 (2011). Ninety percent of law students, who are used to excelling academically, are not in the top 10 percent of their class and realize they are unlikely ever to be so situated. *Id.* at 177.

51. Peterson & Peterson, *supra* note 43, at 380–81.

52. Rosen, *supra* note 50, at 161. The results of a recent survey of Yale Law School students are troubling, but not surprising. The respondents, 296 out of the 650 Yale Law School students, reported as follows: 70 percent had struggled with mental health issues while in law school. Of those, 50 percent said their mental health problems had interfered with their academic performance, and 56 percent with their social relationships. Sadly, although 77 percent of those with mental health challenges had considered seeking treatment for them, only 62 percent had done so. There were various reasons for this discrepancy, notably including concern over intrusive bar licensure questions. Phoebe Kimmelman & Amaka Uchegbu, *Mental health troubles widespread at law school, report says*, YALE DAILY NEWS, Dec. 9, 2014, available at <http://yaledailynews.com/blog/2014/12/09/mental-health-troubles-widespread-at-law-school-report-says/>.

53. Felder, *supra* note 48, at 69, 74.

the top three of his class throughout his years at Duke Law School, yet he had significant levels of anxiety and depression during his entire time there. This may be solely attributable to an underlying pathology, but the studies suggest otherwise.

Perhaps even worse are results from a study of law students and suicide. According to the study, 20.5 percent of the students surveyed had thought seriously about suicide sometime in their lives, and 6.3 percent had thought seriously about suicide in the last twelve months.⁵⁴

Graduation from law school is no panacea. Anxiety and depression pervade the legal profession. Attorneys have a much higher rate of depression than does the general population,⁵⁵ and the distress suffered by depressed lawyers is greater than that of depressed members of other groups.⁵⁶ In a study of practicing lawyers, 20 to 35 percent were found to be “clinically distressed,” compared with only 2 percent of the general population.⁵⁷ Eleven percent of attorneys consider suicide every month,⁵⁸ and they are at least twice as likely to die by suicide as members of the general public.⁵⁹ In the microcosm of Kentucky, for example, recent years have seen a rash of lawyer suicides, especially among

54. Organ et al., *supra* note 46, at 14.

55. E.g., Jolly-Ryan, *Promoting Mental Health in Law School*, *supra* note 43, at 101 (noting that lawyers are 3.6 times more likely to be depressed than are other occupations, and that 19 to 26 percent of lawyers are depressed); Peterson & Peterson, *supra* note 43, at 358 (“Of all professionals in the United States, lawyers suffer from the highest rate of depression after adjusting for socio-demographic factors, and they are 3.6 times more likely to suffer from major depressive disorder than the rest of the employed population.”); Laura F. Rothstein, *Law Students and Lawyers with Mental Health and Substance Abuse Problems: Protecting the Public and the Individual*, 69 U. PITT. L. REV. 531, 532 (2008) [hereinafter Rothstein, *Law Students and Lawyers*] (noting that lawyers are depressed at four times the rate of the general population); Serota, *supra* note 49, at 151 (observing that rate of depression among lawyers is 3.6 times more likely than the rest of working Americans).

56. Serota, *supra* note 49, at 151.

57. Peterson & Peterson, *supra* note 43, at 358.

58. Serota, *supra* note 49, at 151.

59. Felder, *supra* note 48, at 71; Michael L. Perlin, “Baby, Look Inside Your Mirror”: *The Legal Profession’s Willful and Sanist Blindness to Lawyers with Mental Disabilities*, 69 U. PITT. L. REV. 589, 592 (2008). A Canadian study found that attorneys had a suicide rate nearly six times that of the general population. Felder, *supra*, at 71; Debra Cassens Weiss, *Lawyer Personalities May Contribute to Increased Suicide Risk*, ABA JOURNAL (Apr. 30, 2009), available at http://www.abajournal.com/news/article/lawyer_personalities_may_contribute_to_increased_suicide_risk/. Some sources say the attorney suicide rate in the U.S. is also six times that of the general population. See Yvette Hourigan, *When Depression Turns Deadly: The Impacts of Addiction and Depression On Suicide Among Lawyers and How to Recognize the Warning Signs*, in BROKEN-HEARTED IDEALISTS: THE EMOTIONAL AND MENTAL DRAIN UPON LAWYERS 9, 16 (Ky. Bar Ass’n June 19, 2014) (on file with author); C. Stuart Mauney, *The Lawyers’ Epidemic: Depression, Suicide, and Substance Abuse*, 37 THE DEFENSELINE 16 (Summer 2009), available at http://scdtaa.com/resources/Documents/FINAL_DefenseLine_37-2.pdf. See generally Rosa Flores & Rosa Marie Arce, *Why Are Lawyers Killing Themselves?*, CNN (Jan. 20, 2014), <http://www.cnn.com/2014/01/19/us/lawyer-suicides/> (discussing the disturbing trend of attorneys taking their own lives; one of those discussed is a former student of the author). Moreover, these numbers may be deceptively small, as undoubtedly a considerable number of deaths from single-vehicle automobile accidents, drug overdoses, hunting accidents, accidental poisonings, swimming accidents, and similar causes are completed suicides rather than accidents. See Hourigan, *supra*, at 17.

middle-aged trial lawyers.⁶⁰

III. STIGMA FOR LAW AND MEDICAL STUDENTS AND PROFESSIONALS WITH SEVERE MENTAL ILLNESSES

A. Stigma in General

Are these figures regarding the prevalence of mental illness in legal and medical students and practitioners accurate? Probably not. The actual figures are likely higher because those so afflicted often stay in the shadows due to fear of stigma.

Those with mental illness learn that stigma and discrimination have followed it throughout history.

It is no secret that individuals labeled mentally ill by society have been stigmatized and subjected to discriminatory treatment throughout history. Although individuals with physical impairments have also been the subject of disparaging public opinion, the animus directed at psychiatric impairments is proportionately greater and more pervasive. . . . One study recently concluded that individuals today may be more likely to hold stigmatizing attitudes toward the mentally ill than their counterparts nearly five decades ago.⁶¹

People suffering from psychiatric conditions are the most stigmatized group in contemporary society; while most people no longer use the degrading racial and ethnic slurs that once were common, ridicule of those with mental illness endures.⁶² The stigma against people who have a mental illness is so great that job applicants fear to disclose their condition to potential employers; indeed, “[s]ome vocational rehabilitation counselors . . . actually encourage their clients to hide prior hospitalizations or to devise strategies for covering gaps in

60. Andrew Wolfson, *Rash of Lawyer Suicides Worries Colleagues*, LOUISVILLE COURIER-JOURNAL, Jun. 2, 2013, available at <http://archive.courier-journal.com/article/20130602/NEWS01/306020009/Rash-lawyer-suicides-worries-colleagues>. A recent article in the *Journal of Legal Education* details the marked tendency for attorney suicides, especially in Kentucky. Brian S. Clarke, *Coming Out in the Classroom: Law Professors, Law Students and Depression*, 64 J. LEGAL EDUC. 403, 403–05 (2015).

61. Wendy F. Hensel & Gregory Todd Jones, *Bridging the Physical-Mental Gap: An Empirical Look at the Impact of Mental Illness Stigma on ADA Outcomes*, 73 TENN. L. REV. 47, 50-51 (2006) (footnotes omitted).

See Jon Bauer, *The Character of the Questions and the Fitness of the Process: Mental Health, Bar Admissions and the Americans with Disabilities Act*, 49 UCLA L. REV. 93, 193 (2001) (“From the earliest times, mental illness has been associated with violence, divine punishment, and demonic possession. By the late nineteenth century, these were joined by notions of degeneracy, defective character, and deviance”).

62. See STEPHEN P. HINSHAW, *THE MARK OF SHAME: STIGMA OF MENTAL ILLNESS AND AN AGENDA FOR CHANGE* xi (2007) (“Although current standards prevent most of us from using the kinds of racial and ethnic slurs that were common a generation ago, there are few restrictions on terms of ridicule to denote mental disorder”). Accord Kay Redfield Jamison, *The Many Stigmas of Mental Illness*, 367 THE LANCET 533, 533 (2006) [hereinafter Jamison, *The Many Stigmas*] (“Newspapers and television stations can print or broadcast statements about those with mental illness that simply would not be tolerated if they were said about any other minority group”).

employment caused by mental illness.”⁶³ Examples of the impact of stigma include the fall of Senator Thomas F. Eagleton, whom the Democratic Party nominated for Vice President in 1972 and then forced off the ticket when it learned that over ten years previously he had been hospitalized for depression and undergone electroshock treatment.⁶⁴ The stigma of schizophrenia is so great that one authority calls those afflicted “the lepers of the present day.”⁶⁵

The needless suffering due to stigma can cause significant harm like denying symptoms and delaying treatment. Although depression can be successfully treated, only 29 percent of people with depression contact mental health professionals; often this is because of fear of stigma.⁶⁶ The negative views about mental illness, which are at the heart of this stigma, can exclude individuals from access to housing, employment, insurance, and proper medical care.⁶⁷

A study conducted after the school shooting in Newtown, Connecticut, starkly highlights the impact of stigma. Almost half of all respondents thought that people with severe mental disease are more dangerous than members of the general population⁶⁸—this notwithstanding a report by the United States Surgeon General that emphasizes that the vast majority of those with mental illness are not violent and that the amount of the violence in society attributable to those so afflicted is very small.⁶⁹ Most survey respondents stated they were unwilling to have someone with a severe mental illness as a coworker or a neighbor.⁷⁰ When these results are coupled with a study published in May 2013

63. Hensel & Jones, *supra* note 61, at 71. The author is very glad that the law firm where he was working when he had a breakdown in 1983 agreed to keep him on its books as an associate during his hospitalization and recovery period so he could keep his health insurance even after it decided to terminate him. By doing so, the firm averted a fatal gap in his work history because he technically stayed an associate there until he got another job in mid-1984. JONES, *supra* note 1, at 98.

One attorney with bipolar disorder whose father was a psychiatrist reported that her father regularly told his patients to lie about having a psychiatric history. Naomi A. Himmelhoch, *In the Padded Closet: Thoughts on a Secret Life*, 10 HASTINGS WOMEN’S L.J. 463, 467 (1999). The attorney, in turn, lied about suffering from mental illness on job applications, her law school application, and even her Pennsylvania bar application. *Id.* at 467–68. Although the bar question was likely illegal, *see infra*, notes 114–57 and accompanying text, she pursued a risky course of action from which the author was spared because of the timing of his mental-health diagnosis and Florida bar application.

64. E.g., Lawrence N. Strout, *Politics and Mental Illness: The Campaigns of Thomas Eagleton and Lawton Chiles*, 18 J. AM. CULTURE 67, 67–71 (1995); Kirath Raj, Note, *The Presidents’ Mental Health*, 31 AM. J.L. & MED. 509, 520 (2005).

65. TORREY, *supra* note 12, at 406. Traditionally, the leper was the most stigmatized figure in society. *Id.* at 395. Accord Frederick J. Frese, III et al., *Recovery From Schizophrenia: With Views of Psychiatrists, Psychologists, and Others Diagnosed with This Disorder*, 35 SCHIZOPHRENIA BULL. 370, 376 (2009) (noting that the stigma of schizophrenia is the most profound of all stigmas).

66. Laura A. Pratt & Debra J. Brody, *Depression in the Household Population, 2005–2006*, NCHS DATA BRIEF 4 (2008), available at <http://www.cdc.gov/nchs/data/databriefs/db07.pdf>. A recent study disclosed that, while 46 percent of college students in a given year reported having a psychiatric disorder, fewer than 25 percent of them had sought treatment. PRICE, *supra* note 13, at 247.

67. Lorraine Schmall, *One Step Closer to Mental Health Parity*, 9 NEV. L. J. 646, 667 (2009).

68. Colleen L. Barry et al., *After Newtown – Public Opinion on Gun Policy and Mental Illness*, 368 NEW ENG. J. MED. 1077, 1081 (2013).

69. JONES, *supra* note 1, at 5–6.

70. Barry, *supra* note 68, at 1081.

that indicates that psychiatrists are prejudiced against their own patients and that they would provide their patients with mental illness with worse healthcare than individuals who do not have a mental illness,⁷¹ it is no surprise that most people with mental illness choose to keep their condition a secret. Since mental illnesses such as schizophrenia, bipolar disorder, and major depression are biologically based⁷² and can be treated extremely successfully,⁷³ these attitudes are particularly unfortunate and harmful.⁷⁴

Going public about one’s mental illness can be a dangerous proposition. Someone who did so has reported:

I received an astonishing number of letters, many of them quite psychotic and frightening from people who simply hated the mentally ill, or who raved on about the terrible manic depressives they had known. Others told me that I deserved my illness because I had not been a sufficiently devout Christian; yet others said that I had no business writing, teaching, or seeing patients, despite the fact that my illness was well controlled. Several colleagues made it abundantly clear that it would have been best to keep my illness private. Others were obviously embarrassed by my disclosure and appeared to have no idea of what they should say or do when in my presence.⁷⁵

Medical and law students and professionals with mental illness face special stigma concerns. They may pay cash for mental health treatment rather than use their health insurance to avoid having a record of their care appear in an insurance database, and may duck their heads lest someone they know recognize them while they are in their psychiatrist’s waiting room.⁷⁶ Law students fear stigma from their professors if they disclose having a mental illness,⁷⁷ and many legal employers will not hire attorneys with mental illness.⁷⁸ Medical students with a history of counseling suffer reduced prospects for residency placements.⁷⁹

71. Susan Jeffrey, *Psychiatrists Not Immune to Mental Health Bias*, MEDSCAPE (Mar. 18, 2015), <http://www.medscape.com/viewarticle/804499>; see Frese et al., *supra* note 65, at 377 (noting that mental-health professionals stigmatize patients with schizophrenia).

72. Sara Nadim, *The 2008 Mental Health Parity and Addiction Equity Act: An Overview of the New Legislation and Why An Amendment Should Be Passed to Specifically Define Mental Illness and Substance Use Disorders*, 16 CONN. INS. L.J. 297, 316 (2009).

73. Amanda Clark, *The Patient Protection and Affordable Care Act and Efforts of the Mentally Ill to Achieve Equal and Adequate Health Coverage*, 88 U. DET. MERCY L. REV. 357, 360 (2010).

74. E.g., Jamison, *The Many Stigmas*, *supra* note 62, at 533 (“There is a very large group [who are] the silent successful—people who get well from psychiatric illness but who are afraid to speak out. This reluctance is very understandable, very human, but it is unfortunate because it perpetuates the misperception that mental illness cannot be treated”).

75. Jamison, *Stigma of Manic Depression*, *supra* note 37, at 1053.

76. See Genevieve M. Martin, *Lawyers Helping Lawyers*, 61 R.I. BAR J. 25, 25 (2013) (reviewing KAY REDFIELD JAMISON, *AN UNQUIET MIND: A MEMOIR OF MOODS AND MADNESS* (1995)). The author once changed psychiatrists just because the psychiatrist-wife of a junior colleague on the law-school faculty joined the group where his then doctor practiced, and he was afraid that somehow word about his condition would leak back to the law school. JONES, *supra* note 1, at 5, 216.

77. Jolly-Ryan, *The Last Taboo*, *supra* note 42, at 128.

78. Duhl, *supra* note 1, at 811; Jolly-Ryan, *The Last Taboo*, *supra* note 42, at 123–24. As many as 48.3 percent of law students fear to seek counseling because they foresee doing so can pose a threat to employment prospects or academic status. Organ et al., *supra* note 46, at 16.

79. Center et al., *supra* note 19, at 3164.

Practicing physicians with psychiatric disorders encounter discrimination in hospital privileges, health insurance, and malpractice insurance.⁸⁰ Fear of stigma prevents 30 percent of depressed first- and second-year medical students from using mental-health services,⁸¹ and may stop 46.6 percent of law students from doing so.⁸² Medical students who are depressed are much more likely to associate stigma with depression than their colleagues who are not depressed,⁸³ and the beliefs of the two groups about the stigma of depression differ markedly:

Compared with students with low self-identified depression, students with high scores more frequently agreed that the opinions of depressed medical students would be less respected, that the coping skills of depressed medical students would be viewed as less adequate, that they would be viewed as less able to handle their responsibilities by faculty members, and that telling a counselor about depression would be risky. Students with high scores would also be less likely to seek treatment if depressed than would students with low scores.⁸⁴

A physician can try to avoid stigma by taking drug samples to avoid a documented history of taking psychiatric medication.⁸⁵

Finally, and tragically, stigma can kill. Consider the following two examples. The first is attorney and President Clinton's Deputy White House Counsel Vince Foster, who died by suicide in 1993 after a few months in Washington, D.C. Foster did not seek psychiatric treatment for the depression from which he suffered because he was afraid he would lose his White House security clearance if he did so.⁸⁶ The second example is Vermont Law School Professor Cheryl Hanna, who died by suicide on July 27, 2014.⁸⁷ Hanna, a Harvard Law School graduate and expert on constitutional law and women and the law, was severely depressed. She was hospitalized, but the hospital psychiatric unit was so full that she was forced to spend three days in the emergency ward. She then went home for a few days to celebrate her forty-eighth birthday. She was finally admitted to the psychiatric unit, but was afraid that stigma for being there would damage her career and left the hospital after another three days. She then, unbeknownst to her family, purchased a handgun, which she used to end her life.⁸⁸

B. Licensing Stigma

The most pervasive stigma in the medical and legal professions occurs in the

80. *Id.* at 3164, 3165; Martin, *supra* note 76, at 26.

81. Schwenk et al., *supra* note 17, at 1181.

82. Organ et al., *supra* note 46, at 16.

83. Moutier et al., *supra* note 37, at 1.

84. Schwenk et al., *supra* note 17, at 1188.

85. See Himmelhoch, *supra* note 63, at 467 (chronicling how psychiatrist-father of attorney with bipolar disorder got her samples so she had no documented record of taking psychiatric medications).

86. Stanley S. Herr, *Questioning the Questionnaires: Bar Admissions and Candidates with Disabilities*, 42 VILL. L. REV. 635, 643-44 (1997).

87. Vermont Law Professor, *supra* note 10.

88. *Id.*

licensing process.⁸⁹ Traditionally, medical and law-licensing bodies have required applicants to disclose any history of mental-health treatment through the use of questions that are at the least intrusive, if not inquisitorial.⁹⁰ The questions typically focus on whether the applicant merely has a diagnosis of mental illness, not solely on conduct that actually indicates a reason for concern. A positive response leads to additional questions and a demand for access to all the applicant’s mental-health records from psychiatrists, therapists, and hospitals.⁹¹ The result can be a hearing before a panel of untrained lay professionals⁹² (such is the case mainly in the law licensing arena,⁹³ although in the medical arena the panel may be healthcare professionals as opposed to mental-health professionals⁹⁴), a delay in getting a license,⁹⁵ expensive

89. For medical professionals, this is a problem both for those initially applying for a license and those seeking license renewals. Laura F. Rothstein, *Health Care Professionals with Mental and Physical Impairments: Developments in Disability Discrimination Law*, 41 ST. LOUIS U. L.J. 973, 1000 (1997) [hereinafter Rothstein, *Healthcare Professionals with Mental and Physical Impairments*]. See *infra* note 107. The issue in the law-license setting is whether the applicant is of “good moral character,” and the applicant bears the burden of proving he or she qualifies. E.g., Bauer, *supra* note 61, at 199–200.

For an enlightened analysis how the bar-licensing process for an applicant with a history of mental illness should operate, see *id.* at 213–24.

90. This is different from the treatment of those receiving non-psychiatric medical care. Herbert Hendin et al., *Licensing and Physician Mental Health: Problems and Possibilities*, 93 J. MED. LICENSURE & DISCIPLINE 6, 6 (2007). States rarely ask about “conditions such as chronic fatigue syndrome, multiple sclerosis, heart conditions, or various types of cancer that might . . . impair an attorney’s ability to complete work or meet deadlines.” Stephanie Denzel, *Second-Class Licensure: The Use of Conditional Admission Programs for Bar Applicants with Mental Health and Substance Abuse Histories*, 43 CONN. L. REV. 889, 899 (2011). Accord Herr, *supra* note 86, at 642 (making the same observation with respect to narcolepsy and chronic fatigue syndrome).

91. E.g., Center, *supra* note 19, at 3164; Denzel, *infra* note 90, at 909–10; Hendin et al., *supra* note 90, at 9; Herr, *supra* note 86, at 675. Such a demand can be particularly worrisome for a successful attorney with a psychiatric diagnosis who is moving to a new jurisdiction where she seeks a license. See *infra* note 99 and accompanying text. The author has been in mental-health treatment since 1979 and was hospitalized five times between 1979 and 2004. He has been treated by numerous mental-health professionals over the years, many of whose names he does not remember and whose whereabouts he does not know. At least some of them have died; two of the hospitals no longer exist. Even if one assumes the question is lawful under the ADA, more limited questions (for example, whether the applicant has received treatment within five years of application) are more realistic and reasonable.

92. A 2001 article detailed this process in the setting of the Connecticut Bar Examining Committee. Bauer, *supra* note 61, at 113–25, 211–12. Conditional-admission programs also have this problem. Denzel, *supra* note 90, at 926.

93. Marginally better is the lawyer-assistance program, available in all states, that uses lay attorneys with impairments to assist other attorneys who have mental-health concerns. See David B. Wexler, *Lawyer-Assistance Program Attorneys and the Practice of Therapeutic Jurisprudence*, 47 CT. REV. 64, 64 (2011). Such programs quite possibly violate the ADA. See *infra* note 97 and accompanying text.

94. Hendin et al., *supra* note 90, at 10 (arguing that licensing boards should have psychiatrists as members or consultants).

95. One applicant to the Maryland bar suffered a 392-day delay in getting sworn in as an attorney after she passed the bar examination because of her affirmative answer to the mental-health questions and the ensuing investigation of her application. Herr, *supra* note 86, at 658 & n.101. In Connecticut, two different applicants—one a state judicial clerk—had their applications delayed for over a year by such a process. Bauer, *supra* note 61, at 118, 125. Conditional-admission programs typically delay admission to the bar. Denzel, *supra* note 90, at 927.

prerequisites to the license,⁹⁶ and even a conditional admission that can effectively leave the applicant on “probation” for many years and can be a matter of public record.⁹⁷ This is unfortunate given the views of the American Psychiatric Association (APA), which takes the position that having a psychiatric history is not an accurate predictor of mental fitness and, accordingly, status questions are inappropriate.⁹⁸ Additionally, an applicant can have great difficulty getting a license in one state despite being successfully admitted in several others because of the various hurdles erected by licensing agencies.⁹⁹

Gradually, due to the Americans with Disabilities Act (ADA),¹⁰⁰ courts and the United States Department of Justice (DOJ) have attacked these intrusive questions and the process that they create, but some state licensing bodies persist in using them, resulting in a state-by-state battle against their use. Applicants for law and medical licenses often forego desperately needed mental-health treatment to avoid answering “yes” to these application questions.¹⁰¹ This, in

96. Hendin et al., *supra* note 90, at 9. Conditionally admitted attorneys may have to spend thousands of dollars getting and keeping their licenses. Denzel, *supra* note 90, at 913, 917. See Letter from Jocelyn Samuels, Acting U.S. Ass’t Att’y Gen., to The Hon. Bernette J. Johnson, C. J., La. Sup. Ct.; Elizabeth S. Schell, Exec. Dir., La. Sup. Ct. Comm. on Bar Admissions; & Charles B. Plattsmier, Chief Disciplinary Counsel, La. Att’y Disciplinary Bd. 8 (Feb. 5, 2014), available at <http://www.bazelon.org/LinkClick.aspx?fileticket=7fvfHYXZawM%3D&tabid=698> [hereinafter *La. Bar Letter*].

97. Denzel, *supra* note 90, at 893, 912–13 (arguing that states with conditional-admission programs create a form of “second class license”); Jolly-Ryan, *The Last Taboo*, *supra* note 42, at 158–59 (noting that a number of states have conditional admission for some applicants with mental-health histories). Accord Denzel, *supra*, at 913 (“Conditional status is stigmatizing and, if known, may damage an attorney’s reputation and ability to build a practice”). Conditional-admission programs often are based on mental-health diagnosis rather than behavior and thus violate the ADA. *Id.* at 915–16, 922, 924–25. Florida has required conditionally admitted attorneys to live and practice in the state, thus limiting their ability to move out of the state in a manner not faced by non-disabled attorneys. *Id.* at 926. Having conditional-admission status a matter of public record in at least two states, *id.* at 926–27, is an outrage and almost certainly an ADA violation. See Letter from Jocelyn Samuels, Acting Ass’t U.S. Att’y Gen., to Karen L. Richards, Exec. Dir, Vt. Human Rts. Comm’n 9 (Jan. 21, 2014), available at <http://psychrights.org/2014/140121USDoJLtr2VtHumanRightsCommn.pdf> [hereinafter *Vt. Human Rights Letter*].

98. Walker, *supra* note 2, at 462. See Denzel, *supra* note 90, at 892. The APA offers guidelines which provide, in part, “Prior psychiatric history is, per se, not relevant to the question of current impairment.” Walker, *supra*, at 462; Denzel, *supra*, at 928 (“Admission to [conditional admission] programs . . . are not grounded in research or specific evidence that an individual applicant poses a direct threat to the public. Rather, they are based on stereotypes about mental illness . . . and on the biases of those who make the admission decisions”).

99. Bauer, *supra* note 61, at 120–21; Denzel, *supra* note 90, at 897, 899–900 & n.66.

100. See Americans with Disabilities Act, 42 U.S.C. § 12101 (2012).

101. E.g., Center, *supra* note 19, at 3164; Hendin et al., *supra* note 90, at 6, 9; Jolly-Ryan, *The Last Taboo*, *supra* note 42, at 124; Rothstein, *Law Students and Lawyers*, *supra* note 55, at 540. This deterrent effect can, ironically, increase the number of new professionals with untreated mental-health problems who may pose a risk to their patients and clients. Bauer, *supra* note 61, at 150, 169; Denzel, *supra* note 90, at 892. Conditional-admission programs create the same problem. *Id.* at 928. According to a recent study, 45 percent of law students may refuse to seek mental health treatment because they fear doing so will pose a potential threat to their admission to the bar. Organ, et al., *supra* note 46, at 16.

Although most physicians with a declared mental-health diagnosis eventually get an

turn, can lead to needless suffering, and even suicide, of untreated applicants.¹⁰²

1. *Medical Licensing*

Over the years, several articles have focused on mental-health questions in the medical-licensing setting.¹⁰³ Every jurisdiction in the United States has a medical-licensure board.¹⁰⁴ The boards of forty states ask applicants about mental illness.¹⁰⁵ *Medical Society of New Jersey v. Jacobs*¹⁰⁶ was one of the earliest cases that addressed the ADA and licensing. In *Jacobs*, an unpublished decision, the court addressed questions that the licensing board asked of applicants for renewal of their medical licenses.¹⁰⁷ The questions asked applicants about any mental illness or psychiatric problems they had experienced.¹⁰⁸ An affirmative response required a detailed explanation, and failure to answer a question, or a false answer, could result in the loss of the applicant’s license.¹⁰⁹ The court discussed the ADA in detail and held that broad questions about diagnosis rather than narrow questions about the applicant’s conduct were unlawful¹¹⁰ as broad questions about diagnosis led to extra investigation and invidious discrimination of those with disability status.¹¹¹ The court concluded that the licensing board “may not . . . carry out its duties in a fashion that discriminates against applicants with disabilities based on the status of the applicants.”¹¹²

Jacobs reaches an appropriate result. Individualized determination of whether an applicant with a psychiatric diagnosis is qualified for a license is a key consideration under the ADA.¹¹³ As in the legal setting discussed below, questions based solely on one’s status as a person with a mental illness are and ought to be unlawful.

unrestricted license to practice, this is contrary to their expectations. Hendin et al., *supra* 90, at 9. Similarly, some state bar-licensing agencies defend broad questions by saying applicants are rarely denied bar admission because of a history of psychiatric treatment, but most applicants do not know this and shun counseling as a result. E.g., Herr, *supra* note 86, at 642; Rothstein, *supra*, at 543; Symposium, *Assisting Law Students with Disabilities in the 21st Century: A New Horizon?, Suffering in Silence: The Tension Between Self-Disclosure and a Law School’s Obligation to Report*, 18 AM. U. J. GENDER SOC. POL’Y & L. 121, 128 (2007).

102. The majority of physicians who die by suicide are not in psychiatric treatment at the time of their deaths. Hendin et al., *supra* note 90, at 6.

103. E.g. *id.*; Rothstein, *Healthcare Professionals with Mental and Physical Impairments*, *supra* note 89.

104. Walker, *supra* note 2, at 444.

105. Hendin et al., *supra* note 90, at 7.

106. Civ. A. No. 93-3670 (WGB), 1993 U.S. Dist. LEXIS 14294 (D.N.J. Oct. 5, 1993).

107. Although the issue in *Jacobs* was renewal of medical licenses rather than their initial award, the concerns are the same in both situations—attorneys with mental illness do not face this issue unless the jurisdiction requires lawyers to periodically renew their licenses. Herr, *supra* note 86, at 642. The author benefited from this distinction, as he became licensed in Florida before his diagnosis with mental illness. Florida does not require periodic renewal of attorney licenses with concomitant mental-health questions, but rather merely payment of annual dues.

108. *Jacobs*, 1993 U.S. Dist. LEXIS 14294, at *3–5.

109. *Id.* at *5–6.

110. *Id.* at *20.

111. *Id.* at *21, *23–24.

112. *Id.* at *29.

113. Rothstein, *Healthcare Professionals with Mental and Physical Impairments*, *supra* note 89, at 995.

2. Law Licensing

Perhaps not surprisingly, the body of law on questions involving a person with a mental illness obtaining a law license is much more developed than in the equivalent body of law involving those in the medical arena.¹¹⁴ Every state bar in the United States requires applicants to prove they have good moral character and are fit to practice law, a requirement that dates back at least to the eighteenth century.¹¹⁵

In the seminal article on the subject, the late Professor Stanley S. Herr discussed the issues raised by law licensure.¹¹⁶ Herr's article was inspired by the saga of a law graduate represented by the University of Maryland Law School Clinical Law Office in her quest to get a law license after she truthfully answered mental-health questions affirmatively on her bar application.¹¹⁷ Again, there was a discrepancy between questions regarding mere diagnosis and those regarding conduct. Professor Herr argued that such a discrepancy violates the ADA. For example, some bar examiners presume an applicant who has had a psychotic episode is unfit to practice law, notwithstanding the existence of those who can capably practice despite having schizophrenia.¹¹⁸

Professor Herr compared applicants applying for law licenses to federal employees with security clearances and to those in high-level positions of public trust. He noted that in 1995 the federal government dropped mental-health status questions for these individuals, and observed:

Employees working in security-classified positions or holding high-level positions of public trust are no longer asked questions in terms of specific psychiatric diagnoses or required to sign general releases to permit investigators to freely examine their medical records or interrogate their therapists. If the government could adopt such changes in the face of security concerns about employees entrusted with the nation's secrets or nuclear arsenals, surely bar examiners can limit their own fishing expeditions into a candidate's mental health status and any treatment records.¹¹⁹

This was done, at least in part, because of the DOJ's fight against status questions on bar applications and in recognition of the tragic result of such questions in helping to cause Vince Foster, and likely others,¹²⁰ to die by

114. *E.g.*, Walker, *supra* note 2, at 460–61 (discussing cases).

115. Denzel, *supra* note 90, at 894. Some version of this requirement dates back to Moses forming the government of Israel, the fifth century C.E. Roman Code of Theodosius, and thirteenth-century France. Matthew A. Ritter, *The Ethics of Moral Character Determination: An Indeterminate Ethical Reflection upon Bar Admissions*, 39 CAL. W. L. REV. 1, 4–5 (2002).

116. Herr, *supra* note 86. Professor Jon Bauer wrote another major article on the subject in 2001. Bauer, *supra* note 61.

117. Herr, *supra* note 86, at 635.

118. *Id.* at 640–41. For example, consider the successful medical and legal professionals with ongoing schizophrenia discussed *infra* notes 162–68 and accompanying text, 190–214 and accompanying text.

119. Herr, *supra* note 86, at 643.

120. *Cf. supra* note 102 and accompanying text (noting that many physicians who die by suicide were not getting mental-health care).

suicide.¹²¹

A national survey of bar questions disclosed a wide variety of such questions that range from minimally intrusive to the very intrusive.¹²² At their worst, these questions ask if an applicant has ever been hospitalized for a mental-health problem,¹²³ an open-ended question that can force disclosure of a problem resolved years before, such as an adolescent episode of depression in the case of a now-psychiatrically healthy forty-year-old applicant. Intrusive inquiries may also be more limited in scope, such as asking about a diagnosis within five years of an application, but they can still inhibit admission to practice.¹²⁴ The ideal, minimally intrusive inquiries have no mental-health-disability questions at all.¹²⁵ The ADA-inspired trend is to move away from very intrusive questions, but some states continue to ask them.¹²⁶

Professor Herr’s article also raised another important point, namely that the bar should not ask questions that

penalize, through intrusive and humiliating disclosures, the applicant who prudently obtained treatment while the applicant in psychological denial about his or her . . . mental dysfunction can avoid making any disclosure. Rather than exposing applicants to sweeping requests for the candidates’ own explanations of their health status or compelled breaches of doctor-patient confidentiality, bar officials should drastically curtail investigations into health and disability conditions.¹²⁷

Finally, Herr opined that broad questions along the line of “are you now or have you ever been” disabled are just as excessive as McCarthy-era questions about ideological and political beliefs.¹²⁸

Despite being over fifteen years old, Professor Herr’s article rings true today and the DOJ has essentially followed its reasoning. For example, in a January 21, 2014 letter to the Executive Director of the Vermont Human Rights Commission, an Acting Assistant Attorney General distinguished lawful questions about a bar applicant’s past conduct as opposed to unlawful questions about a person’s status as someone with a mental-health diagnosis.¹²⁹ The author of the letter went on to note both that “a history of mental health diagnosis or treatment does not provide an accurate basis for predicting future misconduct”¹³⁰ and that status questions “are likely to deter applicants from seeking diagnosis, counseling

121. Herr, *supra* note 86, at 643–44; *see supra* note 86 and accompanying text.

122. Herr, *supra* note 86, at 646–51.

123. *Id.* at 647.

124. The author has never applied for admission to the Kentucky bar despite working there for twenty-eight years; this is accountable, at least in part, to a reluctance to answer the mental-health questions on its licensure application. JONES, *supra* note 1, at 48.

125. Herr, *supra* note 86, at 650–52.

126. *See infra* notes 152–56 and accompanying text (noting that Louisiana is one such state). Professor Herr noted that in 1996 the DOJ was investigating bar questions, Herr, *supra* note 86, at 671 & n.167, a process leading to litigation that is still going on nearly twenty years later.

127. Herr, *supra* note 86, at 676.

128. *Id.* at 68. *Accord* Bauer, *supra* note 61, at 95.

129. *Vt. Human Rights Letter*, *supra* note 97, at 1, 4.

130. *Id.* at 5.

and/or treatment for mental health concerns, which fails to serve states' interest in ensuring the fitness of licensed attorneys."¹³¹ She stated that requiring conditional admission based solely on an applicant's mental-health diagnosis is illegal,¹³² as are broad demands for mental-health records based solely on an applicant's past diagnosis.¹³³ A February 5, 2014 letter from the DOJ to various Louisiana entities involved in an investigation of Louisiana's licensing process is longer and more detailed, but to the same effect.¹³⁴

As opposed to the dearth of reported cases in the medical-licensure setting,¹³⁵ a number of applicants for law licenses have attacked intrusive mental-health licensing questions. Although some challenges have been resolved without litigation,¹³⁶ several suits have been filed, with decidedly mixed results.

131. *Id.* at 7.

132. *Id.* at 9.

133. *Id.* Any records that are provided to licensure authorities must be kept confidential and thus cannot become part of the public record. *Id.*

[E]xposing this information to the public creates a chilling effect that could deter individuals with disabilities from pursuing the legal profession or seeking treatment, and reduces employment opportunities available to lawyers with disabilities by allowing their prospective employers to access information about their disability to which employers would not otherwise be entitled.

Id.

134. *La. Bar Letter*, *supra* note 96. The Louisiana letter concluded that:

[T]he [Louisiana Supreme] Court's processes for evaluating applicants to the Louisiana bar, and its practice of admitting certain persons with mental health disabilities under a conditional licensing system, discriminates against individuals on the basis of disability, in violation of the ADA. In particular, we find that Louisiana's attorney licensure system discriminates against bar applicants with disabilities by: (1) making discriminatory inquiries regarding bar applicants' mental health diagnoses and treatment; (2) subjecting bar applicants to burdensome supplemental investigations triggered by their mental health status or treatment as revealed during the character and fitness screening process; (3) making discriminatory admissions recommendations based on stereotypes of persons with disabilities; (4) imposing additional financial burdens on people with disabilities; (5) failing to provide adequate confidentiality protections during the admissions process; and (6) implementing burdensome, intrusive, and unnecessary conditions on admission that are improperly based on individuals' mental health diagnoses or treatment.

Id. at 2 (footnotes omitted). In particular, certain applicants were unlawfully required to pay amounts ranging from \$562.50 to \$800 for independent medical examinations solely because of a mental-health diagnosis. *Id.* at 8. In addition, some of them were forced into conditional admissions based solely on a mental-health diagnosis, *id.* at 9-10, including applicants who had practiced successfully in other jurisdictions without oversight. *Id.* at 10. Indeed, essentially the entire conditional-admission program failed DOJ scrutiny. *Id.* at 9-16.

When Louisiana rejected this demand letter it entered into negotiations with the DOJ that resulted in an August 14, 2014 settlement agreement. Settlement Agreement Between the United States of America and the Louisiana Supreme Court Under the Americans with Disabilities Act (Aug. 14, 2014), *available at* <http://lalegaethics.org/wp-content/uploads/2014-08-14-DOJ-LASC-ADA-Settlement-Agreement.pdf> [hereinafter *La. Settlement Agreement*]. See *infra* notes 152-56 and accompanying text (discussing the settlement agreement).

135. *Med. Soc'y of New Jersey v. Jacobs*, Civ. A. No. 93-3670 (WGB), 1993 U.S. Dist. LEXIS 14294 (D.N.J. Oct. 5, 1993), *supra* notes 106-12 and accompanying text, seems to be the only reported medical licensing case.

136. See, e.g., Herr, *supra* note 86, at 658-60 (discussing the Maryland bar); Symposium, *supra* note 101, at 124-25 (discussing the New York bar).

An important early decision, *Clark v. Virginia Board of Bar Examiners*,¹³⁷ featured a challenge to a licensure question that asked, “Have you within the past five (5) years been treated or counselled for any mental, emotional or nervous disorders?”¹³⁸ The plaintiff argued that the question was overbroad and not an effective way to identify unfit applicants, and cited in support the aforementioned APA position against status questions.¹³⁹ Given that the defendant Board had never denied a license to an applicant who answered the question in the affirmative, the court held that it did not identify unfit applicants.¹⁴⁰ Moreover, the court noted its deterrent effect in keeping law students from seeking needed counselling.¹⁴¹ The court also analyzed in detail the questions used in the various state licensing regimes as of 1995, ranging from the very broad to the non-existent.¹⁴² The court concluded the question was overbroad and ineffective, and had a strong deterrent effect. As a result, the court invalidated the question for violating the ADA.¹⁴³ A number of other cases in both state and federal courts in Florida,¹⁴⁴ Minnesota,¹⁴⁵ Maine,¹⁴⁶ Rhode Island,¹⁴⁷ and Wisconsin¹⁴⁸ invalidated as ADA violations similarly broad questions and requirements to pay for psychological evaluations.

Not all applicant challenges to mental-health questions, however, have been successful. In *Applicants v. Texas State Board of Law Examiners*,¹⁴⁹ the court upheld a set of mental-health questions about an applicant’s treatment history within the last ten years.¹⁵⁰ The DOJ rejects this ruling and a related Indiana decision.¹⁵¹

137. 880 F. Supp. 430 (E.D. Va. 1995).

138. *Id.* at 431.

139. *Id.* at 435. See *supra* note 98 and accompanying text.

140. *Clark*, 880 F. Supp. at 437.

141. *Id.* at 437-38.

142. *Id.* at 438-40.

143. *Id.* at 446.

144. See *Ellen S. v. Florida Bd. Bar Exam’rs*, 859 F. Supp. 1489 (S.D. Fla. 1994) (invalidating under the ADA licensing requirements that included questions whether an applicant has ever sought treatment for a nervous, mental, or emotional condition, been diagnosed as having such a condition, or taken any psychotropic drugs; a consent form requiring that applicants authorize the release of any and all mental-health records and waive all confidentiality as to the content of their consultations; a letter of inquiry routinely sent by Board to all past treatment professionals; and the Board’s follow-up investigations).

145. See *In re Frickey*, 515 N.W.2d 741 (Minn. 1994) (holding licensing questions overbroad).

146. See *In re Underwood & Plano*, No. BAR-93-21, 1993 Me. LEXIS 267 (Me. Dec. 7, 1993) (holding licensing questions overbroad in violation of the ADA).

147. See *In re* Petition and Questionnaire for Admission to the R.I. Bar, 683 A.2d 1333 (R.I. 1996) (holding that overbroad licensing questions violate ADA).

148. See *Brewer v. Wisconsin Bd. of Bar Exam’rs*, No. 04-C-0694, 2006 WL 3469598 (E.D. Wis. Nov. 28, 2006) (holding that requiring an applicant with a history of depression to pay for a psychological evaluation violates the ADA).

149. No. A 93 CA 740 SS, 1994 U.S. Dist. LEXIS 21290 (W.D. Tex. Oct. 11, 1994).

150. *Id.* at *32.

151. The Indiana case was a mixed result, as it invalidated one overbroad question but upheld several others, citing *Texas State Board* as precedent. *ACLU of Ind. v. Individual Members of the Ind. State Bd. of Law Exam’rs*, No. 1:09-CV-842-TWP-MJD, 2011 WL 4387470 (S.D. Ind. Sept. 20, 2011). In the *Vt. Human Rights Letter*, the DOJ stated it “is the Department’s position that these decisions are wrongly decided and inconsistent with the ADA.” *Supra* note 97, at 4 n.2.

As noted above, the DOJ has battled what it deems state bar ADA violations. On August 14, 2014, the DOJ entered into a Settlement Agreement with the Louisiana Supreme Court that invalidated the diagnosis and treatment questions, along with other challenged practices, raised in its aforementioned February 5, 2014 letter.¹⁵² Significantly, the Court agreed to pay a total of \$200,000 in compensation to seven of those affected by its discriminatory practices.¹⁵³

According to the DOJ:

The settlement agreement ensures the right of qualified bar applicants with mental health disabilities to have equal access to the legal profession as required by the . . . [ADA]. It prohibits the court from asking unnecessary and intrusive questions about bar applicants' mental health diagnosis or treatment. It also requires the court to refrain from imposing unnecessary and burdensome conditions on bar applicants with mental health disabilities, such as requests for medical records, compulsory medical examinations or onerous monitoring and reporting requirements.¹⁵⁴

In the words of an Acting Assistant Attorney General:

Today's agreement will ensure that qualified bar applicants with mental health disabilities are able to pursue their dream of becoming licensed attorneys, without discrimination based on diagnosis or treatment. . . . Qualified individuals with disabilities, including mental health disabilities, have valuable contributions to make to the legal profession and to their communities. Their diagnosis should not hinder or prevent them from doing so. Though bar licensing entities have the important responsibility of ensuring that all licensed attorneys are fit to practice law, licensing entities must discharge this responsibility in a manner that is consistent with civil rights laws.¹⁵⁵

Finally, the United States Attorney for the Eastern District of Louisiana said:

This agreement is a testament to the United States Department of Justice's commitment to fighting discrimination against persons with disabilities and further ensures that qualified individuals will have the opportunity to pursue

152. *La. Settlement Agreement*, *supra* note 134. *See supra* note 134 and accompanying text (*La. Bar Letter*, *supra* note 96, specified objectionable practices of the Louisiana Supreme Court). The practices included conditional admission based on diagnosis or treatment and failure to insure proper confidentiality. In *La. Settlement Agreement*, the Court agreed, among other things, to re-evaluate applicants denied admission based on the invalid questions and invite them to reapply for admission without additional application expense for the character-and-fitness review. *Supra* note 134 at 8. Further, the Court has to identify applicants who withdrew their applications because of the invalid questions and invite them to reapply for admission without additional application expense for the character-and-fitness review and re-evaluate their applications based on valid questions. *Id.* And the Court agreed to reporting to, and monitoring by, the DOJ to insure Louisiana obeys the agreement. *Id.* at 9-10.

153. *Id.* at 15.

154. Press Release, U.S. Department of Justice, Department of Justice Reaches Agreement with the Louisiana Supreme Court to Protect Bar Candidates with Disabilities (Aug. 15, 2014), available at <http://www.justice.gov/opa/pr/departement-justice-reaches-agreement-louisiana-supreme-court-protect-bar-candidates>.

155. *Id.*

their career goals and make valuable contributions to our community.¹⁵⁶

Although it is certainly too early to know the full impact of the Louisiana Settlement Agreement, the agreement demonstrates the DOJ’s willingness to fight state character-and-fitness requirements that treat applicants adversely solely because of a mental-health diagnosis or treatment. The author does not know where the DOJ will turn next, or to what extent its actions are limited by the political party that controls the White House.¹⁵⁷ This Article does predict that the result in Louisiana, including the legal costs the Louisiana Supreme Court incurred during its fight with the DOJ and the assessed \$200,000 damage award, will earn the attention of states that still ask intrusive questions of bar applicants.

VI. SUCCESSFUL PROFESSIONALS WITH SEVERE MENTAL ILLNESSES

Despite fear of stigma, several successful professionals in law and medicine have declared publicly that they have a severe mental illness. All of those discussed below have done so in order to fight stigma by showing that one can excel in his or her field despite suffering from a potentially debilitating mental illness. As noted, these illnesses can include schizophrenia,¹⁵⁸ bipolar disorder,¹⁵⁹ major depression,¹⁶⁰ and borderline personality disorder.¹⁶¹

156. *Id.*

157. See Symposium, *supra* note 101, at 131 (arguing that the DOJ controlled by a Democratic President will continue to challenge overbroad questions).

For a medical perspective on the Louisiana case, see Paul S. Appelbaum, *Step Up to the Bar: Avoiding Discrimination in Professional Licensure*, 66 PSYCHIATRIC SERVS. 340 (2015).

158. According to the National Institute of Mental Health:

Schizophrenia is a chronic, severe, and disabling brain disorder that has affected people throughout history. People with the disorder may hear voices other people don’t hear. They may believe other people are reading their minds, controlling their thoughts, or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated. People with schizophrenia may not make sense when they talk. They may sit for hours without moving or talking. Sometimes people with schizophrenia seem perfectly fine until they talk about what they are really thinking. Families and society are affected by schizophrenia too. Many people with schizophrenia have difficulty holding a job or caring for themselves, so they rely on others for help. Treatment helps relieve many symptoms of schizophrenia, but most people who have the disorder cope with symptoms throughout their lives.

What Is Schizophrenia?, NAT’L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml> (last visited Apr. 11, 2015).

159. The National Institute of Mental Health provides:

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. Symptoms of bipolar disorder are severe. They are different from the normal ups and downs that everyone goes through from time to time. Bipolar disorder symptoms can result in damaged relationships, poor job or school performance, and even suicide.

What Is Bipolar Disorder?, NAT’L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml> (last visited Apr. 11, 2015).

160. The National Institute of Mental Health defines depression as follows:

Everyone occasionally feels blue or sad. But these feelings are usually short-lived and pass within a couple of days. When you have depression, it interferes with daily life and causes pain for both you and those who care about you. Depression is a common but serious illness. . . . There are several forms of depressive disorders. **Major depression**,—severe symptoms that interfere with your ability to work, sleep, study, eat, and enjoy life. An

A. Successful Medical Professionals with Severe Mental Illnesses

Successful medical professionals with schizophrenia and bipolar disorder have written, spoken, and been mental health advocates.

1. Schizophrenia

In an inspiring 2009 article,¹⁶² a number of medical professionals outlined their successful lives with schizophrenia.

[V]irtually all these persons stress the difficulty of overcoming pervasive stigma, hostile attitudes, and other societal barriers to their recovery. One strong message that is voiced by these professionals is that they see a major barrier to their recovery as being how persons with schizophrenia have been, and continue to be, treated by society, including treatment by those entrusted with their care. Many do not see that their degree of recovery is primarily a function of how disabled they are but feel that traditional cultural, attitudinal, and linguistic barriers to their recovery are important factors that must be considered and measured as we address the issue of recovery.¹⁶³

Dan Fisher, M.D., Ph.D., provided an early voice for successful professionals who had recovered from schizophrenia. Dr. Fisher was diagnosed with schizophrenia while working as a research scientist during the 1960s. Despite his condition, and numerous hospitalizations, he received his A.B. from Princeton University, his Ph.D. in biochemistry from the University of Wisconsin, and his M.D. from George Washington University. Following his graduation from medical school, he completed his residency at Harvard and obtained board certification as a psychiatrist. He became a mental-health advocate, and is presently Executive Director of the National Empowerment Center, Inc. He is one of the few psychiatrists in the country who has publicly discussed recovering from mental illness. He is a role model for others who are struggling to recover, and his life dispels the myth that people cannot recover from mental illness. His recovery and work in the field were recognized by his selection as a member of the White House Commission on Mental Health. Dr. Fisher has written chapters in many books, as well as a number of articles in professional journals such as

episode can occur only once in a person's lifetime, but more often, a person has several episodes.

What Is Depression?, NAT'L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/health/topics/depression/index.shtml> (last visited Apr. 11, 2015) (emphasis in original).

161. The National Institute of Mental Health says the following about borderline personality disorder:

Most people who have BPD suffer from: Problems with regulating emotions and thoughts[,] [i]mpulsive and reckless behavior[, and] [u]nstable relationships with other people. People with this disorder also have high rates of co-occurring disorders, such as depression, anxiety disorders, substance abuse, and eating disorders, along with self-harm, suicidal behaviors, and completed suicides.

What Is Borderline Personality Disorder?, NAT'L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml> (last visited Apr. 11, 2015).

162. Frese et al., *supra* note 65.

163. *Id.* at 377; see also *supra* note 71 and accompanying text.

Hospital and Community Psychiatry and the *Psychosocial Rehabilitation Journal*. He has produced a video and booklet about important aspects of recovery—“Recovery is for Everyone”—as well as a video on “Consumers Working as Providers.”¹⁶⁴

Elizabeth A. Baxter, M.D., is a psychiatrist whose battle with mental illness began in her sophomore year of college. Despite the anguish it caused her, Dr. Baxter led several campus organizations and was elected student-body president during her senior year; ironically, she could hide her illness because she was so prominent on campus. Dr. Baxter began medical school at Vanderbilt University, but there her illness became harder to mask. During her second year she had her first psychotic break and was hospitalized. She returned to medical school, and with medication, psychotherapy, and the support of friends, she was able to continue her studies. When Dr. Baxter told those around her that she had a mental illness, her honesty was often met with discrimination and stigma. “I had trouble getting out of medical school,” she recalled, “because people weren’t too excited about a person with mental illness graduating.” Dr. Baxter’s honesty also hindered her initial application to residency training programs in psychiatry. After an internship in internal medicine, Dr. Baxter began her residency training in psychiatry in Rochester, New York. She completed her residency training on schedule, but became ill afterward and eventually was diagnosed with schizoaffective disorder. A near-fatal suicide attempt put her in the hospital for months. After a long recovery process Dr. Baxter eventually started seeing patients. She is widely known for her mental-health advocacy efforts, and has traveled the nation speaking about her life and experiences with mental illness and recovery. Today she practices in Nashville, and has hospital privileges at Vanderbilt.¹⁶⁵

Patricia Deegan, Ph.D., is a psychologist and another early voice describing living successfully with schizophrenia. She was diagnosed as a teenager and spent considerable time in a state psychiatric hospital, but eventually continued her education and earned her Ph.D. in psychology from Duquesne University. Dr. Deegan has written extensively as a mental-health advocate, stressing that recovery from serious mental illness is possible. She has described her experience with psychiatric treatment as humiliating, dehumanizing, and depersonalizing. She calls for social justice and civil rights for those with mental illness, and advocates for a partnership model of treatment. In addition to being the owner of Pat Deegan PhD & Associates, LLC, Dr. Deegan is an adjunct professor at Dartmouth College Medical School, Department of Community and Family Medicine and at Boston University, Sargent College of Health and Rehabilitation Sciences.¹⁶⁶

164. Frese et al., *supra* note 65, at 374. See NEC STAFF & CONSULTANTS NATIONAL EMPOWERMENT CENTER, <http://www.power2u.org/who.html> (last visited Apr. 11, 2015) (discussing the biography of Dr. Dan Fisher).

165. Frese et al., *supra* note 65, at 374; see also Eve Kupersanin, *Psychosis Fails to Block Psychiatrist’s Career Path*, 37 PSYCHIATRIC NEWS 5, 5 (2002), available at <http://psychnews.psychiatryonline.org/doi/full/10.1176%2Fpn.37.2.0005>.

166. Frese et al., *supra* note 65, at 374–75; see PAT’S BRIEF BIO, PAT DEEGAN PHD & ASSOCIATES, LLC, <https://www.patdeegan.com/pat-deegan> (last visited Apr. 11, 2015).

Frederick J. Frese III, Ph.D., is a psychologist who has been open about his numerous hospitalizations for schizophrenia. He was diagnosed with the disease as a young Marine Corps officer, yet despite his disability he earned a degree from the American Graduate School of International Management and a doctorate in psychology from Ohio University. Dr. Frese has worked in public mental-health care for over forty years and is presently an associate professor of psychiatry at Northeast Ohio Medical University; clinical assistant professor at Case Western Reserve University; and coordinator of the Summit County Recovery Project, serving recovering consumers in the Akron area. For fifteen years, until his retirement in 1995, he was also the Director of Psychology at Western Reserve Psychiatric Hospital. Dr. Frese founded the Community and State Hospital Section of the American Psychological Association and is past president of the National Mental Health Consumers' Association. He served on the Board of Directors of the National Alliance on Mental Illness, and serves on the Board of Scientific Advisors for *Schizophrenia Bulletin*. He has published numerous book chapters and professional articles, and speaks widely as a mental-health advocate about how those with psychiatric disorders can be successfully treated.¹⁶⁷

Although Dr. Fisher denies currently experiencing symptoms of schizophrenia, Drs. Baxter, Deegan, and Frese all acknowledge that they continue to experience at least some of the classic signs of their condition such as delusions and hallucinations.¹⁶⁸ Regardless, they belie a pessimistic view of schizophrenia by their existence, and demonstrate that those with the most serious mental illness can be successful professionals.

2. Bipolar Disorder

Without a doubt, the most famous medical professional with bipolar disorder, or any other mental illness, is Kay Redfield Jamison, Ph.D. Dr. Jamison first suffered symptoms of mental illness when she was a senior in high school, a condition she shared with her father and many other members of her family.¹⁶⁹ She exhibited signs of both mania and depression. She seriously contemplated suicide, but refused to seek medical treatment.¹⁷⁰

Dr. Jamison earned her undergraduate degree from U.C.L.A., and then decided to attend graduate school in psychology rather than medical school.¹⁷¹ She got her Ph.D. in clinical psychology at U.C.L.A., studying mental illness in others while denying its effects on herself.¹⁷² She joined the U.C.L.A. psychiatry faculty,¹⁷³ growing increasingly manic in the process.¹⁷⁴ She eventually started to

167. Frese et al., *supra* note 65, at 375; see ABOUT FRED FRESE, FREDERICK J. FRESE, PH.D., <http://www.fredfrese.com/node/4> (last visited Apr. 11, 2015).

168. Frese et al., *supra* note 65, at 377.

169. JAMISON, AN UNQUIET MIND, *supra* note 1, at 36.

170. *Id.* at 38.

171. *Id.* at 53.

172. *Id.* at 59.

173. *Id.* at 63.

174. *Id.* at 70.

take lithium, the “gold standard” drug for bipolar disorder.¹⁷⁵ She took time off from work while she battled madness, and found that lithium kept her alive and out of the hospital.¹⁷⁶ Still, she resisted taking the medication—in part because of its severe side effects¹⁷⁷—and went on and off lithium contrary to her psychiatrist’s advice.¹⁷⁸

Dr. Jamison refused to be admitted to a psychiatric hospital, in part because she feared losing her hospital privileges if she did so, and lapsed into a suicidal depression.¹⁷⁹ Finally, she took a massive overdose of lithium, but a fortuitous telephone call from her brother led him to alert her doctor, who saved her life.¹⁸⁰ Despite her condition, Dr. Jamison received tenure from U.C.L.A.,¹⁸¹ and she finally decided to take the medication that would maintain her sanity.¹⁸² She was advised not to have children because of the hereditary nature of bipolar disorder.¹⁸³

Dr. Jamison left California for Baltimore, where she now holds The Dalio Family Professorship in Mood Disorders in the Department of Psychiatry at The Johns Hopkins University School of Medicine and is the world’s leading expert on the disease from which she has suffered for so long. She co-authored the seminal medical text on bipolar disorder in 1990;¹⁸⁴ it is now in its second edition.¹⁸⁵ She has written numerous professional books, chapters, and articles, and has spoken widely.¹⁸⁶

In 1993, Dr. Jamison published *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*,¹⁸⁷ a fascinating study of creativity and madness in poets like Byron, Coleridge, Plath, and Whitman; writers like Balzac, Dickens, Fitzgerald, and Hemingway; composers like Berlioz, Handel, Mahler, and Schumann; and artists like Gauguin, van Gogh, Munch, and Rothko. Then, in 1995, she published her masterpiece, the *New York Times* bestseller *An Unquiet Mind: A Memoir of Moods and Madness*,¹⁸⁸ which remains a bestseller nearly two decades later. Her inspiring story has moved millions and brought bipolar disorder out of the closet where it was hidden for so long. Dr. Jamison has won countless honors and awards for her extraordinary work as the face of successful medical professionals with severe mental illnesses, including a MacArthur

175. *Id.* at 81.

176. *Id.* at 88–89.

177. *Id.* at 92–95.

178. *Id.* at 102.

179. *Id.* at 112–13.

180. *Id.* at 116.

181. *Id.* at 134–35.

182. *Id.* at 153.

183. *Id.* at 191.

184. FREDERICK K. GOODWIN & KAY REDFIELD JAMISON, *MANIC-DEPRESSIVE ILLNESS* (1990).

185. FREDERICK K. GOODWIN & KAY REDFIELD JAMISON, *MANIC-DEPRESSIVE ILLNESS: BIPOLAR DISORDERS AND RECURRENT DEPRESSION* (2d ed. 2007).

186. See *Curriculum Vitae of Kay Redfield Jamison, Ph.D.* at 8–25, available at http://www.hopkinsmedicine.org/psychiatry/expert_team/docs/curriculum_vitae/Jamison_CV_2012rev.pdf [hereinafter *Jamison CV*].

187. JAMISON, *TOUCHED WITH FIRE*, *supra* note 12.

188. JAMISON, *AN UNQUIET MIND*, *supra* note 1.

Foundation “Genius Grant” in 2001.¹⁸⁹

B. Successful Legal Professionals with Severe Mental Illnesses

Successful legal professionals with schizophrenia, bipolar disorder, major depression, and borderline personality disorder also have written, spoken, and been advocates about their conditions. The following examples are representative of their experiences.

1. Schizophrenia

Elyn R. Saks is the Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at the University of Southern California Gould School of Law; an adjunct professor of psychiatry at the University of California, San Diego; and faculty at the New Center for Psychoanalysis in Los Angeles. She also has severe schizophrenia. Thus, she truly is an extraordinarily successful professional with the most severe form of mental illness.

Professor Saks graduated summa cum laude with a B.A. in philosophy as class valedictorian at Vanderbilt University.¹⁹⁰ As a student, she experienced undiagnosed warning symptoms of the onset phase of schizophrenia.¹⁹¹ Professor Saks won a prestigious Marshall Scholarship to study at Oxford University¹⁹² following her graduation from Vanderbilt. At Oxford, she earned a M. Litt. (Master of Letters) in philosophy.¹⁹³ Shortly after beginning her studies at Oxford, she began to exhibit psychotic thoughts, self-mutilating acts, and suicidal ideation.¹⁹⁴ She voluntarily entered a psychiatric hospital on two separate occasions, yet she continued to become increasingly paranoid and delusional.¹⁹⁵ She persevered at Oxford, but lost three years to the treatment of her illness.¹⁹⁶

Professor Saks next went to Yale Law School, where she began hallucinating.¹⁹⁷ She was hospitalized for months, often in mechanical restraints.¹⁹⁸ This treatment so deeply scarred her psychologically that she has since refused to be hospitalized.¹⁹⁹ She was diagnosed with schizophrenia, and remained ill despite high doses of antipsychotic drugs.²⁰⁰ Gradually, the

189. *Jamison CV*, *supra* note 186, at 1–4.

190. SAKS, *supra* note 1, at 47.

191. *Id.* at 40, 44.

192. *Id.* at 49.

193. *Id.* at 49, 100.

194. *Id.* at 55–60.

195. *Id.* at 66, 77, 82, 84–86, 99.

196. *Id.* at 101–2, 116.

197. *Id.* at 136–40.

198. *Id.* at 144–82.

199. Professor Saks eventually wrote both a book and an article in which she attacked the use of such restraints. ELYN R. SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL (2002); Elyn R. Saks, *The Use of Mechanical Restraints in Psychiatric Hospitals*, 95 YALE L.J. 1836 (1986).

200. SAKS, *supra* note 1, at 167.

medication took effect, and she finally went home;²⁰¹ mental illness had robbed her of another academic year.

The next year Professor Saks returned to law school. She became an editor on the *Yale Law Journal*, won a major award for litigation skills, and earned her J.D. in the usual three-year period.²⁰² Few of her classmates ever suspected that she has a severe mental illness.

After graduation, Professor Saks took a job at Connecticut Legal Services in order to stay with her Yale psychotherapist.²⁰³ When law practice proved too stressful, she taught legal research and writing at the Quinnipiac University School of Law.²⁰⁴ Despite periods of psychosis, she landed a faculty appointment at the Gould School of Law;²⁰⁵ her illness did not bar her from a tenure-track position at a top-20 law school where no one knew about her condition.

Once in Los Angeles, Professor Saks embarked on an extremely successful career. Her focus on law and mental disability made her a nationally recognized expert. She still suffers from delusions and hallucinations²⁰⁶ despite taking her medication and seeing her therapist five days a week.²⁰⁷ Notwithstanding that burden, she won tenure,²⁰⁸ was awarded an endowed chair,²⁰⁹ and earned numerous awards for her prolific scholarship.²¹⁰ In 2010, Professor Saks earned a Ph.D. in psychoanalytic science from the New Center for Psychoanalysis.²¹¹

In time, Professor Saks decided to fight stigma by going public with her story of maintaining an extremely successful career despite her grave diagnosis. In 2007 she published her acclaimed memoir, the *New York Times* bestseller *The Center Cannot Hold: My Journey Through Madness*, which *Time* magazine named one of the top-ten non-fiction books of 2007.²¹² She has been an extremely active mental-health advocate since 2007,²¹³ and has won many honors and awards for her efforts.²¹⁴ Foremost of these is a MacArthur Foundation “Genius Grant,” a portion of which she used to fund the Saks Institute for Mental Health Law, Policy and Ethics, a major force in the mental-health field.

At this point in her life and career, Professor Saks has accomplished far more than most lawyers and law professors ever do. She has defied dire psychiatric prognoses and bounced back from repeated bouts of psychosis. She is a shining star in the firmament of those who protect the rights of people with mental

201. *Id.* at 182.

202. *Id.* at 211–12.

203. *Id.* at 215, 218–23.

204. *Id.* at 224.

205. *Id.* at 239.

206. *Id.* at 328–29.

207. *Id.* at 250–51, 273–77, 311, 321, 326.

208. *Id.* at 286.

209. *Id.* at 316.

210. See *Curriculum Vitae of Elyn R. Saks* at 9-17, available at http://weblaw.usc.edu/portal/directory/photos/Saks_Elyn_CVJune52014.pdf.

211. *Id.* at 1.

212. *Id.* at 2.

213. *Id.* at 13–18.

214. *Id.* at 1–3.

illnesses. By all measures, Professor Saks is a high-functioning professional.

2. Bipolar Disorder

Several legal professionals have gone public about their successful careers while living with bipolar disorder. Among them is this Article's author, Professor James T. R. Jones of the Louis D. Brandeis School of Law at the University of Louisville.²¹⁵

Professor Jones was bullied unmercifully as a child and adolescent, trauma that can contribute to mental illness later in life.²¹⁶ He suffered symptoms such as frequent irritability, bouts of depression, and poorly handled stress.²¹⁷ His mother wanted to take him to counseling, but his father feared he would face stigma later in life if he had a documented history of such treatment and vetoed the idea.²¹⁸ By age fifteen he developed a severe case of duodenal ulcers, a harbinger of evolving mental illness.²¹⁹

Professor Jones received his B.A. in history, with highest distinction, from the University of Virginia after three years of study.²²⁰ Nevertheless, he struggled with depression, and his digestive problems worsened. In his last semester, he nearly died from gastrointestinal bleeding,²²¹ and he underwent ulcer surgery which caused complications²²² that have led to two additional surgeries. Coupled with a later operation caused by a side effect of a psychiatric medication, Professor Jones has endured four major operations because of mental illness.

At Duke University School of Law he served on the editorial board of the *Duke Law Journal*²²³ and graduated second in his class. Still, he again battled depression, and had difficulty in the employment process.²²⁴ Nevertheless, Professor Jones landed a position at one of the premier firms on Wall Street,²²⁵ as well as a clerkship with a judge on the United States Court of Appeals for the Fifth Circuit.²²⁶ While in New York City, he was desperately depressed, lonely, and unhappy;²²⁷ he concluded that he was unlikely to live past thirty due to the probability of suicide.²²⁸

215. Others include Texas A & M University Mays School of Business Professor Ramona L. Paetzold, author of Ramona L. Paetzold, *How Courts, Employers, and the ADA Disable Persons With Bipolar Disorder*, 9 EMP. RTS. & EMP. POL'Y J. 293 (2005); law graduate Naomi A. Himmelhoch, author of Himmelhoch, *supra* note 63; and attorney Terri Cheney, author of TERRI CHENEY, MANIC: A MEMOIR (2009).

216. JONES, *supra* note 1, at 13–14, 17–18.

217. *Id.* at 18.

218. *Id.* at 13.

219. *Id.* at 15–16, 18.

220. *Id.* at 25.

221. *Id.* at 24, 27.

222. *Id.* at 25.

223. *Id.* at 31.

224. *Id.* at 33–35.

225. *Id.* at 37–38.

226. *Id.* at 32–33.

227. *Id.* at 43.

228. *Id.* at 43–45. Bipolar disorder is the leading cause of suicide in the nation; it is estimated that

During his clerkship, Professor Jones took and passed the Florida bar examination.²²⁹ Fortunately, his disorder had not yet been diagnosed and he had never sought counseling, so he truthfully denied having any mental illness on the very intrusive, if not inquisitional, Florida bar character-and-fitness questionnaire.²³⁰ The judge eventually convinced him to seek psychiatric treatment, which resulted in him taking psychotropic medication for the first time.²³¹

Professor Jones’s time in law practice was not a success.²³² He grew so depressed that he was hospitalized for the first time.²³³ Due to his fear of stigma, he kept the real nature of his condition a secret.²³⁴ Finally, in May 1983, he attempted suicide and was voluntarily admitted to the locked psychiatric unit of a local hospital.²³⁵ Eventually his psychiatrist sent him to a private psychiatric facility in North Carolina where he was a patient for the remaining six months of 1983.²³⁶

By the time Professor Jones reached that hospital, he was in bad shape. He could not focus or concentrate, and his memory was almost completely gone.²³⁷ Though no one told him that he was suffering from bipolar disorder, his doctor put him on lithium²³⁸ and an antidepressant and he gradually improved.²³⁹

When Professor Jones was ready for discharge his employer, who now knew about his illness, told his doctor that he was not welcome to return to the firm.²⁴⁰ While working for a year as the legal assistant for a federal magistrate judge,²⁴¹ Professor Jones won a one-year position teaching legal research and writing²⁴² at

25 to 33 percent of those so afflicted attempt suicide and up to 15 percent of them die by suicide. Bauer, *supra* note 61, at 167; JanaLee S. Kraschnewski, Note, *Something Must Be Done: An Argument for the Partial Deregulation of Research on Bipolar Disorder and the Implementation of Rolling Informed Consent*, 39 U. MICH. J.L. REFORM 625, 630 (2006).

229. JONES, *supra* note 1, at 47.

230. *Id.* at 47-48.

231. *Id.* at 52-55.

232. *Id.* at 60-61, 78-79.

233. *Id.* at 63-64.

234. *Id.* at 64.

235. *Id.* at 80-82. He has never been judicially committed, both because he has recognized the need for care and he fears losing his law license if such action is taken against him. *Id.* at 83.

236. *Id.* at 85-101. One of the coincidences between Professors Jones and Saks is that they both endured long confinements in psychiatric hospitals at essentially the same time.

237. When he has had a severe breakdown like this it feels like his brain has suffered a severe electrical shock, short circuited, and withdrawn into itself to recover—it takes a long time to return to normal. He needs quiet and rest, and much medical treatment, to function in the world again. *Id.* at 86.

238. Lithium kept him from getting manic until he had to stop taking it because of a side effect. It did chronically keep him at a somewhat depressed, or dysphoric, level—with periodic dips into a deeper depression—but he thought that was a worthwhile alternative to further uncontrolled mania.

239. *Id.* at 90.

240. *Id.* at 98.

241. *Id.* at 106-12.

242. Another coincidence between Professors Jones and Saks is that they both taught legal research and writing before getting their permanent law-faculty jobs.

the University of Chicago Law School.²⁴³

In Chicago, Professor Jones regained his health despite the stress of teaching for the first time and searching for a permanent academic position,²⁴⁴ and the Brandeis School of Law hired him to start in August 1986.²⁴⁵ He began seeing a University of Louisville psychiatrist²⁴⁶ who was the first doctor to tell him explicitly that he has bipolar disorder.²⁴⁷ He did not disclose his psychiatric history to anyone at the law school because of stigma fears.²⁴⁸

Although his mood swings and medications interfered with his scholarship, Professor Jones wrote enough articles over the years to win tenure in 1992.²⁴⁹ In 1997 he was promoted to the rank of full professor of law.²⁵⁰

Things went well until 2004, when Professor Jones learned he had a major medical problem caused by long-term lithium ingestion. He underwent major surgery²⁵¹ and had to stop taking lithium. Unfortunately, the quick withdrawal from lithium caused a severe manic episode,²⁵² and Professor Jones was hospitalized for over three weeks.²⁵³ As a result, he was unable to work in the fall of 2004 and his wife had to inform the law school's dean of his condition, thus disclosing the secret he had maintained for eighteen years. Fortunately the dean kept the situation quiet, and gave him a medical leave.²⁵⁴ He told a few close faculty friends about his condition and was pleased at their supportive reactions.²⁵⁵

Over the next three years, Professor Jones gradually returned to normal. Mania caused him to vacillate between irritability and euphoria,²⁵⁶ and suicidal depressions also were a major issue.²⁵⁷ He went on a cocktail of over five different psychiatric drugs to control his symptoms.²⁵⁸

At the same time, Professor Jones contemplated going public with his disorder to the legal academic community in an effort to fight stigma and show that there are successful law professors with severe mental illnesses. He decided to reach this audience through an article in the *Journal of Legal Education*, and by mid-2007 circulated a draft to a few individuals. He learned that Professor Saks's memoir was due out in the near future; coincidentally, two law professors with

243. *Id.* at 111–12.

244. *Id.* at 115–17.

245. *Id.* at 117–18.

246. *Id.* at 119.

247. *Id.* at 120–21.

248. *Id.* at 122.

249. *Id.* at 158. He has written seven articles about using tort law to force mandated reporters to protect domestic-violence victims, and has been recognized as a national expert on this important social issue.

250. *Id.* at 203–4.

251. *Id.* at 221–22.

252. *Id.* at 224–25.

253. *Id.* at 228–49.

254. *Id.* at 241–42.

255. *Id.* at 259.

256. *Id.* at 275–78.

257. *Id.* at 306–7.

258. *Id.* at 278–79.

serious mental illnesses were going to go public at essentially the same time. The *Journal of Legal Education* accepted Professor Jones’s article and it was published in early 2008.²⁵⁹ He soon became an active mental-health advocate by writing and speaking widely to groups of lawyers, law students, medical students, nursing students, psychology students, occupational-therapy students, social-work students, and others about successful professionals with severe psychiatric disorders,²⁶⁰ and has won several awards in recognition of these efforts. Despite periodic problems like episodes of extreme suicidality in 2008 and paranoid delusions in 2013, he has lived a fulfilling life. In 2011 he published his own memoir, *A Hidden Madness*.²⁶¹

As Professor Jones has demonstrated, a law professor with severe bipolar disorder can be a highly successful professional. When mental illness has incapacitated him, as it did in 1983 and 2004, like the “Energizer Bunny,” he keeps on going. He will always have a serious mental illness, but will nevertheless continue to work at the highest level. His nearly thirty years in legal academics is a clarion call.

3. Major Depressive Disorder

Touro Law Center Professor Marjorie A. Silver has gone public with having major depressive disorder, which has not kept her from enjoying a successful career.²⁶² In an unpublished manuscript,²⁶³ she has outlined her life with severe mental illness.

Professor Silver earned her B.A., *summa cum laude*, from Brandeis University and her J.D., *magna cum laude*, from the University of Pennsylvania Law School. She clerked for a United States District Judge and then worked for a decade in the federal government. She has been a law professor for over thirty years. Her depression has been episodic rather than chronic: she has had six periods of major depression in over three decades.²⁶⁴ The first of these followed the birth of her first child, and was debilitating for some time.²⁶⁵ Her marriage collapsed soon thereafter, causing a relapse that resulted in an attempt to end her life and subsequent hospitalization.²⁶⁶ She moved back in with her parents and secured employment with the Department of Health, Education and Welfare, where she rose to the position of Chief Regional Civil Rights Attorney for the

259. Jones, *supra* note 8.

260. In particular, he explains to students in the healthcare professions how important those who work with patients or clients with mental illness are to their patients. For a list of his mental-health writings and speeches, visit his Web page at JAMES T. R. JONES, http://www.law.louisville.edu/faculty/james_jones (last visited Apr. 11, 2015).

261. JONES, *supra* note 1.

262. Anita Bernstein, *Lawyer with Disabilities: L’Handicape C’Est Nous*, 69 U. PITT. L. REV. 389, 403 (2008); Perlin, *supra* note 59, at 601 n.77. Professor Brian S. Clarke of Charlotte School of Law has also written about his experience of being an attorney and law professor with major depression. Clarke, *supra* note 60.

263. Marjorie A. Silver, *A Transformational Melancholy: One Law Professor’s Journey Through Depression* (June 13, 2014) (unpublished manuscript) (on file with author).

264. *Id.* at 1.

265. *Id.* at 8–16.

266. *Id.* at 24–25.

federal Department of Education.²⁶⁷ She entered legal academia in 1983.²⁶⁸ Following her second marriage in 1985, she again fell into the abyss, which led to another—this time voluntary—hospitalization.²⁶⁹ In due course she recovered and, despite being turned down for tenure, did not fall apart.²⁷⁰ In 1991, she joined the faculty at Touro and fit in successfully.²⁷¹ A few years later, both of her elderly parents had health crises which overwhelmed her with anxiety and depression to the point that she had to forego teaching for a semester.²⁷² This depression eventually lifted, and she won tenure and a promotion to full professor status.²⁷³

At this point, unlike previous occasions, Professor Silver and her doctors decided to keep her at a therapeutic dose of an antidepressant rather than phase her off of it. That allowed her to maintain stability despite the deaths of her mother and father, a cancer diagnosis, and other highly stressful events.²⁷⁴ A few years later, an avalanche of stressors precipitated what was her sixth, and so far last, depressive episode. Unable to teach her spring-semester classes, she was forced to take another medical leave.²⁷⁵ A change in medication helped her stabilize once more.²⁷⁶

Professor Silver is a curricular innovator, and works to help her students achieve balance in their lives.²⁷⁷ To achieve this, she has remained open about having a mental illness with friends, loved ones, and students.²⁷⁸ In the past, she has served on the (now de-funded) Board of Trustees of the New York State Lawyer Assistance Trust, which assisted impaired attorneys by helping those with mental illnesses and those with substance-abuse issues.²⁷⁹ Currently, she is a volunteer with the New York State Lawyer Assistance Program, providing lay support to lawyers suffering from depression and other mental illnesses. She also serves on the Advisory Board of the Dave Nee Foundation, an organization devoted to educating law students, lawyers, and others about depression and suicide risks.²⁸⁰ She and her husband have attacked the stigma of mental illness more broadly through his work as a documentary filmmaker.²⁸¹ Professor Silver

267. *Id.* at 26–29.

268. *Id.* at 30–31.

269. *Id.* at 32–36.

270. *Id.* at 39.

271. *Id.* at 42–43.

272. *Id.* at 44–47.

273. *Id.* at 47. As Professor Silver notes, “As far as I could ascertain, much to my colleagues’ credit, my mental health was never a consideration, one way or the other.” *Id.* She clearly works at an enlightened place.

274. *Id.* at 48–52.

275. *Id.* at 59–60.

276. *Id.* at 60–61.

277. *Id.* at 62–66, 70–72.

278. *Id.* at 68–69, 72.

279. *Id.* at 69–70, 72–73.

280. In 2013 Professor Jones won a major award from the Dave Nee Foundation for his mental-health-advocacy efforts. See JONES, *supra* note 260; see also the Dave Nee Foundation web page, at <http://www.daveneefoundation.org> (last visited Apr. 11, 2015).

281. Silver, *supra* note 263, at 73.

emphasizes the obligation of legal professionals with job security like tenure to fight against stigma.²⁸² As she ends her message of hope: “I hope my story here about my experiences with depression will help some readers with their own struggles, and help all readers better understand the struggles of their students, colleagues, clients and loved ones.”²⁸³

Professor Silver contributes a valuable story about those with the most common type of mental illness, one that afflicts many millions every year: depression.²⁸⁴ As noted, depression is a particularly salient problem in the legal and medical professions.²⁸⁵ Professor Silver shows that it can be as debilitating as more “severe” forms of mental illness like schizophrenia or bipolar disorder—she has lost more semesters of teaching to mental illness than either Professor Jones or Professor Saks. Like them, she understands the need for regular mental-health treatment, including medication. Her advocacy efforts are laudable and especially valuable given the huge number of professionals she represents. She is a successful professional with an important mission in the battle against social stigma and the personal shame many with mental illness experience.

4. Borderline Personality Disorder

A final form of severe mental illness is addressed by Professor Gregory M. Duhl of William Mitchell College of Law, who has written about his life and career as a lawyer and law professor with borderline personality disorder (BPD).²⁸⁶ He was motivated to do so by his desire to fight the stigma of mental illness and begin to overturn the barriers afflicted academics face in legal education.²⁸⁷

Professor Duhl graduated from Yale College, and attended Harvard Law School. As a first-year student at Harvard, he felt alienated from his classmates, professors, and school.²⁸⁸ He developed problems with both severe anxiety and depression,²⁸⁹ and was so disillusioned and alienated from law school that he skipped his graduation.²⁹⁰

Over the next seven years Professor Duhl worked at various law firms for periods ranging from six days to eighteen months. He quit jobs “because of some combination of depression, irritability, anxiety, and boredom,”²⁹¹ and was fired from one for “resisting” the firm hierarchy.²⁹² He never had problems moving to a new position, and repeatedly made impulsive employment

282. *Id.* at 75.

283. *Id.* at 76.

284. *See supra* note 3 and accompanying text.

285. *See supra* notes 18–34 and accompanying text, 44–56 and accompanying text.

286. Duhl, *supra* note 1.

287. *Id.* at 774. Demonstrating the difficulty many with mental illness face in being properly diagnosed by mental-health professionals, Professor Duhl notes ten different diagnoses that were applied to him over the previous twenty years. *Id.* at 778.

288. *Id.* at 780.

289. *Id.*

290. *Id.* at 781.

291. *Id.*

292. *Id.*

decisions; he always blamed the firm rather than himself.²⁹³

Eventually Professor Duhl was deeply depressed and reached a dead end in law practice. He was hospitalized for six weeks at the Menninger Clinic along with other patients who were professionals in law, medicine, business, and academia, and began to feel like less of an outsider with them.²⁹⁴ He then decided to work in the field of legal education. He was a teaching fellow at Temple Law School, where he earned his LL.M.²⁹⁵ He then taught at the law schools at Southern Illinois University and the University of Tulsa before he began working at William Mitchell; as he notes, he has been there over four years, which is over two years longer than he had held any previous job.²⁹⁶ He regularly earns superior teaching evaluations, has published widely, and performs substantial service.²⁹⁷ As he says, he is successful because of having BPD, not despite it.²⁹⁸ He further notes: "At the same time, I face extraordinary struggles: frequent mood swings over the course of a day; feelings of emptiness, abandonment, and low self-esteem; difficulties in interpersonal relationships; self-injurious behaviors such as cutting and addictions; and even paranoia."²⁹⁹

Professor Duhl has gone into detail about the challenges he confronts. He suffers from chronic abandonment issues, and he has been addicted to prescription drugs off and on for nearly two decades.³⁰⁰ Though he has not displayed suicidal tendencies, he has engaged in self-mutilating behavior by cutting his arms and legs.³⁰¹ His mood swings have turned his daily life into a roller-coaster ride and he is plagued by angry outbursts when he deems that he has been wronged.³⁰² Colleagues have dismissed him as hypersensitive, overemotional, and self-promotional,³⁰³ and he often is viewed as difficult or demanding.³⁰⁴ In this, he believes that he is like some other faculty with mental illness, whose collegiality may be doubted.³⁰⁵ He thinks in some ways his condition makes him better able to contribute to legal education as he can empathize with others, and often works with great drive and energy.

Professor Duhl offers much to the legal academy despite—or, as he would argue, because of—having BPD. He is to be commended for being willing to go public with his story before, rather than after, winning tenure.³⁰⁶ His narrative is

293. *Id.* "At every firm where I worked, I felt empty and alienated—I found no meaning in the work, was bored with its tediousness, and did not like the firms' hierarchical and undemocratic structures." *Id.* This is consistent with the National Institute of Mental Health's definition of BPD. *See supra* note 161.

294. Duhl, *supra* note 1, at 782.

295. *Id.* at 783.

296. *Id.*

297. *Id.*

298. *Id.*

299. *Id.* at 783–84.

300. *Id.* at 784–85.

301. *Id.* at 785–86.

302. *Id.* at 786–87.

303. *Id.* at 790 n.64.

304. *Id.* at 803.

305. *Id.* at 802–3.

306. Unlike Professors Jamison, Saks, Jones, and Silver, all of whom had its job security when

another attack on stigma, and a means for breaking down the secrecy and isolation that those with mental illness experience.³⁰⁷

V. CONCLUSION

Mental illness is a pervasive problem in modern society, especially in the medical and legal worlds. Students and professionals in the medical and legal fields battle anxiety, depression, and suicide at levels far greater than those in the general population. The fear of stigma forces many professionals with mental illness to hide their condition, afraid that seeking treatment will damage job prospects or make obtaining or keeping a law or medical license difficult. Contrary to public perception, individuals with severe mental illnesses can be highly successful despite—or because of—their psychiatric diagnoses. This article has introduced medical and legal professionals with schizophrenia, bipolar disorder, major depression, and borderline personality disorder who function at the highest level. Society, and the legal and medical professions in particular, should recognize the truth about professionals in these fields with serious mental diseases—all are people, all face challenges, and all can live good lives of substantial accomplishment despite their psychiatric conditions. May all so situated be encouraged to join the high-functioning Dan Fisher, Elizabeth Baxter, Pat Deegan, Fred Frese, Kay Jamison, Elyn Saks, Jim Jones, Marjorie Silver, and Greg Duhl in a world free of stigma and discrimination against those with severe mental illness.

they first spoke out.

307. *Id.* at 811.