Overturning involuntary commitments at a psychiatric hospital in New York State: implications for the societal reaction model

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Abstract The revised commitment laws in the United States in general and in New York State in particular are reviewed to show that dangerousness is not the paramount criterion for commitment and that expanded discretion granted to admitting officials is the essence of the new laws. A qualitative portrait of psychiatric admission in the context of the new laws is offered followed by a discussion of implications for the societal reaction model.

Introduction

In reviewing the literature on the new commitment laws in the United States, which numbers slightly over one hundred articles, one is struck by the fact that most of them are not published in sociology journals and do not concern themselves with sociological issues. Rather, the theoretical articles tend to focus on the issue of ‘dangerousness,’ which has become a buzzword among scholars today, while the empirical articles center on the outcome of civil commitment hearings. The former generally hold that the concept of dangerousness, in general and as it is used in the new laws, is vague and unworkable while the latter indicate that deinstitutionalization has not occurred, that a large percentage of those who are initially committed for observation and treatment are not finally hospitalized, and that ‘dangerousness’ is not the main criterion for commitment even when it is supposed to be.

It is difficult to guess why the sociological profession has had so little to say about the new commitment laws. This neglect probably has something to do with the theoretical controversies within the discipline, best exemplified by the Gove-Scheff debate, and the vested interests of sociologists in deinstitutionalization. It is well known that Gove claimed that there is a fairly rigorous screening process and that the substantial majority of persons who are hospitalized are suffering from
a serious disturbance.\textsuperscript{3} Scheff replied that labeling theory was never meant to be ‘scientific’ in the sense used by Gove but that its aim was to create a ‘crisis of consciousness’ with regard to how the role of the hospitalized mentally ill patient is negotiated.\textsuperscript{4} Becker made a similar point; namely, that labeling theory is not really a theory, ‘with all the achievements and obligations that go with the title,’ but is, ‘rather, a way of looking at a general area of human activity; a perspective whose value will appear, if at all, in increased understanding of things formerly obscure.’\textsuperscript{5} The general tenor of these replies to Gove is not entirely satisfactory. More importantly, the essence of the Gove-Scheff debate is irrelevant today. This is because the most recent reviews of empirical studies of the impact of the new commitment laws show that a large percentage of those who are committed are released prior to hospitalization. These studies do not indicate why this is the case. A conceptual problem makes it difficult to incorporate the findings available at present into sociological theory and to continue research: it is the assumption that to be committed is to be admitted to some form of inpatient care (Gove and Scheff share this assumption). But one of the novelties in the new laws is precisely that commitment is not the same as admission. In practice, commitment is actually a referral that gives admitting officials enormous discretionary powers normally reserved for the judiciary. In fact, enlarged discretion is the essence of recent statutory changes.

But Scheff and Gove, who still influence sociological research in mental health, are irrelevant to recent developments in psychiatry in other ways. They both exaggerate the medical profession’s alleged ‘imperialism’ in wanting to treat patients.\textsuperscript{6} As Strong put it, most doctors see themselves as frustrated idealists, persons who want to help but often cannot, and that ‘in criticising the imperialism of other professions, sociologists also advance their own empire and do so under exactly the same banner as other professions – the service of humanity.’\textsuperscript{7} Emerson has also observed that ‘under prevailing law and policy recommendation, hospital commitments should be made reluctantly and only in extreme instances, and even then only if preventive measures to keep the disturbed in the community are impractical.’\textsuperscript{8} In other words, commitments in the context of the new laws are a last resort.

Second, Scheff and Gove have oversimplified the concept of ‘commitment’ to a mental hospital in terms of procedure. Even in the heyday of sociology’s attack on psychiatry, Martindale pointed out that:

The flexibility of most jurisdictions in the United States appears in the fact
Commitment to a psychiatric hospital has been more complex than most sociologists realize independent of and prior to recent legal changes. It may never have been the automatic ‘funnel of betrayal’ that the early writers in this field indicated. Under the new laws, it is certainly an accomplished, open-ended process.

In short, sociology may indeed be guilty of a form of imperialism of its own, as Strong has suggested. Sociology has a vested interest in deinstitutionalization and in its continual attacks on psychiatry. Meanwhile, a bona fide revolution in psychiatry is occurring, quietly and without a clear sense of its antecedents or destiny. A first step in catching up with the work in this field already achieved by law and psychiatry should be to recapture that spirit of intellectual honesty found in Durkheim’s admonition that all preconceptions must be eradicated and that researchers should feel they are entering the unknown. That is, rather than presupposing the ‘medical model,’ the ‘dangerousness’ standard and other present-day ‘idols’ (as Francis Bacon put it), we should examine the commitment criteria as they really are in the laws and compare them with commitment procedures as they are truly practiced, not as we want or expect them to be.

This paper will begin with a discussion of the commitment criteria and process implicit in the new laws in general, and in New York State in particular. We shall devote a section to an examination of New York’s revised law, using verbatim quotes, to demonstrate that dangerousness could not possibly be construed as the paramount criterion for commitment and to indicate that discretion granted to admitting officials is the distinguishing feature. Next, we shall focus on the process whereby a client is committed to a psychiatric hospital but not admitted. Our aim is two-fold: to demonstrate that commitment is not the same as admission and that ‘societal reaction’ under the new laws is a complex, contextual, and often ambiguous process. Finally, implications for research in the area of the sociology of mental health will be discussed briefly.

Old versus new: commitment criteria and process

The current obsession with the alleged ‘dangerousness’ standard in the new laws is as erroneous as the previous exaggeration of the ‘medical
model.’ Sociologists used to believe that psychiatrists want to treat all those who are ill, and now they believe that psychiatrists want to treat all those who are dangerous. Thus, Gove et al. conclude that social scientists need to modify substantially their understanding of mental hospitalization as a means of social control because the new laws favor commitment of dangerous individuals.10 They do not offer a single reference to the text of the laws as support. Similarly, in chapter 11 of his recent book, Cockerham11 refers to dangerousness ‘as the paramount criterion for involuntary civil commitment’ but offers only selective quotes from a handful of states as evidence. Hiday, in particular, is fond of making statements such as the following:

By 1978 most of the American states (48) had adopted commitment codes that incorporated dangerousness into their criteria for involuntary commitment to a mental health facility.12

And,

Increasingly state statutes have been limiting involuntary civil commitment of the mentally ill to those who are dangerous to self or others.13

Warren, too, makes the erroneous assertion that:

Legally, a person may not be committed involuntarily simply for being mentally ill. The person involuntarily committed for dangerousness and mental disorder must meet an additional legal test: Is the behaviour seriously, predictably, and imminently dangerous enough to be a threat to others in society?14

Not one of the proponents of the alleged dangerousness standards has supported it with verbatim quotes from the law nor with empirical results that use valid and reliable criteria for dangerousness.

There is nothing subtle about the mistake on the part of the authors listed above. There is the obvious point made by Petrunik (summarizing a host of other scholars) that ‘Many highly dangerous acts (both wilful and unwilful) such as pollution, shoddy manufacturing, child abuse and neglect and drunken driving are not specifically defined as dangerous in criminal or civil statutes.’15 Then there are the reviews of court decisions by Shah and Wexler which conclude that ‘the Supreme Court did not say that “dangerousness” was constitutionally required for commitment’16 and that the emphasis on ‘need for treatment’ in the laws provides ‘no real constraint on the exercise of therapeutic power.’17 Finally, inventories of the new laws that include verbatim quotes, as found in Schwitzgebel, the Practice Manual or Mestrovic and Cook, for example, make it clear that dangerousness is not the paramount criterion for commitment in the United States.
For example, Schwitzgebel concedes that the wording of the laws is so complex that he had to use his intuition to capture the primary intent, and that ‘most States do not limit or define the harm,’ adding that ‘the conduct required is also usually not defined.’ Given these caveats, he concludes that ‘twenty statutes use a criterion of dangerousness.’ The Practice Manual, too, notes that the definitions of ‘mental illness’ incorporate additional criteria for commitment, usually phrased in terms of ‘deterioration’ or ‘harm’ (which include simply placing others in fear of probable danger, not any recent, overt act). Mestrovic and Cook offer an extensive appendix which shows that most states define mental illness in terms of need for treatment and likelihood of harm such that a finding of illness automatically implies the other two phenomena. Finally, an examination of the model state law on civil commitment of the mentally ill, approved recently by the American Psychiatric Association, indicates the use of terms like ‘harm,’ ‘distress,’ and ‘deterioration’ as criteria for commitment rather than ‘dangerousness,’ terms defined badly or not defined at all. The claim that dangerousness is the paramount criterion for commitment is just too simplistic: it ignores other criteria, and it is not supported by a reading of inventories of the new laws.

As for the process implicit in the new laws, Emerson has already noted that ‘various sociological analyses have accorded last resorts a factual rather than an accomplished, justificatory character.’ He points out that Gove, ‘for example, ascribes last-resort qualities to mental hospitalization, contending that typically in the event of hospitalization “it is only when the situation becomes untenable that action is taken.” There can be no doubt that the concept of “commitment” is treated by Gove and most sociologists in this field as not only a synonym for admission, but for “last resort” as well. The problem is that except for a handful of studies sociologists have not been sensitive to the idea of commitment as a process whereby staff have tried and failed to contain the “trouble” so that they arrive at a formal societal reaction as a last resort. Many studies, in fact, have bastardized the concept of last resort, and distorted its sociological import.

A case in point is Warren’s study entitled The Court of Last Resort. In a recent review of the book, Steadman writes that most prior sociological literature examined the initial civil commitment hearing whereas Warren’s work focuses on patients involuntarily admitted to state mental hospitals who petition for release after initial civil commitments. This is more of a lay notion of “last resort” than a sociological one – Emerson urges the sociologist to look for the process by which ‘normal remedial responses’ are inappropriate or
have failed prior to hospitalization. A sociological study of commitment as a last resort would focus on the initial commitment (what happens to the committed who are not admitted, and why?) or on the entire patient career through one full sequence in the commitment process. 

Furthermore, one is not surprised that Warren found that ‘decision making is particularistic, situational, and arbitrary rather than universal and fair . . . and organizational needs take precedence over legal and psychiatric requirements.’ We know, from Emerson and Pollner, that patients have things done to rather than for them and that the law is used, not followed. Apparently, she feels that the hospital is a better place for these patients than ‘the streets,’ and that most of them deserved to be committed. This is a continuation of the fallacy begun by Gove, the assumption that hospitalization is a last resort without bothering to prove or document it.

In sum, research in the sociology of mental health needs to be explicit and crystal clear about the commitment criteria in the new commitment laws. Relevant verbatim quotes are almost never found in the literature, so that readers are simply expected to accept the myth that dangerousness is the paramount criterion. Second, sensitivity to the complexity of commitment as a last resort – the clear theme in the new laws – means that the sociologist should focus on the junctures and points in a State’s commitment process that would best illustrate whether other alternatives were examined, and how staff arrived at the decision that all alternatives were exhausted.

What has been revised in New York’s laws?

A special committee of the Association of the Bar of the City of New York made sweeping recommendations in revising the mental hygiene laws of New York State that essentially amounted to granting physicians powers typically reserved for the judiciary. In fact, the judiciary is not involved at all in the commitment process unless the client requests its intervention. An examination of the law reviews concerning the new statute and accounts by some of the designated examiners suggests that the response to the revisions has been mainly negative. Concern has been expressed in these articles over the curious definition of mental illness such that it denotes need for treatment (Mental Hygiene Law, 1.03):

Mental illness means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior,
feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment, and rehabilitation.

This definition is not only a tautology, but is so broad that it can include the conditions of mental retardation, epilepsy, sexual disorders, senility, and a host of others. Moreover, the provisions for what constitutes need for care, treatment, and rehabilitation and just what these phenomena could be in practice are left unspecified. However, the most controversial provisions of the law have to do with the power granted to the admitting physician to honor, modify, or disregard a duly certified involuntary commitment. For example, Mental Hygiene Law 9.37 reads:

The director of a hospital may receive and retain therein as a patient any person alleged to be mentally ill and in need of involuntary care and treatment upon the certificates of two examining physicians. . . . The director of the hospital where such person is brought shall cause such person to be examined forthwith . . . and, if such person is found to be in need of involuntary care and treatment, he may be admitted thereto as a patient as herein provided (emphasis added).

It is presumed that this provision was written into the law to maximize the therapeutic options available to the treatment facility. Ironically, the granting of so much discretionary power to the physician results in a lessening of ‘medical imperialism,’ as we shall demonstrate.

Despite articles that cite dangerousness as the main criterion for commitment in the United States, New York’s laws stand out because dangerousness is not required for all involuntary commitment. For example, the ‘two physician commitment,’ Mental Hygiene Law 9.27, enables the commitment of ‘any person alleged to be mentally ill and in need in involuntary care and treatment.’ This requirement is redundant when one recalls that mental illness is defined in 1.03 as denoting need for treatment. Furthermore, ‘in need of care and treatment’ is defined in 9.01 as a condition such that ‘a person has a mental illness for which in-patient care and treatment in a hospital is appropriate.’ Redundancy on top of redundancy, the effect is that the criteria for commitment under 9.27 are whatever the physician wishes. Mental Hygiene Law 9.37, commitment by a ‘Director of Community Services’ (who does not even have to be a physician) is for any person who has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others’ – the same redundancy is written into the law. Finally, there is 21.09, ‘Emergency services for intoxicated persons’ which is for ‘a person who appears to be incapacitated by alcohol to the degree that he may endanger himself or
other persons or property’ – these ‘dangers’ are not defined.

_Mental Hygiene Law_ 9.27 is signed by two physicians and is valid for 60 days; it is usually referred to as a ‘2-PC’ by staff; 9.37 is made for 72 hours, and is abbreviated ‘DCS’ by staff. Finally, a 21.09, referred to as such, is made for 24 hours. These terms are used in imaginative ways by the staff: ‘Get him 2-PC’d will you?’ ‘I don’t think she’s DCS-able’ ‘How many 21.09’s have you had?’ At the expiry of the maximum duration of any of these commitment orders, a person’s commitment type may be converted into another type or the person may be committed for an additional 6 months by a judge under 9.31. Under 9.33, the committed person may request a hearing, but it is not mandatory.

This researcher finds that need for treatment, as defined by State officials, is the central criterion for commitment under the revised laws in New York State, _not_ mental illness or dangerousness, alone or in combination. But ‘need for treatment’ is undefined and therefore problematic. How do staff determine what it is, and what is its theoretical significance?

**How ‘need for treatment’ is negotiated**

Standard participant-observation techniques were used at an admissions unit of a State psychiatric hospital in New York from 1979 to 1981. Rapport was established with the staff such that the researcher was allowed to sit in during all interviews with the patients, the conferences between psychiatrists and other staff, and informal interactions among all staff on the unit. My goal in this section is to provide an overview of findings that will be analyzed later.

The staff appeared to be quite aware that neither mental illness nor ‘dangerousness’ were criteria for admission. A copy of New York’s _Mental Hygiene Law_, in its complete or abridged form, was never present on the unit. The decision rule used by the staff may be summarized as ‘Even if I am absolutely sure this person is crazy, I will not admit unless he or she is crazier than is normal for him or her.’ This finding was arrived at through direct observation and interviews with the staff about how and why they admit patients. ‘Normal craziness,’ whatever that is, was distinguished sharply from ‘more than normal craziness.’

Furthermore, the staff agreed that not all suicidal or assaultive clients should be admitted – even if involuntarily committed – because it was felt that (1) some patients are ‘faking it’ in order to get free room and board, (2) some dangerous persons would ruin the morale of the
other patients, (3) some dangerous persons were criminal and should not have been committed in the first place, and (4) some dangerous persons would be harmed by hospitalization. In sum, the staff was consistent in self-report in indicating that admission was determined using ‘gut feelings’ to assess need for hospitalization, regardless of how the client came to be referred to the facility. The staff was consistently wary of clients ‘faking’ symptoms to get into Hotel ———, as it was mockingly nicknamed by them. In fact, their first tendency seemed to be not to admit when confronted with a client.

It was sometimes the case that a person was deemed ‘crazy’ and ‘dangerous’ but was not admitted because it was felt that admission would not be beneficial. This rule was particularly applied to the ‘Personality Disorders’ (301.00 to 301.89 under DSM-III) whom the staff called ‘borderlines.’ These committed patients were either not admitted, or if they were admitted, they were usually discharged by the units as quickly as possible because the units considered ‘borderlines’ destructive to the morale of the other patients, and basically untreatable. If a staff member felt that someone was a ‘benign borderline’ – as when a psychiatrist commented on a patient, ‘He’s a dealer, but I can’t help liking him’ – the diagnosis was changed to something less severe, like ‘Transitory Situational Disturbance’ to insure that a patient would be kept and treated at the units. Transitory Situational Disturbance was the diagnosis most preferred; it implied that a person is going through a temporary, severe ‘deterioration’ and once patched up, the person would be functioning ‘normally’ in the ‘community’ again.

Approximately 25% of all commitments were overturned for what the staff regarded as ‘obvious’ reasons. That is, the staff disagreed outright that a client was ‘crazy’ – ‘Maybe very weird, but not crazy’ a staff member would say. The physicians who had committed such persons were depicted as being ‘trigger-happy’, unintelligent, or likely to commit their own mothers.’ Such patients were released without any recommendation for any treatment. They were regarded as ‘mistakes.’ Other commitments were honored in part, but changed in some way; for example, a ‘2-PC’ might be changed to a ‘DCS’ or vice versa. The staff tended to use the law to suit its conclusions. For example, a patient who was so ‘obviously’ suicidal that he had been comatose for a week and told everyone he would attempt suicide again as soon as he could was initially DCS’d. However, the staff reasoned that under this commitment type he would be kept only 72 hours, which they did not think was enough time to guarantee his safety. They committed him under a ‘2-PC’ for 60 days, which was technically illegal, but which they felt guaranteed his safety. Frequently, the
commitment forms were not filled out in their entirety. For example, a ‘2-PC’ form lists several criteria, all of which must apply: the patient must be ill and in need of treatment and there must be no alternative to inpatient care. Some of these criteria are tautologies under the law in any case, as already noted. Typically, some of the criteria would be circled as being applicable, meaning that the official thought the person needed to be hospitalized even though he or she could not claim that all criteria were met. Sometimes these partial commitments were honored, sometimes not. In general, the staff’s perception of the patient’s need for treatment and impact on the other patients were considered first, and the law second, if at all. The overall impression was that the staff were, in the words of Everett Hughes and Emerson and Pollner, ‘good people’ doing ‘shit work’: they wanted to help people in need; often, they felt frustrated that they could only do things to people and not for them in the long run. Consequently, they seemed to feel justified to interpret the law to help people as they saw fit. What is different from the era in which Scheff and the early pioneers in this field wrote is that the new law is written so as to permit the commitment of persons solely on the determination of perceived need, not mental illness or dangerousness per se. And, the staff was not interested in avoiding Type 1 errors, as Scheff found. Far from acting like imperialists, they seemed to convey a sense of being at the mercy of social forces beyond their control.

Commitment as a last resort

Thus far, we have shown that dangerousness is not the paramount criterion at this particular hospital, neither by law nor in practice. The staff was definitely reluctant to admit, but one of our aims is to conceptualize a juncture in the commitment process that best illustrates the way in which commitment is a last resort. There is no better way than to focus on the phenomenon whereby a commitment is either not at all honored or is modified in some way. That is, the patient had been committed in the first place because officials felt that hospitalization was a last resort. But prior to admission, a second set of officials openly disagree, and point to other alternatives. This incongruity of societal reactions is fertile ground for the application of labeling theory because it shows how the concept of ‘last resort’ is subject to negotiation.

In general, the staff overturned or modified a commitment if it felt that the client was criminal, even if ‘crazier than normal.’ Of course, the option of labeling behavior as criminal rather than ‘crazy’ is always
present, but the staff was most likely to apply it if the client was assaultive during the admissions process. In a real sense, they could accept that a client might have been violent outside the walls of the admissions unit, but they would not tolerate it on the unit, and would resist admitting a client who would be dangerous to other patients.

Consider the following case as illustration: A 26-year-old man, on parole for robbery, with no psychiatric history, was brought to the hospital having been ‘2-PC’d’ at a neighbouring city. He had overdosed on alcohol and valium, and had been comatose for three days. He was committed even though no psychotic symptoms were noted by the two physicians at the medical hospital where he had received treatment for his suicide attempt. The social worker who opened the legal papers commented that they were incorrect. His reasoning was that the patient was dangerous to himself and others, but not psychotic, and therefore he should not have been ‘2-PC’d,’ or committed at all. The two physicians who had committed him wrote on the official form:

**Physician 1**: ‘Patient is violent, combative, inconsistent, although no definite hallucinations or free associations. Wife fears for her safety and patient seems unrelatable and violent enough to justify her fears.’

**Physician 2**: ‘Patient brought in on overdose of Valium and alcohol. Presently uncooperative – refuses to be examined.’

The commitment papers were technically illegal because not all of the criteria for a ‘2-PC’ were checked off on the form – a common occurrence. The patient escaped before he could be processed fully. The technically illegal papers were treated as legal by the police; the man was later apprehended and brought back to the psychiatric hospital.

The admitting physician – who was ridiculed for being a ‘bleeding heart’ – gave the man a diagnosis of Transitory Situational Disturbance and honored the commitment to prevent the patient from going to prison for breaking parole (he threatened a staff member). However, by now, the upper echelons of the hospital were involved and decided to press criminal charges against the man rather than admit him. The commitment status was overturned; the man was handed over to his parole officer; he was not admitted.

In this case, we can see that imprisonment was perceived as an alternative to hospitalization essentially because the client did not behave ‘decently’ toward the staff. There was some disagreement among the staff as to the humanity of regarding prison as an ‘alternative to treatment,’ and in-house ‘experts’ were called upon to settle the dispute (a process already described by Emerson and
Messinger\cite{34}). But the staff always considered the safety of colleagues and patients when negotiating 'alternatives.'

A second major factor in overturning commitments was whether the non-prison alternatives would be as helpful as hospitalization. If a client was perceived as being 'sincere' and non-threatening, the staff actually took great pains to spare him the stigma of involuntary hospitalization. They would try to convince him to sign in elsewhere or at this hospital on voluntary status. A person's commitment status would be honored, in fact, if the staff could not regard him as criminal or could not trust him to sign in on voluntary status. Two cases serve as illustrations.

A 19-year-old man was 'DCS'd' and brought down handcuffed by the police because his family told some medical doctors that he threatened to kill them. 'You know how you say things you regret when you're mad' he said. The psychiatrist liked him – she considered him a 'nice boy' who needed to be away from his family for a while to 'clear out his head.' She told him she would overturn the commitment if he would agree to sign in on voluntary status, which would carry less stigma. He agreed. The commitment was overturned. The psychiatrist later disclosed that she gave him a diagnosis of Transitory Situational Disturbance to make sure that he would not be immediately discharged.

A man who held a highly paid job was brought to a medical hospital by his therapist because he told her he wanted to kill himself. He had been '2-PC'd.' The therapist and police brought him down to the psychiatric center. He clearly did not feel he belonged there, and was physically restrained from escaping. The staff did not want a man of his superior education to be hospitalized. 'Why wasn't he sent to a private hospital?' the head social worker asked. Because the local private hospitals were full. It was proposed to the patient that he should cooperate with them, but he answered that he did not belong there. They asked him to sign in voluntarily so that he could leave when an opening at a private hospital became available. He refused. Many phone calls were made to local hospitals, but it was a Friday afternoon, typically a busy time, so that no beds were available. He was admitted on '2-PC' status, with 'deep regret,' the head social worker told me later.

Finally, it is worth reiterating the third major category of overturned commitments, the 'mistakes.' For example, a 27-year-old white female had been '2-PC'd' by her mother because she was living with a 65-year-old black boyfriend, something her mother considered 'crazy.' The staff was embarrassed that two physicians could have affixed their names to a document that took away this woman's liberty, and
released her immediately. In general, ‘mistakes’ were clients whose
deviance could not be regarded as criminal and who were not ‘crazier
than normal.’ Very bizarre behaviors, so long as they were routine for
the client and non-criminal were regarded as ‘normally crazy’ and not
worthy of hospitalization.

A final, somewhat more detailed, illustration may help to bring
together the many issues being addressed in this paper. A 17-year-old
woman I will call June was brought to the psychiatric hospital by the
police after she had been ‘DCS’d’ at a local general hospital. She had
swallowed Raid bug killer, Secret deodorant spray, Amitril, spray
paint, and some other chemicals. She had apparently sprayed these
chemicals down her throat at a halfway house for hours, until she
passed out.

‘I ain’t answering any questions’ were her first words. The admitting
psychiatrist decided to interview June at the same time as the social
worker interviewed her – which is technically illegal – because there
were so many other patients to be examined that night. ‘What
happened?’ he asked. ‘I inhaled a bunch of shit man, that’s all’ June
answered, adding, ‘there’s nothing wrong with that.’ ‘Why do you
want to feel pain?’ he asked. ‘Cause I want to!’ She lit a cigarette and
began smoking. The social worker continued: ‘Did you want to kill
yourself?’ ‘Maybe.’ ‘Did something happen?’ he asked. ‘Maybe.’ June
told them she wanted to go. They explained to her that she had been
involuntarily committed and unless she talked to them, they would
have no choice but to let the commitment ‘go through.’

‘Do you want to kill yourself?’ the psychiatrist asked bluntly. ‘The
temptation is there but the need is not there yet’ she answered after a
pause. ‘The need for what?’ he asked. ‘To fuck up my head so I’ll be a
goddamned vegetable’ she answered. ‘I want to die off for a while’ she
added. ‘Suicide is permanent’ the social worker quipped. ‘Not die,
just start a new life’ June retorted.

‘Did anything happen to upset you?’ the psychiatrist asked. June
 recounted a long tale about her mother’s lesbian affairs and how her
mother ‘called me ugly, spread a rumor that I’m the biggest slut
around.’ June continued: ‘You can’t help me. I’m unhelpable. I’m
incurable. I’ll be insane the rest of my life.’ The psychiatrist said to her
‘I would like to help you,’ ‘What’s it to you? You don’t even know
me!’ she answered. ‘I do know you. I’ve seen you on unit ——’ he
said. She grew calmer after this, and lit another cigarette. There was a
moment of silence, and then she burst out with ‘I refuse to get into
your psychological bullshit.’

‘How often have you tried to kill yourself?’ the psychiatrist asked.
‘This is my 11th time.’ ‘Do you keep tabs?’ ‘Yes! I want to see how
many times it takes me before I do it. 'Are you angry at someone?' 'No one in particular' June answered. 'Your mother?' 'Somewhat.' A pause, then, 'I'm very angry now, in a lot of emotional pain, feeling let down by people. Maybe I don't want things better. I fucked up my home. When you're a bad person like I am you might as well do away with yourself. Everyone is angry at me. Everyone puts me down. I hate my life. I wish I could be reincarnated.'

The interview ended at this point. Her records indicated that she had been put into a mental hospital when she was 13 years old. Her diagnosis all those years had been 'character disorder,' one of the 'borderlines.' The psychiatrist said to the social worker during conference that a 'DCS' commitment would be too stigmatizing for a 17-year-old. The social worker argued with him. She insisted on diagnosing June as a borderline and not admitting her because she had heard that June was 'a slut' who gave everyone at the half-way house venereal disease. The psychiatrist wanted to give the diagnosis of Transitory Situational Disturbance. A fierce argument ensued, with many other staff joining in. A compromise was reached. June agreed to sign in voluntarily - which was important to the psychiatrist - but she would be diagnosed as a 'borderline.' Naturally, her unit discharged her within 12 hours.

She came back to the admissions unit the next day, after her quick admission and discharge. She said she felt rejected and hurt, and wanted some place to take care of her. She was made to wait for hours because the social workers openly said they did not like her. The psychiatrist on duty was different from the day before. June slipped into the bathroom and cut up both of her arms with a piece of glass she had carried in secretly. She walked out of the bathroom with both arms bleeding, acting nonchalant. One of the social workers looked at her and said: 'Shit, June, why did you have to go and do that? Now we have to admit you!' She was indeed admitted, again as 'borderline,' and again discharged almost immediately. I do not know what eventually happened to her.

Ultimately, this patient was hospitalized not because she was 'crazy' or 'dangerous,' in the eyes of the staff, but because she was 'crazier than normal' for her, non-criminal and because no one else in the community would have her.

What does it mean to be committed?

One of the primary aims of this paper was to describe the complexity of an issue, commitment, that has been oversimplified in the literature.
Commitment is not the same as inpatient admission; this is particularly true under New York State law, but is an important facet of the new commitment laws in general, and may be the beginning of a trend. Commitment in New York State is simply not based on dangerousness coupled with mental illness, and there is reason to suspect that this is not the case in most of the United States either. Finally, commitment was not perfunctory at this hospital, and sociologists need to be open-minded about the possibility that the medical profession is weaker and more benign than how it has been depicted. In his reply to Gove, Scheff wrote that:

Gove’s interpretation repeats the classic fallacy of the medical model, which is to assume that hospitalization was inevitable, even though no observations have been made on the incidence and outcome of similar cases in the unhospitalized population.\textsuperscript{35}

It is a moot point whether the ‘medical model’ was ever that simplistic. Under the old laws, it was difficult to find the unhospitalized population that had the same amount of ‘residual deviance’ as the hospitalized population for comparison purposes. Under the new laws, the process is easy, and vital: of all the committed, simply compare the characteristics of those who are hospitalized and those who are not. Instead of noticing the importance of this, the fallacy of the ‘medical model’ cited by Scheff continues to be perpetuated by sociologists. Consider two recent examples. Hiday writes that ‘studies have reported a decrease in the number of mental commitments’ and in the next sentence cites studies which have ‘demonstrated an immediate and significant drop in involuntary admissions. . . .’\textsuperscript{36} as an illustration (my emphases). Clearly, Hiday is treating ‘commitment’ as a synonym for ‘admission’ – but this is an error under the new laws. Another example is Rosenfield’s recent study that involved New York State’s revised commitment laws, which are not even cited by her. She glides easily from her discussion of Scheff and Rushing – who dealt with the old laws – to her conclusion that ‘males are more often hospitalized for “feminine” types of disorders than are females.’\textsuperscript{37} Rosenfield fails to define what she means by ‘hospitalization’ so that one does not know if she means males are more often committed and retained than females for certain disorders or if they are more often committed initially than females and then released for certain disorders.

While it is true that the National Institute of Mental Health and other agencies use direct and sophisticated methods of assessing the epidemiology of mental illness, it is also true, as Cockerham put it, that ‘a common method of ascertaining the magnitude of mental disorders is to measure admissions to psychiatric facilities.’\textsuperscript{38} But over-
reliance on this method assumes that Gove is correct that only the most seriously ill are admitted. Why is this assumption not being tested systematically? Since the mandate of community-based care is to keep mentally ill persons out of the hospital, hospitalization rates by themselves may tell us little about actual rates of mental illness. And if ‘need for treatment’ is more of a criterion for hospitalization than ‘dangerousness’ one ought not assume that mental hospitals have become repositories for the dangerously mentally ill. In short, the fallacy of the ‘medical model’ is being perpetuated by sociologists using the language of ‘dangerousness.’ We need to know what happens to the committed who are released and why they are not admitted to inpatient care, and why the committed who are retained were retained.

The new commitment laws also force us to rethink the use of the concept of ‘normalcy’ in sociology. For example, Cockerham explains the ‘paradox of normalcy’ with reference to Lemert’s concept of secondary deviance: ‘That is, the person will be regarded as “mentally ill” or “crazy” and that circumstances will be viewed as normal for the person in question.’ Cockerham adds that ‘at this point, action to remedy the situation will be an obvious conclusion for most of the people involved in coping with the problem.’ On the contrary, when a given level of ‘craziness’ is appropriated as ‘normal’ for a person, the not so obvious conclusion sometimes drawn by the admitting staff was that the person should not be admitted. If their ‘craziness’ is part of their ‘place’ in the community, they are to be left in the community. Given that the ill person’s ‘place’ (to borrow a concept from Goffman) in the community is to be out of ‘place,’ one should be interested in ascertaining the point at which ‘normal craziness’ is considered so abnormal, and community resources so deficient, that inpatient admission is chosen for a committed client. Sociologists have not been interested in this problem at all, if one judges by recent articles in sociological journals.

Finally, the whole issue of mental hospitalization as ‘social control’ needs to be re-examined. This assumption is found in Gove et al.’s understanding of the societal reaction model and in Horwitz’s recent extension of Black’s theory of law. Neither Gove nor Horwitz consider what is really new about the new commitment laws, and simply superimpose concepts relevant in the era of the 1960s on to the 1980s. No doubt there is some element of social control in society’s reaction to all forms of deviance, including mental illness. But something else, something new, needs to be considered, namely why society commits someone and then fails to ‘control’ – hospitalize – that person. Why does society change its mind about some committed patients? This
new phenomenon does not fit in neatly into theories of social control.

In conclusion, sociologists ought to leave behind them the conceptual tools of the 1960s when it comes to mental health and devise new concepts relevant to mental health law and its application in the 1980s. What does commitment mean today – in theory, in the laws, and in practice – and how should we study it? What does it mean as an index of mental illness, need for treatment, dangerousness, and of ‘persons subject to involuntary commitment’? What does it mean with regard to the concepts of normalcy, deviance, and social control?

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References


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15 M. Petrunik, op. cit., p. 226.
17 D. Wexler, op. cit., p. 15.
19 Practice Manual, op. cit.
23 Ibid.
24 C. Warren, op. cit.
26 Examples of what I consider to be appropriate studies of commitment as a last resort are Emerson and Pollner, Martindale, and Strong, all previously cited.
28 R. Emerson and M. Pollner, op. cit.
33 Gove et al., op. cit.; V. Hiday, 1983, op. cit.
34 R. Emerson and S. Messinger, op. cit. A worthwhile focus of study would be to focus on the interpretive processes involved in the decision to bring in a third party to intervene in handling what Emerson and Messinger call ‘trouble.’
35 T. Scheff, op. cit., p. 446.
38 W. Cockerham, _op. cit._, p. 168.
39 _Ibid._, p. 259.
40 _Ibid._
41 A. Horwitz, _The Social Control of Mental Illness_, New York, Academic Press, 1982. I do not mean to reproach Horwitz, because his analysis of the controversy between adherents of the psychiatric and labeling perspectives is lucid and astute. But, he does not move beyond the worn-out focus on mental illness, which is _not_ the paramount criterion for hospitalizing patients, and he seems to equate ‘social control’ with involuntary commitment.
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