

# Foucault, Forensic Psychiatry, and the First Involuntary Commitment

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My romantic interest arrived in town, and, eager to impress her, I suggested that we amble through downtown New Haven on this radiant August day to build appetites for dinner. Graduates of Yale have praised the Green for its majestic ancient churches, seasonal open concerts, and perpetually maintained landscaping. My medical internship felt imprisoning with its long hours in the hospital attending acutely sick patients. Her visit promised an emotional and professional reprieve, even if only for two days. To mark the occasion, I wanted to show her the city in which I lived but to which I ironically had little access.

We met as I finished graduate school in religion and anthropology. Working toward a career in cultural psychiatry and psychiatric anthropology, I desired more training than the medical curriculum provided. For three years, I devoured social theory. The work of Michel Foucault particularly captivated me with his creative, incisive studies into the relationships between power and knowledge. Academics across the human and social sciences were applying his theories on how governments create social and political institutions to control bodies and information. Foucault decried psychiatrists who possessed powers to declare people insane and treat them involuntarily. Friends asked whether I too would treat

patients against their will; I responded vehemently that I would not practice a coercive psychiatry that robs patients of their rights.

Foucault lay dormant, however, as we traversed the Green. A sensual breeze softened the sun's heat. Street vendors peddled food of unknown provenance. Loud, awful poetry blared through a makeshift sound system as throngs gathered around a stage during a carnival. Parents fretted over children spilling into the streets as cars cautiously maneuvered around entitled bikers on the road.

Against this idyllic setting, a man suddenly accosted us. A wiry, unshaven, middle-aged male in tattered denim overalls with matted, unkempt hair staggered from the façade of one of the churches. He hadn't showered recently. His dramatic steps to block our path stunned us. His eyes narrowed as he examined us from head to toe, scowling as he inched closer.

"What made you decide to come to this country, Gandhi?" he shouted.

I stammered several words in Hindi to my companion about avoiding him. He kept pace.

"Answer me, you insolent fool! What made you come to this country, Gandhi?"

After the 9/11 attacks, I, like many brown folks, had become accustomed to such insults as "terrorist," "baby killer," "A-rab," and some variation on Osama bin Laden's name. But this was different. Rather than insult and then dismiss us, he persisted. My heart raced in fear of this man's unpredictability. Once we exited the Green, he stopped pursuing us. We continued to dinner, banishing the incident from our memories.

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I next met him one year later as the psychiatry resident who inherited his inpatient admission. The on-call psychiatrist had committed him because he was suicidal, gravely disabled, and withdrawing from alcohol. Details of his life materialized. Descended from an immigrant Caribbean family, he had graduated with honors three decades ago from an Ivy League institution with a degree in the classics. He had spent two years in graduate school for English literature at another Ivy university until his psychosis erupted. He refused to acknowledge the possibility of a mental disorder or take medications, triggering a protracted course of inpatient hospitalizations. He passed entire years in inpatient settings. Upon discharge, he would take medications until they ran out, refusing to follow up. Left to psychosis, his explosive anger terrified the clinical staff as he berated anyone perceived as a threat. His voluminous charts recorded that his chronic depression and suicidality started when he acknowledged the unlikelihood of becoming a famous writer. With his antipsychotic and mood stabilizer, however, his fury subsided, his thoughts became organized, and he wrote exquisite poetry that he sent to national journals from inpatient units. I gleaned this information from the chart, since initially he was too ill to communicate. I debated whether to ask him if he remembered me, but decided that this would only satisfy my curiosity, not confer therapeutic benefit. Over time, he improved. He joked with patients and staff. He joined groups and recited his work. Two months later, we discharged him to an apartment with visiting nurses to fill medications daily. This recovery could not have taken place without involuntary commitment.

Sixteen months afterward, I met him in the psychiatry emergency room that I staffed for third-year, overnight call. He stumbled in with a police escort. He had changed. His hair had curled into dreadlocks and his graying beard had grown longer, but he still wore the same scowl and overalls. He was disheveled. He demanded immediate release and threatened to hurt the staff. After several minutes, he agreed to stay when I reminded him that he could eat and sleep peacefully without worrying that people would harass him.

“OK, Gandhi,” he muttered scornfully, “I’ll rest for now, but only to get enough energy to kill myself in the morning!”

As I printed the emergency certificate to commit him involuntarily, I understood how I too had

changed. I recalled Foucault’s work in which he argued that in the modern legal system, the psychiatrist serves as a “subsidiary authority” and an “advisor on punishment” for the subject considered dangerous to society.<sup>1</sup> Foucault continued to claim that the hospital institutionalizes medical discipline (in both senses of the word), the psychiatric history elicits confessions, the chart reflects surveillance, and the medication internalizes control.<sup>2</sup> Medicine fills the contemporary void of religion, constructing a reality and rationality to stave off the evil of disease and death.<sup>3</sup> These critiques haunted me as I braced myself to become the very object disdained by an intellectual hero. I had become a psychiatrist.

The next day, I returned home, exhausted and weary. I revisited Foucault’s landmark book *Psychiatric Power*.<sup>2</sup> He attacked psychiatrists for profiting from families who commit ill relatives: “Re-familialized individuals will be produced inasmuch as it is the family that, by designating the mad person, provided the possibility of a profit to those who constitute the profit from marginalization” (Ref. 2, p 113). He criticized the family for “conform[ing] to a model of sovereignty in the nineteenth century” when the family inherited the discipline of schools, militaries, and hospitals as “the agency that decides between normal and abnormal, regular and irregular” (Ref. 2, p 115).

But contemporary American psychiatry differs from Foucault’s descriptions. Many patients lack family relationships, let alone general social supports. What disciplinary forces affect the homeless, the defeated substance abusers, the chronically psychotic, the stigmatized paraphiliacs, and other mentally ill whose families have exiled them because of embarrassment, shame, or fatigue? Moreover, few psychiatrists receive direct profits from commitment in a system that only recently granted mental health parity.

Foucault also assailed psychiatrists for falsifying reports about dangerousness for involuntary commitment: “The doctors of the period from 1840 to 1860 say this clearly. They say: To get care for him we have to write false reports, to make the situation look worse than it is and depict the idiot or mental defective as someone who is dangerous” (Ref. 2, p 221). Foucault then criticizes the medical literature that stigmatizes the mentally ill for the possibility of committing crimes, justifying detention.

However, this characterization of psychiatry reads as obsolete. Today's psychiatrists recognize that families, patient groups, attorneys, and judges may contest commitments, aside from insurance administrators with other concerns. Nurses, psychologists, and social workers collaborate in decisions, complicating the absolute authority of psychiatrists in Foucault's depiction. Finally, medical literature now addresses the basic science of disease processes more than the social or cultural factors of illness.

I see Foucault condemning me: disciplined by the discipline of psychiatry, I have only internalized the discourse of self-justification. I accept legitimate criticisms of involuntary commitment. Psychiatrists consistently overestimate the risk of dangerousness for suicidal and homicidal patients.<sup>4</sup> Forensic psychiatrists have moved from classifying the dangerousness of an individual to performing risk assessments for the security of the community.<sup>5</sup> Activists have lobbied to end commitments, promote deinstitutionalization, protect civil liberties, and enact procedures to safeguard patients' rights during commitment.<sup>6</sup>

Yet Foucault and his descendants have erroneously prioritized institutions against individuals. Why should psychiatrists refuse the protection of others if threatened by a treatable psychiatric patient? Should we let patients aggrieved by severe melancholia or persecutory voices take their lives when treatments are available? Does the risk of overestimation outweigh the disaster of underestimation? What alternatives are on hand when economic shortfalls cheat the mentally ill of services? Reductionist condemnations of involuntary commitment devalue the suffering of patients and the dilemmas of psychiatrists constrained in these systems. They also do not reconcile how involuntary patients may appreciate treatment despite coercive measures.<sup>7</sup>

I still have disagreements with involuntary commitment. Why should suicide always be illegal, particularly with terminal illnesses such as cancer that cripple quality of life? Why are homicidal patients boarded with nonhomicidal, psychiatric patients, and how does their placement represent psychiatric stigma? How does subjective determination of "grave disability" vary among psychiatrists? Should psychiatry allow advance directives that enable patients to refuse treatment and hospitalization even in their

worst states? How can we apply patient-centered approaches to coercive models?

Medical education is a moral education.<sup>8</sup> Medical training promotes psychological distance from patients, emotional numbing through repetition, and a commitment to learn "the way" from senior practitioners.<sup>9</sup> We lack reflexive ethnographies that chronicle the lives of patients and psychiatrists enmeshed in involuntary commitment, suggesting a potentially fertile research agenda. My reflections should therefore be seen as autoethnography within a broader call to examine critically the construction of medical consciousness through its distinctive forms of language, knowledge, practice, and hierarchy that control the practitioner.<sup>10</sup> Social and cultural theorists like Foucault can help psychiatrists to engage the moral conundrums between law and medicine and contemplate points of dissonance with medical morality.

I may see him again before I graduate. I will commit him again if he is suicidal. I'll take my chances of being a "subsidiary authority," even if it alleviates his suffering for only a few days. His moving poetry recitals in the inpatient units were not the words of a man desiring death. After all, the right to freedom means little to those not alive to enjoy it.

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