

Civil Commitment: A Range of Patient Attitudes

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The authors interviewed adult civil commitment excandidates about their perceptions of commitment six months after discharge. Scales were developed for the following constructs: perceived need of commitment, perceived personal consequences of commitment, view of medication, view of primary hospital physician, and view of hospital experience. Excandidates had a mixed view of commitment. The majority reported positive views, but a substantial minority endorsed negative descriptors.

This article examines the attitudes of candidates for civil commitment to learn how they retrospectively view their involuntary hospitalization and make sense of what happened to them. It sets their attitudes in the context of the debate between civil libertarians and psychiatrists. Using data on a large sample of excandidates from across one state, it describes candidates' perceptions of their own hospital medications, physi-

cians, and experiences, of the consequences of their involuntary hospitalization, and of their need for commitment at the time they became candidates.

In the debate surrounding civil commitment reforms of the 1970s, a central argument was over its punitive versus its beneficial nature. The traditional view of involuntary hospitalization, endorsed by psychiatrists, was paternalistic, emphasizing the state's *parens patriae* power to care for those who could not care for themselves and medicine's ability to heal the sick.¹ In contrast, civil libertarians emphasized the punitive nature of the process which incarcerated individuals against their wills, deprived them of their basic freedom, and dehumanized them in large, custodial institutions.^{2,3} The civil libertarians views prevailed in federal courts and state legislatures which affirmed individual rights of the mentally ill and limited the state's commitment power by both procedural and substantive restrictions.⁴ Pa-

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ternalism, however, has continued in limited ways;^{5,6} and the public debate has subsided on the nature of involuntary hospitalization.

Throughout the debate each side contended, either implicitly or explicitly, that mental patients viewed civil commitment as it did. Both sides used anecdotal evidence to support their contentions, although civil libertarians in one state did employ Goffman's work at St. Elizabeth's⁷ to buttress their case of mental patients experiencing civil commitment as punitive.⁸ Neither side sought survey evidence of mental patients' attitudes towards their hospitalization or commitment.

Weinstein⁹ later reviewed research on attitudes towards hospitalization of mental patients in general. He reported quantitative studies found predominantly positive attitudes, whereas qualitative studies found negative attitudes. His review did not distinguish between voluntary and involuntary status, although he did suggest that involuntary patients were more negative than voluntary ones. Most studies Weinstein reviewed were completed before civil commitment reforms.

Since restrictive reform standards and procedures reduced commitments and lengths of stay, checked old abuses, and virtually eliminated railroading,⁵ one might expect involuntary patients to be less negative. If civil commitment now operates as the reforms intended—excluding nonmentally ill deviants and nondangerous mentally ill persons who had been involuntarily hospitalized under pre-reform statutes and giving to the fewer persons who go through the pro-

cedure the dignity of due process, greater attention, and earlier release,—conditions exist for excandidates to be more positive toward their involuntary hospitalization. If civil commitment also gives treatment, respite, and healing, excandidates might be grateful for their involuntary hospitalization. Indeed, one psychiatrist proposed changing the civil commitment criteria to insure that all committed patients can be treated and healed.¹⁰ His proposal, dubbed the "Thank You Theory," would produce grateful patients after their release. On the other hand, if reforms have produced an involuntary patient population which is more dangerous, it may be more resistant to authority and to treatment. In such cases, it is possible that involuntary patients would express more negative views than the ones reported in earlier research.

A few studies have been conducted since civil commitment reform; but they have consisted of small samples, been limited to private or university hospitals, were foreign, and/or questioned patients while they were still hospitalized and possibly not free to express their true attitudes.¹¹⁻¹⁶ We, thus, cannot generalize very well from their results.¹⁷ The present study attempts to correct past limitations by assessing attitudes towards civil commitment and involuntary hospitalization of a relatively large, representative sample of excandidates. The sample includes persons who were committed, released, or assigned an alternative by the court. All excandidates were held at least 5 to 10 days in mental wards in state, local or, university hospitals prior to their hearings; and all had

court hearings six months prior to attitude assessment and had been living in their communities from one to six months at the time of attitude assessment.

Methods

The data come from a larger study of 1,226 adult civil commitment candidates who were alleged to be mentally ill and dangerous. They were selected on the basis of stratified cluster sampling from all such respondents with hearings in North Carolina in 1984–1985. We proportionately sampled from counties according to their contribution to civil commitment cases: counties with state mental hospitals (80.2%); and counties with local inpatient facilities holding civil commitment candidates (19.8%), one of which was a university medical center. At the time of the hearings, information on demographic and clinical characteristics and on dangerous behavior was recorded from legal affidavits. Before their hearings, researchers attempted to contact all sample candidates while they were hospitalized for observation and evaluation in order to explain the research and obtain informed consent for a six months follow-up.

Informed consent was obtained from 740 candidates. We were able to follow all but 13 of them 6 months later by record checks in community mental health centers and the mental hospitals where they were initially contacted. Ninety-eight were hospitalized at the sixth month, 17 were in jail or prison, 15 were in nursing homes, and 16 were in other institutions such as alcoholic rehabilitation centers, leaving 587 non-

institutionalized. We were able to conduct telephone interviews to assess attitudes with 187 (31.9%) noninstitutionalized excandidates. If an excandidate could not be reached after multiple attempts, we attempted to contact a relative or friend whom the candidate had named as someone who would always know where he or she was. We interviewed 247 friends/relatives concerning other information about the candidates. We had no telephone contact with 31.3 percent of the noninstitutionalized because of their having no phone, having given a wrong number, having a phone that was disconnected, or not being at home during our repeated calls. We focused on perceptions of commitment obtained directly from excandidates, rather than information obtained from kin or friends.

The 740 candidates who gave their consent to the follow-up were not different from the initial sample in demographic, clinical, or dangerousness characteristics except age. The elderly were more likely to be nonconsenting largely because of their greater likelihood of being incompetent. Only nine percent of candidates refused to participate in the research; most nonconsenters were ones we could not contact because of their being asleep, in seclusion, with a clinician, or off their wards during our visits.¹⁸

Table 1 presents a comparison of the larger sample of all candidates whom we did not interview by phone with the telephone interview subsample. As with other studies of the involuntarily hospitalized, our sample is drawn heavily from the lower socioeconomic strata.

Table 1
Comparison of Respondents Interviewed by Telephone and All Others

Variable	Respondents Not Reached by Phone		Respondents Interviewed by Phone	
	(N = 1,039)		(N = 187)	
	N	Percentage	N	Percentage
Sex				
Male	590	57.1	99	52.9
Female = 443	443	42.9	88	47.1
	<u>1,033</u>	<u>100.0</u>	<u>187</u>	<u>100.0</u>
Race				
White	480	46.9	95	50.8
Nonwhite	543	53.1	92	49.2
	<u>1,023</u>	<u>100.0</u>	<u>187</u>	<u>100.0</u>
Age*				
<30	335	32.7	63	33.7
30-50	546	53.4	110	58.8
<50	142	13.9	14	7.5
	<u>1,023</u>	<u>100.0</u>	<u>187</u>	<u>100.0</u>
Marital status†				
Married	212	22.3	52	28.6
Single	464	48.9	97	53.3
Separated	99	10.4	6	3.3
Divorced	113	11.9	19	10.4
Widowed	61	6.4	8	4.4
	<u>949</u>	<u>99.9</u>	<u>182</u>	<u>100.0</u>
Community size				
<1,000 (or rural rt.)	330	33.0	71	38.8
1,000-2,499	43	4.3	10	5.5
2,500-4,999	74	7.4	12	6.6
5,000-9,999	79	7.9	12	6.6
10,000-24,999	67	6.7	11	6.0
25,000-49,999	152	15.2	31	16.9
50,000-99,999	37	3.7	4	2.2
>100,000	217	21.7	34	17.5
	<u>999</u>	<u>100.0</u>	<u>183</u>	<u>100.0</u>
Education‡				
0-11 years	244	50.0	63	36.4
High school	134	27.5	67	38.7
Some college	110	22.5	43	24.9
	<u>488</u>	<u>100.0</u>	<u>173</u>	<u>100.0</u>
Employment				
No	368	68.5	103	66.0
Yes	169	31.5	53	34.0
	<u>537</u>	<u>100.0</u>	<u>156</u>	<u>100.0</u>
Primary diagnosis‡				
Organic mental disorders	92	8.9	4	2.1
Substance abuse disorders	39	3.8	4	2.1
Schizophrenic disorders	404	38.9	83	44.4
Psychotic disorders	132	12.7	26	13.9
Affective disorders	214	20.6	53	28.3
Adjustment disorders	41	3.9	7	3.7
Paranoid disorders	15	1.4	2	1.1
All other disorders	102	9.8	8	4.3
	<u>1,039</u>	<u>100.0</u>	<u>187</u>	<u>99.9</u>

Civil Commitment: A Range of Patient Attitudes

Table 1 Cont.

Variable	Respondents Not Reached by Phone		Respondents Interviewed by Phone	
	(N = 1,039)		(N = 187)	
	N	Percentage	N	Percentage
Prior hospitalization				
None	500	48.1	85	45.5
1 or more	539	56.9	102	54.5
	<u>1,039</u>	<u>100.0</u>	<u>187</u>	<u>100.0</u>
Prior dangerousness				
None	634	61.0	114	61.0
1 or more	405	39.0	73	39.0
	<u>1,039</u>	<u>100.0</u>	<u>187</u>	<u>100.0</u>
Psychiatric recommendation‡				
Release	98	9.5	14	7.5
Voluntary hospitalization	28	2.7	7	3.7
OPC	152	14.7	50	26.7
Other Alt.	6	.6	0	—
Involuntary hosp.	716	69.3	116	62.0
Split/IV hosp. and OPC	33	3.2	0	—
	<u>1,033</u>	<u>100.0</u>	<u>187</u>	<u>100.0</u>
Court decision‡				
Release	206	19.8	25	13.4
Voluntary hospitalization	31	3.0	10	5.5
Nursing home	1	.1	0	—
OPC	185	17.8	53	28.3
Other alternative	8	.8	2	1.1
Involuntary hosp.	548	52.7	96	51.3
Conditional release	4	.4	0	—
Split/IV hosp. and OPC	56	5.4	1	.5
	<u>1,039</u>	<u>100.0</u>	<u>187</u>	<u>100.0</u>

* By χ^2 test, $p < .05$.

† By χ^2 test, $p < .01$.

‡ By χ^2 test, $p < .001$.

Both groups tend not to be currently married or employed, and tend to have low levels of education. A majority (56.9%) of the larger sample have been previously hospitalized, and many of them have been dangerous before (39.0%). Almost two-fifths (38.9%) received a primary diagnosis of one of the schizophrenic disorders; and just over one-fifth (20.6%) received a diagnosis of one of the affective disorders, with manics twice the number of depressives or mixed. Psychiatrists recommended most candidates for commitment to in-

voluntary hospitalization (69.3%) and recommended less than 10 percent for release (9.5%). Commitment to outpatient treatment (OPC), which has been encouraged by the division of mental health, was recommended for 14.7 percent of candidates. Judges tended to follow the psychiatric recommendation in their court decisions, but they were less likely to commit to involuntary hospitalization (52.7%), and more than twice as likely to release as psychiatrists were (19.8%).

The telephone interview subsample is

different from the larger sample in marital status, education, diagnosis, psychiatric recommendation, and court decision. The telephone interview subsample has somewhat higher levels of married and single candidates: 28.6 percent of the telephone subsample were married, and 53.3 percent were single at the time of their involuntary hospitalization compared with the overall rate, 22.3 percent and 48.9 percent, respectively. A greater proportion of the telephone subsample completed high school (63.6% compared with 50.0% of the larger sample). More of the telephone subsample were diagnosed with a major psychosis (44.4% schizophrenic and 28.3% affective, compared with 38.9% and 20.6%, respectively). Psychiatrists recommended more of the telephone subsample for outpatient commitment (OPC, 26.7% to 14.7%) and fewer to involuntary hospitalization (62.0% to 69.3%), whereas the court released fewer of the subsample (13.4% to 19.8%) and ordered more to OPC (28.3% to 17.8%)

Marital status and education data suggest that our phone subsample consists of excandidates who tend to have more resources, which is not surprising in that people with greater resources are more likely to have a phone. Although being single rather than married might suggest fewer resources, single subsample respondents did have home/kin structures which enabled us to reach either the excandidates or members of their networks. Differences in psychiatric recommendations and court decision suggest that psychiatrists and judges thought our phone subsample had a better

chance of surviving in the community under the supervision and treatment of a community mental health center. Differences in diagnosis, on the other hand, suggest that the phone subsample had a lesser chance of making it in the community, given the bleaker prognoses of major psychoses. There were no differences within the subsample on any variable between those reached directly and through friends/relatives.

Our telephone subsample had varying lengths of stay in the hospital. The great majority (70.5%) stayed from 1 to 30 days, and just over half of them stayed 10 days or less. Another 16.5 percent stayed between 31 and 60 days, and 12.9 percent stayed more than 60 days. As one would expect, those ordered to involuntary hospitalization by the court had the longest stays.

Most studies of attitudes to commitment and involuntary hospitalization have measured those attitudes with a single or only a few items; however, civil commitment and involuntary hospitalization represent complex processes. We, therefore, measure excandidates' attitudes toward them with five distinct constructs: perceived need for commitment, perceived personal consequences of commitment, view of medication while hospitalized, view of primary hospital physician, and overall view of involuntary hospital experience. Each construct is measured with multiple indicators which are then combined into a scale to yield a single score incorporating the construct's dimensions. All scales have acceptable reliability with Cronbach's alphas ranging from .61 to .78 (see tables).

Civil Commitment: A Range of Patient Attitudes

Tables 2 through 6 include questions and response categories for each construct.

Results

Table 2 presents excandidates' perception of the effect of commitment/involuntary hospitalization on relationships with family, friends and coworkers, and perception of its global impact. Only a minority of excandidates felt commitment harmed their relationships with family and friends. Slightly more excandidates found the experience helped rather than harmed their relationships with friends and coworkers, but more than twice as many perceived improved family relationships. Only 35 percent of the telephone sample were working, accounting for the larger number of cases in the missing category. If one were to restrict analysis to working excandidates, 37.9 percent felt the process was helpful, 33.3 percent felt it had no effect, and 28.0 percent felt it hurt their work relationships. When asked about the overall effect of being involuntarily hospitalized, 46.5 percent reported that involuntary hospitalization was helpful, whereas only 19.8 percent reported it

was harmful. Excandidates' mean on the scale of these items is just beneath the midpoint indicating neutral to slightly positive effects on relationships of commitment/involuntary hospitalization in the aggregate.

Table 3 presents excandidates' perceived need for commitment, divided into two categories: retrospective belief (respondents' recollection of their perceptions, 6 months earlier) and belief at the time of telephone interview. According to their recall, respondents did not agree with their need for commitment at the time of their involuntary admissions. Most reported that they were not willing to be hospitalized at that time (54.6%), less than half believed they were sick (41.2%), and even a smaller proportion of respondents thought they should have been hospitalized (35.3%).

With hindsight at the time of interview, a small majority of excandidates thought they should have been hospitalized (54.0%) and viewed involuntary hospitalization as having been necessary (57.8%); however, only one-fourth thought they were dangerous at the time of their involuntary admissions. Three-fifths said that if in the future they be-

Table 2
Perceived Consequences of Commitment/Involuntary Hospitalization

	Helped		No Effect		Hurt		DK/NA		Summation		Item Total Correlation
	N	%	N	%	N	%	N	%	N	%	
Effect on family relations	67	35.8	60	32.1	27	14.4	33	17.7	187	100	.49
Effect on friends relations	42	22.5	74	39.6	34	18.2	37	19.8	187	100	.59
Effect on work relations	25	13.4	22	11.8	19	10.2	121	64.7	187	100	.53
Global effect	87	46.5	30	16.0	37	19.8	33	17.7	187	100	.46

Scoring: helped = 1, no effect = 2, hurt = 3.
Scale range = 4 (helped) to 12 (hurt); midpoint = 8.
Cronbach's α = .73, \bar{X} = 7.64, SD = 2.42.

Table 3
Perceived Need of Commitment

	Yes		Neutral: Not Sure, Somewhat		No		Missing		Summation		Item Total Correlation
	N	%	N	%	N	%	N	%	N	%	
<i>Retrospective Belief</i>											
Then willing to be hospitalized	62	33.2	23	12.3	102	54.6	0	–	187	100	.49
Then believe were sick	78	41.2	16	8.6	80	42.8	13	7.0	187	100	.50
Then think should have been hospitalized	66	35.3	10	5.3	95	50.8	16	8.6	187	100	.62
<i>Belief at Time of Phone Interview</i>											
Now think should have been hospitalized	101	54.0	14	7.5	58	31.0	14	7.5	187	100	.57
Now think commitment personally necessary	108	57.8	7	3.7	54	28.9	25	13.4	187	100	.52
Now think were dangerous	47	25.1	7	3.7	117	62.6	16	8.6	187	100	.33
Believe hospitalization is necessary when seem dangerous	141	75.4	12	6.4	19	10.2	15	8.0	187	100	.41
Want to be committed if become sick and dangerous	114	61.0	9	4.8	39	20.9	25	13.4	187	100	.47

Scoring: yes = 1, neutral = 2, no = 3.

Scale range = 8 (need) to 24 (no, not need); midpoint = 16.

Cronbach's $\alpha = .78$ $\bar{X} = 14.77$ $SD = 4.30$.

came sick and dangerous they would want to be committed, and even more (75.4%) believed hospitalization is necessary when one seems dangerous. Overall, excandidates tended to agree with the civil commitment criteria that involuntary hospitalization is appropriate for the dangerously mentally ill, thought they did not meet the dangerousness criterion themselves, yet thought they needed hospitalization when they were involuntarily admitted. Mean score on the scale (14.77) is on the side of endorsing their need for commitment but is very close to the midpoint reflecting rejection of their own dangerousness and earlier denial of their need.

Table 4 depicts excandidates' view of

medication taken while in the hospital. Over half (53.5%) thought they needed the medication that was prescribed; and three times as many thought it did more good than harm (48.7% vs. 15.5%). There was no majority opinion about the effects of medication on length of stay: almost two-fifths (39.0%) thought that it had no effect, 29.4 percent thought it shortened their stay, and 10.2 percent felt it lengthened their stay. Although generally positive about need for and usefulness of medication, excandidates reported medication's side effects caused them problems: 25.7 percent said there were a lot of problems, and 19.3 percent said the problems were slight. Mean scale score (6.93) is on the positive

Civil Commitment: A Range of Patient Attitudes

side of the scale; but again it is a mean close to the midpoint, reflecting a mixed view of medication.

Excandidates' view of their primary hospital physicians is very positive, with just over three-fifths liking them and thinking that they were helpful (Table 5). Although positive, these attitudes towards their primary hospital physicians are not as positive as those towards their regular or family doctors. Over 90 percent of excandidates with family doctors endorsed positive qualities such as liking

them and finding them helpful. Despite the large proportion of foreign physicians working in state mental hospitals, the majority of excandidates (73.8%) thought their physicians spoke English well. Mean scale score (4.18), well beneath the midpoint, reflects the strongly positive view of their hospital physicians.

Responses to adjectives describing how involuntary hospitalization affected them indicate a mixed overall view of the experience (Table 6). In general, they

Table 4
View of Medication

	Yes		Neutral		No		Not Answered		Summation		Item Total Correlation
	N	%	N	%	N	%	N	%	N	%	
Needed Medication	100	53.5	12	6.4	48	25.7	27	14.4	187	.00	.53
	Helped		Neutral		Harmful						
Medicine was Helpful vs. Harmful	91	48.7	31	16.6	29	15.5	36	19.3	187	100	.63
	Shortened		Neutral		Lengthened						
Effect on Length of Stay	55	29.4	73	39.0	19	10.2	40	21.4	187	100	.39
	No Problem		A Little Problem		A Lot of Problems						
Side Effects	68	36.4	36	19.3	48	25.7	35	18.7	187	100	.34

Scoring: yes, helped, shortened, no problem = 1; neutral, a little problem = 2; no, harmful, lengthened, a lot of problems = 3.

Scale range = 4 (positive) to 12 (negative); midpoint = 8.

Cronbach's $\alpha = .68$, $\bar{X} = 6.93$, $SD = 2.35$.

Table 5
View of Primary Hospital Physician

	Positive		Neutral		Negative		Missing		Summation		Item Total Correlation
	N	%	N	%	N	%	N	%	N	%	
Like	114	61.0	21	11.2	27	14.4	25	13.4	187	100	.59
Helpful	113	60.4	14	7.5	32	17.1	28	15.0	187	100	.58
Speaks English well	138	73.8	-	-	20	10.7	29	15.5	187	100	.25

Scoring: positive = 1, neutral = 2, negative = 3.

Scale range = 3 (positive) to 9 (negative); midpoint = 6.

Cronbach's $\alpha = .61$, $\bar{X} = 4.18$, $SD = 1.69$.

Table 6
View of Involuntary Hospital Experience

	Yes, Definitely		Somewhat, Sometimes		No, Not at all		DK/NR		Summation		Item Total Correlation
	N	%	N	%	N	%	N	%	N	%	
Embarrassing	50	26.7	20	10.7	93	49.7	24	12.8	187	100	.43
Necessary*	101	54.0	7	3.7	54	28.9	25	13.4	187	100	.46
Unpleasant	77	41.2	20	10.7	67	35.8	23	12.3	187	100	.57
Helpful*	101	54.0	18	9.6	40	21.4	28	15.0	187	100	.59
Depressing	86	46.0	27	14.4	49	26.2	25	13.4	187	100	.50
Degrading	54	28.9	19	10.2	86	46.0	28	15.0	187	100	.47
Gave hope*	96	51.3	6	3.2	56	22.0	29	15.5	187	100	.50

Scoring: positive view = 1, mixed view = 2, negative view = 3.

Scale range = 7 (positive) to 21 (negative); midpoint = 14.

Cronbach's $\alpha = .78$, $\bar{X} = 12.92$, $SD = 4.20$

* Items were reverse coded to preserve directionality of scale.

tend to agree with positive descriptors and disagree with negative ones. A majority said hospitalization was definitely necessary (54.0%), definitely helpful (54.0%), and definitely gave them hope (51.3%). Almost half said it was not at all embarrassing (49.7%) and not at all degrading (46.0%); however, almost half described it as definitely depressing (46.0) and unpleasant (41.2%). Excandidates' aggregate response was slightly positive with a scale mean (12.92) below the midpoint.

Discussion

Testing excandidate attitudes towards their commitment and involuntary hospitalization with five distinct constructs and multiple indicators, we find a mixed view of their experiences. The majority of excandidates living in the community have predominately positive views. They tend to report that civil commitment helped rather than hurt their relationships with family, friends, and coworkers, that they needed to be hospitalized when they were involuntarily admitted,

that they needed medication and it was helpful rather than harmful, that they liked their primary physicians, and that involuntary hospitalization was helpful and gave them hope. In this respect, our research supports the findings of recent studies, which had fewer measures and smaller, limited samples. It also concurs with findings of earlier, pre-reform research, (see ref. 21) thus indicating continuity in patient attitudes towards their commitment and involuntary hospitalization regardless of criteria. Although we were not able to directly test Stone's "Thank You Theory," our study supports several aspects of it in that the majority view commitment as helpful and necessary and want to be committed if they become sick and dangerous in the future (a finding analogous to his "reasonable man" test).

One might wonder why one-third of candidates were hospitalized under civil commitment when they were "then willing to be hospitalized" (Table 3). It is possible that they misunderstood the question or that their retrospective re-

Civil Commitment: A Range of Patient Attitudes

port of past belief is influenced by subsequent experience. Toews and colleagues¹⁹ examined patients attitudes over time from one week to six months postcommitment and found that only 13.6 percent claimed to know they were committed at the time of the first interview, which changed to 64.7 percent at three months. The authors discussed a number of explanations for changes in the patients' knowledge of commitment status: learning effect, denial of status, failure to understand the question, or not being told early on of their commitment status. On the other hand, some candidates may have been hospitalized under civil commitment despite having been "then willing to be hospitalized" because clinicians took into account patients' histories of ambivalence about hospitalization and medication, and/or past noncompliance with voluntary treatment or perceived patients' illnesses as rendering them incapable of contracting for voluntary hospitalization; thus, clinicians invoked judicial review to obtain hospitalization. A final possibility is that these candidates may be representative of what Miller²⁰ calls "the briar patch syndrome" in which some patients, who want to gain access to hospital care but cannot be admitted voluntarily, arrange for their own commitment by behaving dangerously to meet the dangerousness criterion for involuntary hospitalization.

Although a majority of excandidates tend to report positive attitudes, a substantial minority view their experiences negatively, seeing their relationships harmed, their physicians and medica-

tions as not helpful, and their hospitalization as unnecessary, degrading, and depressing. Our findings, thus, give support to civil libertarians who argue the punitive nature of involuntary hospitalization as well as give support to clinicians who view it as beneficial.

Concern about social stigma, clinically noted by professionals involved with patients and their families, was minimal in the responses given by excandidates in our study. One could speculate that (1) their illness had a more deleterious effect on relationships with family and friends than did the process of commitment, (2) underplaying the effect could be a socially adaptive posture, or (3) because of sample loss, our interviewed respondents were not representative and had an uncharacteristic response.

In interpreting results of this study, we must keep in mind potential biases and limitations. As Toews and colleagues²² have noted, these patients are difficult to track. Although our attitude assessment was of a larger sample than that of previous studies, we were able to interview by phone only 31.9 percent of the noninstitutionalized excandidates who had given their informed consent. These were no different on any sociodemographic, clinical, or disposition variables than others whose friends/relatives we interviewed by telephone. In comparing the phone subsample with the larger sample, including both those who gave consent and those who did not, we found no difference with respect to race, age, or sex. It is possible that the higher educational level and the larger proportion

married of the telephone subsample could be associated with a more positive view of commitment in the interviewed group. Functional psychoses were overly represented in the telephone subsample; however, that is the diagnostic group for whom commitment is typically sought.^{5,15} Sample respondents with organic diagnoses were more likely to remain institutionalized than to be at home. Finally, having access to a telephone does represent a minimal level of resources and social connectedness. It is possible that those who had no telephone or a disconnected telephone or who had given us the wrong number may represent a more isolated, financially disadvantaged group who would not have endorsed the same perceptions if given the opportunity.

We acknowledge the cross-sectional nature of the study, though we included some retrospective questions. Both Toews *et al.*¹⁹ and Kane *et al.*¹¹ note the significance of time. Overall, in Toews *et al.*'s study there is little change post-commitment, with the exception of knowledge of status and rights. Kane and colleagues report a significant change between admission and discharge, with greater recognition for the original need for commitment with the passage of time. They also note more positive attitudes in the patients for whom remission of symptoms was achieved. Since all our sample were released from hospitalization, we can assume that their more florid symptoms and dangerous behaviors were in remission at discharge. Thus, our findings at the six-month point of predominantly positive attitudes are fairly consistent

with previous work and sample a larger group of patients than those previously reported.

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Civil Commitment: A Range of Patient Attitudes

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