# Voluntary "Involuntary" Commitment — The Briar-Patch Syndrome

ROBERT D. MILLER, M.D., Ph.D.*

## Summary

Szasz and others have pointed out that many so-called voluntary admissions to mental hospitals have various elements of coercion involved, and are thus not truly voluntary. The author contends that the converse situation is also true, that many patients admitted under involuntary commitment papers arrange for their own commitments. Reasons for such choices are discussed in the context of a review of the literature and several case histories.

"Oh, please don't throw me in that briar patch!"
— Joel Chandler Harris, Tales from Uncle Remus

Much has been made by patient advocates and critics of involuntary psychiatric treatment of the coercive nature of some "voluntary" admissions to mental hospitals.[1,2,3,4,5] Szasz in particular has been quick to point out that patients are forced to seek admission, and to stay in hospitals against their will under the threat of commitment if they refuse. He states ". . . voluntary mental hospitalization is often actually a type of involuntary psychiatric confinement."[1] In addition, Ennis[2] and Gilboy and Schmidt[3] point out that many "voluntary" patients are unable to understand the meaning of hospitalization, and that their lack of informed consent prevents their admissions from being truly voluntary.

Although most authors support the idea of truly voluntary admissions,[6,7,8] the current trend is to emphasize those patients whose decisions to seek hospitalization are not totally free. By contrast, the assumption that involuntarily committed patients are by definition unwilling to seek or accept hospitalization has been accepted as axiomatic, and unchallenged. Szasz states simply: "involuntary mental hospitalization is just that — hospitalization in opposition to the will of the so-called patient."[1] The image persists of patients being dragged into hospitals in straight jackets and handcuffs, as does the "snake pit" picture of the level of care in the institutions to which most patients are

*Dr. Miller is Director of Residency Training and Director of Clinical Research, John Umstead Hospital, Butner, NC 27509. He is also Clinical Associate Professor of Psychiatry, Duke University Medical Center, Durham, NC 27706.

still committed, lending support to the wide-spread assumptions that few would actively choose to come to such places, and that little or no amelioration of their conditions will result if they do.

Nevertheless, it is the contention of this paper that a number of patients who enter mental hospitals under involuntary commitment have actively chosen to do so, if not always at a conscious level. Four case examples will be presented to illustrate this hypothesis, and the discussion will contain other examples from the literature.

*Case 1*

Mr. A., a 27-year-old single man came to the hospital on a Saturday accompanied by a friend; both were moderately inebriated and requested inpatient detoxification; neither displayed any signs of withdrawal or mental illness. The hospital policy prohibited non-emergency admissions for simple detoxification on weekends; there was an agreement with a nearby Alcohol Rehabilitation Center (ARC) to refer all patients requiring detoxification. The ARC agreed to accept both men, and Mr. A.'s friend readily agreed; Mr. A. refused and angrily demanded admission to the hospital. When the hospital policy was again explained to him, he feigned collapse, sliding out of his chair onto the floor. When this ploy did not work, he began cursing and threatening, stating "If you don't admit me, I'll go out and get myself committed." Despite his companion's efforts to talk him into accepting the ARC referral, Mr. A. stormed out of the admitting office and went to the local magistrate's office where he convinced the magistrate to issue commitment papers after threatening to harm himself or someone else if not committed. He was returned to the hospital, but as there was no difference in his condition, admission was again refused. Mr. A. became quite hostile and aggressive, and the police had to be called to remove him from the hospital. He subsequently was jailed for starting a fight in a local restaurant.

*Case 2*

Mr. R., a 62-year-old divorced man was admitted involuntarily to our unit for the first time, after having recently moved into our catchment area. He had had twenty-five previous psychiatric admissions in the area where he had lived before, mostly under involuntary commitment. He had carried many diagnoses: schizophrenia, schizo-affective disease, manic-depressive illness (both manic and depressed type) as well as various personality disorders including passive-aggressive, passive-dependent, and inadequate. He was committed on this admission after threatening suicide in a local emergency room. Within hours of admission, he appeared calm and relaxed, with no evidence of depression or of any type of thought disorder. Contact with his local mental health center revealed that they had strongly opposed hospitalization, which they felt reinforced Mr. R.'s unrealistic dependency wishes; they had been seeing him frequently, and recommended a brief hospitalization

and a return to outpatient treatment. Mr. R. agreed to this contract, and was discharged after six days with appointments at the mental health center and the department of social services.

After keeping the mental health center appointment the day of his discharge, he returned to the hospital at 6:00 A.M. the following day, again anxiously complaining of suicidal ideation and his inability to live outside the hospital. When the on-call psychiatrist asked him to wait until the regular unit staff arrived, he sat calmly reading magazines for two hours, with no sign of anxiety or depression. When I arrived, he instantly reverted to his passionate plea for admission, crying and begging. After we talked to him for over an hour, and arranged even more community support, he agreed to return home and denied any depression or suicidal ideation. We arranged for the hospital security to drive him home (he had spent all his money for taxi fare to the hospital, a frequent maneuver used by prospective patients to make it hard to deny admission). He told the officers he would kill himself if they didn't get him committed, so they took him to the magistrate who sent him bck to the hospital under commitment papers. When I saw him again, he presented the same picture of instant agitation which quickly subsided. He denied suicidal ideation, saying that he had told the police that in order to get himself committed, which he thought would guarantee his admission. After another talk, Mr. R. agreed once again to return home and keep the various appointments already set up for his support. At his own request he was given a ride to the nearby interstate highway; there he climbed onto a bridge and jumped onto the highway, fracturing a number of vertebrae but sustaining no permanent injuries. He spent four months in the neurosurgical unit of a local general hospital, where he told the staff that he had jumped not to kill himself, but rather to find some way to be completely cared for. After his recovery, he returned to his former home, and has had multiple, lengthy admissions to the previous psychiatric unit, which has been afraid to deny him admission on any grounds.

*Case 3*

Miss T., a 45-year-old single woman, was brought to the hospital for her ninth involuntary admission in seven years. The admission was precipitated (as were most of her previous ones) by her bizarre appearance and postures in a local shopping mall, which disturbed shoppers and store operators. When a security guard approached her, she kicked him accurately in the groin, as she had done on several previous occasions. This action, coupled with her strange appearance, resulted in another direct emergency commitment to our hospital.

As on previous admissions, she was quite psychotic, with persecutory auditory hallucinations and delusions; she denied any need for help and refused medication initially. When she finally accepted medication, her psychosis remitted rapidly. Usually this improvement would result in

increased demands for discharge which were sustained by the court. Upon this admission, however, she asked to stay voluntarily, saying that she was tired of being crazy and of being committed every few months. During her two-month stay, she accepted her illness and the need for treatment, and realized that the behavior which had led to her commitments had been designed to obtain the help which she was unable to ask for directly. She was encouraged to seek help as an outpatient before she became so psychotic as to require hospitalization, and she agreed to do so. Since her discharge, she has attended the local mental health clinic regularly (which she had uniformly refused to do before) and has not needed hospitalization in over a year.

*Case 4*

Miss J. was a 23-year-old single woman who had been under psychiatric care for over eight years, suffering from a severe borderline personality disorder, with splitting, projective identification, tremendous rejection fear, and a strong hostile-dependent symbiosis with her mother. When she became upset, she would act out through excessive use of alcohol and illicit drugs, which usually ended up with bouts of sexual promiscuity, suicidal threats and gestures, or both. The first admission to our hospital followed such a series of events, and was arranged jointly by Miss J., her current outpatient therapist, and our hospital staff. All agreed that the admission should be under involuntary commitment, as Miss J.'s impulsive decisions to leave treatment had prevented previous hospitalizations from being effective. Miss J. made a therapeutic contract which included staying in the hospital under commitment until both she and the treatment team felt that she was ready to leave. Despite the aggressive efforts of the attorney representing her at her commitment hearing to convince her to "fight" the commitment, Miss J. refused, and even told the judge at the hearing that she could not be treated effectively if she were allowed to change to a voluntary status. Even though she probably no longer satisfied the strict criteria for "imminent dangerousness" specified at the time by statute as being necessary for commitment, the judge concurred with the patient and treatment team by ordering commitment for a period of ninety days.

She stayed under this arrangement for the three months, receiving group and individual psychotherapy as well as various rehabilitation services. She achieved relatively little functional insight into her psychopathology during this period, and was quite resistant to any attempts by her individual or group therapists to help her face up to her relationship with her mother, which was a central focus in her problems; but she was able to control her dependency wishes for her mother and to avoid acting out in any significant fashion as a result of any of the stresses she experienced during her hospitalization. She was able to make a reasonable decision to leave the hospital, with which the treatment team agreed, and to make appropriate plans for what she

would do after discharge, including educational, career, and therapy decision.

While this hospitalization probably did not make major lasting changes in her problems, it realized the limited goals set up in the original therapeutic contract of stabilizing her extremely erratic behavior, and considerable practice under support of new coping behaviors. None of these gains would have been realized if the patient had been admitted voluntarily, as her mental condition at that time would not have permitted her to persevere in her treatment long enough to achieve sufficient self-control for therapeutic alliances.

## Discussion

The decision whether to admit a patient or not is a complex one, with many factors besides clinical considerations exerting an influence.

The nationwide trend towards higher pecentages of voluntary admissions[10] has been influenced by stricter criteria for involuntary commitment, by the persistent criticisms of commitment as a method,[2,9,11] by administrative decisions at hospital and state levels, and by the establishment of many community-based inpatient facilities which do not accept committed patients.[12] Gilboy and Schmidt[3] claim that hospital staffs prefer to admit patients voluntarily because of less paperwork, while Crowder and Klatte[5] charge that many patients who seek voluntary admission are committed by the hospital staffs because of *de facto* incompetence to sign in voluntarily. Critics of involuntary commitment have assumed that hospital staffs seek to admit as many patients as possible;[13] but some authors point out that many hospitals are now under significant pressures to admit fewer patients and to decrease their census.[14] The difficult path to voluntary admission (or indeed any treatment) over various bureaucratic obstacles has been vividly discussed by Lebensohn[15] and Wilder and Karasu.[16]

There is extensive discussion in the literature concerning the decision-making process involved in hospital admissions. Beam[17] refutes Scheff's claim[13] that hospitals admit indiscriminately; and several authors have studied attitudes about admissions of mental health professionals[18-20] as well as how these attitudes affect the decision-making process.[21] The plight of patients not admitted under present criteria and policies has also attracted considerable attention throughout the world.[22,29] These studies have concentrated on decisions made by hospitals, courts, and legislatures, and have generally accepted the simplistic assumptions that voluntary patients want treatment while committed patients do not.

There have been few studies of what patients themselves say about their reasons for coming to hospitals, or for their behaving in ways which will predictably lead to hospitalization. One such study, which questioned 86 consecutively admitted involuntary patients, revealed that 7.2% had "some part in initiating their hospitalization,"[30] but no

conclusions were drawn as to the meaning of this finding. Two studies surveying patients' attitudes towards treatment on closed wards, undertaken after the patients had recovered from the acute problems which resulted in hospitalization, found that most patients preferred closed to open wards during the acute phases of their illnesses.[31,32] While not directly addressing the issue of involuntary hospitalization, it is a logical assumption that these patients would also have expressed a need for the hospitalization itself.

Several anecdotal case histories document situations similar to some of the cases presented above, in which patients displayed purposefully bizarre behavior in order to secure mental hospitalization,[3,33] or committed criminal acts to obtain at least some type of attention for their problems.[34,36] In fact, several authors point out that the current requirements for dangerousness as a necessary criterion for commitment may actually be causing some patients to escalate the severity of their behavior to comply with the requirements of the laws.[3,34,35,36] In a very Szaszian article, Penn *et. al.* argue that "one can learn 'crazy' behavioral responses just as easily as he can learn normal responses, if the 'crazy' responses should happen to be reinforced."[37]

In addition to the reasons for volitionally seeking an "involuntary" commitment demonstrated in the cases, there are many other reasons:

1) Many patients do not have convenient transportation to regional hospitals, which may be as far as 200 miles away in parts of North Carolina and in other parts of the country. Most local communities do not have local psychiatric inpatient facilities, particularly for indigent patients. If a patient is committed, the sheriff's department or other officials provide the transportation.

2) A patient's chances of gaining admission to many hospitals are greater if he comes in under commitment than if he comes voluntarily — for example, the denial rate at our hospital is only 5% for involuntary versus 23% for voluntary patients. Therefore, people whose reasons for wanting admission are questionable (avoidance of criminal charges, wanting a place to stay, or just getting out of an unpleasant situation) find that if they do something bizarre or threaten themselves or someone else, in order to be committed, they are much more likely to be admitted.

3) Many hospitals which accept committed patients have limited the times of day during which they will accept patients on a voluntary basis; but most accept committed patients at any time; therefore, many patients arrange to be committed so that they will not have to wait around the hospital or come back the next day.

4) Many states have been attempting for a number of years to implement a "single portal of entry" philosophy whereby patients seeking admission to a state mental hospital should first be seen at their local community mental health centers before presenting themselves at the hospital. The decision to refer for hospitalization should be made by

the local center in consultation with the patient. Many patients who do not choose or are unable, for a variety of reasons, to get to the mental health center which may have few evening or weekend hours of operation, have discovered that the policy does not yet apply to commitments, and that if they can get themselves committed, they can bypass the mental health center.

Some of the previously mentioned reasons for seeking "involuntary" admission are clearly manipulative attempts to coerce hospital staff to admit patients for whom hospitalization is not clinically indicated. However, Case 4 is an illustration of a situation in which commitment is clearly indicated on clinical grounds, where both the patient and the therapist agree in advance to place limits upon the patient's ability to act out and disrupt the therapy. In that case, the patient was conscious of the motivation to seek involuntary status. In numerous other instances the motivation is there on an unconscious level. Many patients' conditions deteriorate outside the hospital, especially if they go off needed medications. Their illnesses often do not permit them to control their overt behavior sufficiently to seek admission, but they have learned that when they reach a certain point, their behavior will cause them to be committed. These patients, while objecting at the time of admission, frequently say after recovery in the hospital that deep inside they realized their need for help before admission but could not act upon it. For such patients, involuntary commitment represents the only way in which they are able to receive help.

While the controversy about forcing anyone into a hospital against his will still rages, even the strongest critics of involuntary commitment do not deny the value of truly voluntary hospitalization, although there is still disagreement about who would benefit from it. It is vital to realize that involuntary commitment, as it now exists in all fifty states, is a necessary mechanism to allow access to treatment for many patients who themselves feel the need for treatment, and who otherwise would be denied help because of the very illness for which they need the treatment.

The actual number of such patients is not known at present, and the author is presently pursuing a separate study to attempt to define the scope of the problem by talking with the patients themselves rather than making assumptions based on personal or therapeutic biases. More work needs to be done in this area in order to justify continuation of a very necessary mechanism to permit patients to seek help on terms which they can accept.

## References


1. Szasz TS: Voluntary mental hospitalization: An unacknowledged practice of medical fraud. New England J. Medicine 287: 277-278, 1972
2. Ennis BJ: Legal rights of the voluntary patient. Nat Assoc Private Psychiatric Hosp J 8:4-8, 1976
3. Gilboy JA and Schmidt JR: "Voluntary" hospitalization of the mentally ill. Northwestern Law

Review 66: 429-453, 1971
4. Redlich F and Mollica RF: Overview: Ethical issues in contemporary psychiatry. Am J Psychiatry 133: 125-136, 1976
5. Crowder JE and Klatte EW: Involuntary admissions to general hospitals: Legal status is not the issue. Hosp Comm Psychiatry 31: 325-327, 1980
6. McGarry AL, Greenblatt M: Conditional voluntary mental-hospital admission. New England J Medicine 287: 279-280, 1972
7. American Bar Foundation: The Mentally Disabled and the Law. 1961
8. Klatte EW, Lipscomb WR, Rozynko VV, Pugh LA: Changing the Legal Status of mental hospital patients. Hosp Comm Psychiatry 20: 199-202, 1969
9. Szasz TS: Law, Liberty and Psychiatry. Collier Books, New York, 1963
10. Data supplied by Division of Biometry, National Institute of Mental Health and by the National Association of State Mental Health Program Directors for 1972, 1974, 1979.
11. New York Civil Liberties Union: Objections to involuntary admission to mental hospitals. Psychoanal Review 58: 385-394, 1971
12. Leeman CP: Involuntary admissions to general hospitals: Progress or threat? Hosp Comm Psychiatry 31: 315-318, 1980
13. Scheff TJ: The societal reaction to deviance: Ascriptive elements in the psychiatric screening of mental patients in a midwestern state. Social Problems 11: 401-413, 1964
14. Zwerling IM, Conte HR, Plutchik R *et. al.*: "No-Commitment week": A feasibility study. Am J Psychiatry 135: 1198-1201, 1978
15. Lebensohn ZM: Pilgrim's progress, or the tortuous road to mental health. Compr Psychiatry 16:415-426, 1975
16. Wilder JF and Karasu TB: Games institutions play: An exclusionary plot. Hosp Comm Psychiatry 28: 459-460, 1977
17. Bean P: Psychiatrists' assessments of mental illness: A comparison of some aspects of Thomas Scheff's approach to labelling theory. Brit J Psychiatry 135: 122-128, 1979
18. Kumasaka Y and Stokes J: Involuntary hospitalization: Opinions and attitudes of psychiatrists and lawyers. Compr Psychiatry 13: 201-208, 1972
19. Affleck GG, Wintrob RM, Peszke MA: Psychiatrists' evaluations of emergency involuntary hospitalization. Compr. Psychiatry 21: 13-21, 1980
20. Peszke MA, Affleck GG, Wintrob RM: Perceived statutory applicability versus clinical desirability of emergency involuntary hospitalization. Am J Psychiatry 137: 476-480, 1980
21. Mendel WM and Rapport S: Determinants of the decision for psychiatric hospitalization. Arch Gen Psychiatry 20: 321-328, 1969
22. Bachrach LL: The least restrictive environment is always the best? Hosp Comm Psychiatry 31: 97-103, 1980
23. California Senate report says state hospitals remain indispensable. Hosp Comm Psychiatry 25: 489-492, 1974
24. Bassuk EL, Gerson S: Deinstitutionalization of mental health services. Scientific American 238: 46-53, 1978
25. Fitzgerald OWS: Mentally disordered offenders. Brit Medical J 485-486, 17 Feb 1979
26. Rollin HR: Mentally disordered offenders. Brit Medical J 263-264, 27 Jan 1979
27. Telford SB: Mentally disordered offenders. Brit Medical J 264, 27 Jan 1979
28. Bailey KC: Mentally disordered offenders. Brit Medical J 264, 27 Jan 1979
29. Williams D: Mentally disordered offenders. Brit Medical J 264, 27 Jan 1979
30. Gove WR, Fain T: A comparison of voluntary and committed psychiatric patients. Arch Gen Psychiatry 34: 669-676, 1977
31. Fischer A, Weinstein MR: Mental hospitals, prestige, and the image of enlightenment. Arch Gen Psychiatry 25: 41-48, 1971
32. Rachlin S: On the need for a closed ward in an open hospital: The psychiatric intensive-care unit. Hosp Comm Psychiatry 24: 829-833, 1973
33. Halleck SL: Law in the Practice of Psychiatry. Plenum Books, New York, 1980, p. 134
34. Sadoff RL: Developing community mental health center-criminal justice system interactions. Int J Law & Psychiatry 1: 427-436, 1978
35. Clanon TL: Public protection and the trend to determinate sentence structure. Bull Am Acad Psychiatry and Law 7:179-189, 1979
36. Meadow JB: The private hell of Andy McCoy. Denver Magazine, August 1980, pp. 39 ff.
37. Penn NE, Sindberg R, Roberts A: The dilemma of involuntary commitment: Suggestions for a measurable alternative. Mental Hygiene 53: 4-9, 1969