

# The Ethics of Involuntary Hospitalization

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## Abstract

This article utilizes a public health ethical framework proposed by Roberts and Reich (2002) to deconstruct and examine the practice of involuntary commitment of suicidal individuals. The author employs a case example to describe the decision-making process involved in involuntary commitment through libertarian, egalitarian liberal, and communitarian ethical frameworks. Finally, using a postmodern lens, this paper explores the potential power dynamics inherent in the practice of involuntary psychiatric hospitalization. The author demonstrates how the process of deconstruction can lead to both increased self-reflection and greater ambiguity.

*Key words:* involuntary commitment, psychiatric hospitalization, ethics, suicidal treatment

## 1. Introduction

In my previous position as a psychiatric social worker in emergency rooms (ERs), I frequently faced ethical dilemmas regarding the involuntary hospitalization of suicidal, homicidal, or reality-impaired individuals. My decisions regarding whether to hospitalize patients involuntarily or to send them home were made based upon factors such as documented suicidality, availability of a support system, and severity of perceived threat to self or others.

This paper will deconstruct the social and ethical positions that guided a clinical case of

involuntary hospitalization through a public health ethical framework (Roberts & Reich, 2002). It will explore the decision making process through both a libertarian and liberal egalitarian perspective. This paper will also demonstrate that the liberal egalitarian framework does not sufficiently explain my decision to hospitalize Mary because it does not take into account innate relative communitarian values which were less visible but equally present. Finally, this paper will utilize a postmodern perspective to demonstrate how involuntary commitment has become normalized and clinicians have become adept at transforming individuals into mental health patients. The paper demonstrates how the process of deconstruction can lead to both increased self-reflection and greater ambiguity.

### 1.1 Mary

Mary was a white, middle class, middle aged, single woman. She arrived at the local ER via ambulance after having told a friend that she was going to hang herself. Mary's physician had noted that she had poor eye contact, bizarre behavior, and was noticeably distraught. During my interview, she was disheveled and spoke rapidly with racing thoughts and a manic appearance. She rescinded her suicidal statements at the ER, claiming that she was upset and that she didn't really mean it. Her friend, however, stated that Mary had verbalized a detailed plan, including the acknowledgment that she had a rope prepared to hang herself. He further explained that Mary did not recant

this plan to him even after several prompts about the consequences of her actions and his statement to her that he was going to call 911.

Due to her last psychiatric hospitalization, Mary reported that she was in jeopardy of losing her job and health insurance. In addition, she revealed that she had voluntary outpatient mental health treatment appointments scheduled for the following day and would prefer to attend these rather than have a forced hospitalization: "I know what these places do for you. You sit there, they throw medication at you and then you leave no better off than when you started." As I sat there actively empathic, I knew that Mary's claims rang true. In my professional experience, I have seen adult psychiatric hospitalizations become significantly shorter and medications quite common. Many patients claim that they do not feel any better after leaving the hospital than when they were first admitted. Recidivism rates for adult psychiatric patients are high (Montgomery & Kirkpatrick, 2002; Schmutte, Dunn, & Sledge, 2010). It is not uncommon to see someone such as Mary several times a year, cycling in and out of inpatient facilities, without a noticeable change in depression or suicidal status.

Mary's case presented the classic ethical dilemma for a social worker: involuntary hospitalization might prevent her from killing herself; however, it could also create serious long-term social and health consequences because losing insurance could mean losing access to medication and talk therapy. It should also be noted that Mary had been at this same ER a month earlier with a similar set of thoughts and behaviors. While waiting for a psychiatric bed, she had escaped the attention of the security guard and had attempted to hang herself in an unoccupied room. The ER doctor stated that, had the handicap bar not broken, she likely would have succeeded. In other words, Mary's circumstances and history did not make it easy for others, like me, to advocate for her right to freedom.

## **1.2 Traditional clinical decision-making tools**

Determining Mary's level of care required traditional clinical decision-making skills, such as assessing her level of immediate intent, determining the appropriateness of her aftercare, evaluating her ability to participate in a safety plan, examining her access to means (Heilbron, Compton, Daniel, & Goldston, 2010), and reviewing her history of attempts, hospitalizations, and suicidal planning (Miret et al., 2011). However, as Smith (2010) relates, these difficult clinical decisions must often be made in the face of suicidal patients' projection of anger, sadness, panic, and hopelessness, as well as multiple competing legal and professional pressures. Social workers are charged with the lofty task of weighing innumerable risk and protective factors while maintaining objectivity in the face of extreme emotions. The ability to anchor clinical decisions in an ethical framework can assist social workers as they formulate their patient plans in the midst of this complex environment.

## **2. Employing an Ethical Framework**

Social work has often been criticized for not employing empirically supported interventions (Manuel, Mullen, Fang, Bellamy, & Bledsoe, 2009) or operating too often on instinct rather than evidence. Recent studies indicate that social workers frequently use embodied knowledge (Sodhi & Cohen, 2012), experience, professional values and beliefs, and an "empathic understanding of their client's uniqueness" (McLaughlin, Rothery, Babins-Wagner, & Schleifer, 2010) in formulating interventions and making decisions. Employing an ethical model may aid the decision-making process by allowing the clinician to situate herself while filtering in important clinical material.

This section will explore the decision to hospitalize Mary through the Roberts and Reich (2002) public health ethical framework, which suggests that there are three philosophical views employed in public health decision making: utilitarianism (views derived from consequences and outcomes), liberalism (positions concerned with

rights and opportunities), and communitarianism (perspectives based on character and virtue). Utilizing this ethical framework may help organize the clinician's position as well as enhance transparency and encourage the decision maker to acknowledge the philosophical position underlying the decision-making process.

## **2.1 Mary goes home: A libertarian perspective**

A libertarian's position is rooted in the concept of liberalism, a philosophical position asserting the importance of individual rights (Larmore, 1999). This philosophy grew to a political understanding that individual rights were to be protected by government (Schmidt, 1999). Over time, these rights divided into two different categories: 1) negative rights, or those which guarantee *only* individual freedom, property, and personal liberty, and 2) positive rights, "the minimum level of services and resources needed to assure fair equality of opportunity" (Roberts & Reich, 2002, pg. 1056), commonly thought of today as education, some form of health care, and a safety net for children. Liberalism became divided into two factions: 1) libertarians who believe that a political system's primary responsibility is to protect individuals' negative rights of personal freedom, property, and political representation, and 2) egalitarian liberals who believe in the protection of both negative and positive rights, asserting that without basic means, such as health and education, individuals will not have the opportunity to exercise choice regarding freedom and negative rights protection (Cappelen & Tungodden, 2006; Freeman, 2001; Friedman, 2004).

A libertarian might disagree with hospitalizing Mary because it: 1) takes away her freedom for 72 hours, 2) puts restrictions on what she is allowed to do with her body, and 3) prevents her from protecting her property, because a job loss will almost certainly prevent her from maintaining her home and belongings. Justification for hospitalization might be possible if Mary had the intent to infringe upon another person's rights or was expressing suicidality and asked for treatment.

However, the willingness to hospitalize Mary when she is stating that she is safe raises serious questions for libertarians. From a strict libertarian perspective, hospitalizing Mary directly contradicts the only role that government should have: protecting the negative rights of individuals.

A libertarian could also argue that taking away the right of freedom on the basis of danger to self is a complex and potentially dangerous position that oversteps the role of government policy. Involuntary commitments have been criticized as a means using hospitalization to manage people who do not adhere to social norms (Morse, 1982). Historically, "annoying family members" (Szasz, 2003), women who refused to do house work (Zuckoff, 1997), gay children (Goishi, 1996), and disproportionate numbers of people from minority races and ethnic backgrounds (Hicks, 2004) have all been hospitalized under the auspices of protection from mental illness. As recently as 1993 Jack Shelley had his wife, Judene Shelley, involuntarily committed for being "a woman who turned into a feminist overnight." (Zuckoff, 1997). The libertarian perspective asserts that social policy should not inform decisions regarding danger to self because determining the line between protecting from self and controlling those who do not conform raises significant questions about who will be protected.

Libertarians do not believe in coerced treatment. Providing treatment to Mary might be appropriate if she said that she was suicidal and that she wanted help; however, given that she negated her suicidal comments, compulsory treatment may be unlikely to be effective. Mary herself stated, "I've been here before, and it doesn't work." Moreover, if we are to believe Mary when she says that she will lose her insurance if hospitalized, mandated treatment could result in preventing her from receiving her own current voluntary treatment.

The monetary expenses that are associated with hospitalization are also points of contention for the libertarian stance against involuntary hospitalization. Recent statistics reveal that the cost of one day of inpatient psychiatric care is \$1,000

(Personal Communication, Local Hospital Administrator, October, 2010). If Mary does not have private insurance, public insurance and the psychiatric hospital will absorb the costs of her admission. This will eventually be paid for by taxes in the form of public health care programs and government agreed-upon tax breaks to hospitals that are willing to admit “free care” individuals. Moreover, if Mary loses her job as a result of hospitalization, she may become reliant upon Medicaid and unemployment benefits, which are also paid for by taxpayer dollars. Hospitalizing Mary not only infringes upon Mary’s rights but also the eventual property rights of other citizens. Suddenly what appears to be an individual decision becomes a social responsibility with substantial repercussions.

A libertarian can assert that suicide is sometimes a rational choice based upon competent thought processes and clear decision making skills. Certainly, in reviewing Perlman’s article on self-determination (1965), social workers could question if some responsibly well-thought out suicides are perhaps the ultimate expression of self-determination. For example, US national organizations such as Final Exit Network and the Hemlock Society emphasize “choice, dignity, and control at the end of life” (Hemlock Society, 2011) and support the human right to “a death with dignity” (Final Exit, 2009).

Suicide has also been glamorized as the ultimate expression of libertarian freedom in the idealization of movie characters such as Thelma and Louise who make heroic suicidal exits. Other times, suicide is perceived as a well-planned escape from a poor quality of life, such as those who live in excruciating pain and have tried every medical means available to them to alleviate it (Wilson, et al., 2000). Libertarians can argue that society has limited rights to tell individuals how to manage their bodies, their freedom, or their pain, and suicide may represent a final expression of personal autonomy. For example, Hunter Thompson got old, felt pain, and aimed a shotgun at his head. His last note, titled “Football Season Is Over,” read:

*No More Games. No More Bombs.  
No More Walking. No More Fun. No  
More Swimming. 67. That is 17 years  
past 50. 17 more than I needed or  
wanted. Boring. I am always bitchy.  
No Fun — for anybody. 67. You are  
getting Greedy. Act your old age. Re-  
lax — This won’t hurt (Thompson cited  
in Brinkey, 2005).*

The libertarian argument is compelling in its simplicity. In protecting only the rights of freedom, property, and politics, I am not required to make complex and ambiguous decisions which seem benevolent at first but which may become complicated, multifaceted, and potentially dangerous to the individual over time. Internally I wrestle with this balance. While keeping it simple means that Mary goes home and her minimal rights will be protected, it also might mean that Mary dies.

## **2.2 Mary is hospitalized: Egalitarian liberal perspective**

Egalitarian liberals, whose philosophical beliefs are also rooted in classic liberal tenets, are similar to libertarians in their conceptualization of the government’s role to provide and protect the rights of individuals. However, unlike libertarians, they believe that if additional rights, such as a basic level of resources, are not protected, then the minimal rights of liberty and personal choice may not be possible (Cappelen & Tungodden, 2005). Many egalitarian liberals maintain that a protection of rights should include equal access to healthcare and/or at least some version of health.

Emergency rooms in America embody an egalitarian liberal position. Each individual who enters is supposed to receive equal access to health treatment, regardless of insurance, illness, or status in American society. Mary’s suicidal ideation, like a heart attack, stroke, or broken leg, has a quick triage protocol with clear parameters of disease, treatment, and cure. An egalitarian liberal perspective would assert that Mary should be involuntarily

committed in order to protect her from her diseased “disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment” and places her at risk of self-harm or death (MA Section 12, Involuntary Commitment Law).

Egalitarian liberals justify this position by claiming that treating Mary’s disease of depression and suicidal ideation grants her equal domain to rights of health, without which other liberal rights, such as property and freedom, may not be possible. Unhealthy people may not be able to work, provide for their families, or maintain homes and property. In cases like Mary’s, unhealthy people might lose their lives. While this distinction has value, it may be unlikely that ER personnel have philosophically evaluated the rationale for their protocols. However, ER’s often provide rights of health even when they infringe upon the rights of the individual and others.

Another egalitarian liberal rationale for hospitalizing Mary is to ensure that mental health problems receive equal and adequate treatment. For years, mental health advocates have discussed the severity of mental health disorders, particularly those which relate to suicide. Neglecting to view Mary’s suicidal ideation as a condition that is worthy of treatment and/or hospitalization is argued by many mental health advocates as unequal and unfair discrimination against those who have mental health problems. Mary, a woman with a known history of suicide attempts and admission of recent suicidal ideation should be treated with the same type of strict disease protocol offered to individual with cardiac, asthma, or stroke symptoms. Similarly, an egalitarian liberal ethics of care feminist perspective, which emphasizes that people make choices based on caring relationships and family outcomes (Parton, 2003), might assert that the only right decision is the one which asks, “What would you do if this were your family member?” We know from some cultures without involuntary hospitalization that family members will tie self-destructive individuals to beds, keep vigil, and protect them from suicide (Rousseau, Said, Gagne, & Bibeau, 1998). One can only imagine what would

happen to these same individuals if they did not have equal access to loved ones willing to assume this burden. A decision based on the egalitarian liberal ethics of care tenets would require that Mary receive the same treatment that you would want your loved one to have, most sensibly an involuntary admission over family imposed shackles.

Similarly, hospitalizing Mary reflects a just action according to Rawls in his book, *A Theory of Justice* (1971). Just decisions can be made if “no one knows his place in society, his class position or social status, nor does anyone know his fortune in the distribution of natural assets and abilities... their conceptions of the good or their special psychological propensities” (Rawls, 1971, p. 118). For example, if I were depressed and suicidal in an ER, I would hope that the person making my involuntary commitment decision was more concerned with my rights of health and treatment than my rights of freedom. I would certainly prefer a mistake that warranted 72 hours of lockup to a mistake that ended in death. Similarly, from an ethics of care perspective, if Mary were my mother or sister, I would most certainly advocate for mandated hospitalization.

Further supporting this egalitarian liberal position is current knowledge of formerly suicidal people who are grateful for their hospitalizations, substantiating that their frame of mind was irrational and they are later happy that they did not have the choice to kill themselves or that they were unsuccessful in their efforts. Occasionally, many months after I have involuntarily hospitalized an individual I will receive a phone call, note or personal visit with a comment like, “Thank you for saving my life.” Research suggests that over 90% of individuals who were prevented from jumping off the Golden Gate Bridge never attempted suicide again (Seiden, 1987). Similarly, first hand testimony from survivors demonstrates that in the process of suicide many individuals wish to reverse their actions. A survivor relates, “I’ll tell you what I can’t get out of my head. It’s watching my hands come off that railing and thinking to myself, My God, what have I just done” (Anderson, 2008).

### **2.3 Suicide is bad: A communitarian perspective**

Upon closer inspection, a careful reader might note that the egalitarian ethics of care principles do not adequately explain the decision to hospitalize Mary. Involuntary commitment involves an additional ethical decision-making tool that relies upon the decision maker's internal principles. "Will I feel morally ok if I let Mary go and she kills herself?" Unlike the libertarian and egalitarian liberal models which focus on protecting or providing positive and negative rights, or even the ethics of care model which focuses on making tough ethical choices from a family or community perspective, communitarianism disregards the client's self-determination in its exclusive concern for the decision-maker's community values. This ethical model is further divided into two different camps: relativist communitarians who believe that each community can define its own beliefs and morals (such as communities of indigenous peoples and communes) and universal communitarians who believe that there is only one single right society (some fundamentalist religious groups and expanding dictatorships) (Roberts & Reich, 2002).

Postmodern transparency requires the acknowledgment that I am planted in a relative (and questionably universal) communitarian society that opposes suicide. Americans loathe suicide. Public opinion endorses the legal policy of hospitalizing people when they are a danger to themselves or others. While Americans love *Thelma and Louise*, enjoy watching movies in which characters are placed in exciting and potentially dangerous situations, and want freedom of choice in seat belts, helmets, and guns, we hate suicide. Our society is one of the few which is reluctant to allow old people to die and our citizens vehemently oppose self-harm. In short, suicide is not bad because it is a disease or an unhealthy lapse of judgment which socially must be righted; instead, suicide is bad because it is morally wrong in the community. It goes against the common good and it is offensive to those in the dominant group. It is often

particularly offensive to social workers who, like I, are trying to save lives.

### **3. A Postmodern Perspective of Involuntary Commitment**

Postmodernism emphasizes that "cognitive representations of the world are historically and linguistically mediated" (Best & Kellner, 1991, p.4), and that meaning is constructed through language, common knowledge, and rational unified subjective thought, which is often established by the majority powerful elite. A Foucaultian postmodern critique of involuntary hospitalization (Mohr, 1999) raises important questions about how one is involuntarily committed and why. Moreover, a postmodern libertarian perspective, which challenges established belief systems by deconstructing who benefits from certain structures in terms of power, financial benefits, and maintenance of social status (Hassan, 1985) has real merit: psychiatric hospitalization has historically been used as a means to discipline the deviant. One could argue that hospitals, pharmaceutical companies, and health care companies have become formidable industries by profiting from the construction of deviance of individuals like Mary. While the previous section described the decision maker's ethical position behind involuntary commitment this next section will describe how a postmodern inspection of involuntary psychiatric admission offers different insight into the social scripts to which medical doctors, social workers, and patients adhere.

Taking away an individual's liberty, particularly when no crime has been committed, is a profound moral undertaking. In order to justify this process, the postmodern perspective explains how a clear distinction is made between people who are not considered to be a danger to themselves and other people who are. This separation often involves considerable conscious and subconscious tools involving language, normalization of the process, and complicity of mental health professionals and patients. Mary has to be made non-normal.

### **3.1 Using language to construct “other”**

In looking more closely at the example of Mary, she becomes “crazy” through the medical team’s use of language. Her physician labels her behavior as bizarre and notes that she has poor eye contact. I write that Mary is disheveled and that she speaks rapidly, with racing thoughts and a manic appearance. Mary has now assumed the identity of a mentally ill person.

The importance of language in the psychiatric commitment process is similarly exemplified in the case of Susan Rockwell who was involuntarily hospitalized in 1992. After appearing at a grief support group, upset about the death of a close friend, Susan was described as “anxious and a bit disheveled, wearing a soiled down coat that belied her achievements as a law school graduate and former librarian” (Zuckoff, 1997). Although she denied having thoughts of self harm and her personal psychiatrist opposed the admission (Zuckoff, 1997), the narrative created about her mental illness was stronger than the reality. “Language is no longer thought merely to convey information but is believed to thoroughly mediate everything that is known. What is recognized as social reality, therefore, is a matter of definition and conceptualization” (Pardeck, Murphy, & Choi, 1994). Language redefined Susan from a grieving person into a person requiring hospitalization. The mental health community has become accustomed to terms such as crazy, manic, rapid speech, poor eye contact, and disheveled. The words have begun to take over the person as a means of attributing an “ill” mental health status that the normative discourse can comprehend.

### **3.2 The social worker’s role to normalize**

Laura Epstein suggests that the media and society have assigned to social workers the task of “normalizing” troublesome people.

*The meaning of normalize is clear: to make to conform or reduce to a norm or standard, to make normal, by transforming elements in a person or*

*situation. This is certainly what social workers try to do, with the caveat—more observed in the breach—that the persons being transformed should want this, should consent to it, and should do it of their own free will (Epstein, 1999 p. 9).*

A social worker transforms a non-conforming individual into a “mentally ill” person with the altruistic assumption that this is what the client wants and needs. My role with Mary was clear. She was not normal; and therefore, she needed to be placed in a social context that would make sense. Rossiter (1996) explains that knowledge outside of the dominant discourse and power relations—truth, as we social workers have always known it—is non-existent. It is an end to the belief in “innocent knowledge.” The truth created about Mary was based on dominant view points, an anything but innocent knowledge. I defined Mary as crazy through a social work medical model discourse by using a power that was assigned to me. “When social workers create clients through social work language, the definition of normal is socially produced through relations of power” (Rossiter, 1996).

Once it was determined that Mary was not normal, she needed to be fixed. She needed to be made healthy. Social workers often become complicit partners in this process. While I may believe that my intentions to help Mary were good, my perspective was narrow. I think that this is perhaps what Laura Epstein warns us about in her chapter “The Culture of Social Work.” “To accomplish its purposes, social work must dominate its clients, although in theory and in its manner of interpersonal relations with clients it puts forward a democratic egalitarian manner” (Epstein, 1999, p. 8). First, the social worker is convinced that the client’s choices are placing her at risk and that she needs to be protected from herself. Second, a legal document is created that substantiates this need—an involuntary commitment document. Third, and perhaps most debilitating, the client becomes convinced that she is a danger to herself and needs to be

locked up. The social work profession adheres to a social script.

### **3.3 Client buy-in**

Perhaps the most serious consequences of “making crazy” is that, over time, clients often assume the label. A longitudinal study of inpatient recidivism and “mental illness careers” (Pavalko, Harding, & Pescosolido, 2007) suggests that frequent hospitalizations are more often related to a person’s belief in their label as a “person with mental illness” than with actual symptoms.

## **4. Mary**

Based on multiple clinical, community, and structural factors, I ultimately decided to hospitalize Mary. First, her immediate risk was high. Several reports indicated that she had a very clear intent and plan to kill herself with access to means. Moreover, she had made several other serious attempts in the past. Second, she was a notoriously poor reporter. She had misled doctors and clinicians in the past about her suicidality and had made a serious attempt in the hospital after clearly stating to professionals that she was not suicidal. Third, she did not have a significant clinical or personal support system to enable a comprehensive safety discharge plan. Although she had a therapy appointment scheduled, she had previously cancelled many sessions and had not yet made contact with an outpatient provider. Similarly, she did not have any close relatives or friends to help engage her in behavioral activation strategies or ongoing supportive community interventions. Fourth, and finally, the ED doctor was reluctant to remove the involuntary commitment paperwork in light of his memory of Mary’s near lethal attempt on her previous ED admission. While this decision was well-grounded in traditional suicidal assessment protocols, I will never know the full consequences of hospitalizing Mary or even if it was the correct assessment.

## **5. Ignorance Is Bliss**

Exploring these decisions through an ethical framework lends insight into my previous decisions. Prior to deconstructing my position behind involuntary hospitalization, I reflexively followed social norms. People who commit suicide have a disease and hospitalization is the solution to protect them from their “dis-health.” Upon reflection, it becomes clear that no single ethical model can capture the complexities of Mary’s case. The egalitarian liberal/communitarian perspective, which forms the basis of my decision, fails to address the sum total concern about complex and ambiguous cases: the Hunter Thompsons or those suffering from a chronic pain related to a terminal illness who legitimately may be making an educated and non-disordered choice. Moreover, in an effort to protect everyone equally, the egalitarian liberal perspective disregards individual differences, which may, in fact, harm people; hospitalization for Mary meant loss of job, economic security, insurance, and access to future mental health resources.

Examining ethics also reveals the underlying assumptions and beliefs that subconsciously factored into my decision. That which was guised under egalitarian liberal principals was also a maternalistic means by which to exercise my own relative communitarian beliefs. Given the litigious climate of our society and the ER doctor’s need to protect her license, I doubt my position would have changed: I am an egalitarian liberal and I possess the communitarian (and ethics of care) moral values that suicide should be prevented; however, I now question if this position is good, just, and right. Herein lies the ultimate irony: in the moment where decisions meet ethical deconstruction, when the layers are peeled back and the decision-maker’s position is revealed, there is also an acknowledgment (if you have any postmodern realism in you) that you may be wrong. As a social worker who cares, this is particularly hard. I have to suspend disbelief, throw consequences out the



window and act in the hope that what I think of as “true” or “good,” derived from the free discussion afforded to me in my egalitarian liberal society, will be “right” for Mary. In that moment, I have to believe, as Rorty (1989) writes about when discussing private irony and liberal hope, “that if we take care of political freedom, truth and goodness will take care of themselves” (p. 84). The process of reflection does not change my position, but it does make me acutely aware that my decisions are merely my ethical positions—no more, no less.

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