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The Language of Involuntary Mental Hospitalization: A Study in Sound and Fury

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THE LANGUAGE OF INVOLUNTARY MENTAL HOSPITALIZATION: A STUDY IN SOUND AND FURY

I. INTRODUCTION

Involuntary civil commitment is the business of hospitalizing and treating, without their consent, persons whom a court, with the aid of professional diagnosticians, determines to be psychologically disturbed or mentally ill. The purpose of the present study will be to demonstrate that the medical diagnoses of mental illness which justify involuntary civil commitment are achieved on the basis of at least unreliable and at worst invalid sets of diagnostic categories and assessments. For the purpose of determining the reliability of these diagnostic findings, the author selected a representative sample of the involuntary mental hospitalization proceedings of the Wayne County Probate Court, which serves the metropolitan Detroit area. Before setting forth the procedure and results, however, it is necessary to examine briefly the statutory basis for involuntary mental hospitalization.

II. THE MICHIGAN CIVIL COMMITMENT STATUTE

Because the study was conducted in Michigan, particular attention will be given to the Michigan statute. Nonetheless, it should be noted that the Michigan act is similar to those throughout the United States, in that it requires a determination of mental illness as a precondition to involuntary mental hospitalization.[1]

Under the Michigan act, involuntary mental hospitalization is appropriate when "the condition of the person examined is such as to require care and treatment in an institution for the care, custody and treatment of such *mentally diseased person.*"[2] (Emphasis added). The probate court is authorized to issue orders for

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[1] *See, e.g.*, MICH. COMP. LAWS ANN. §§ 330.19-.21 (Supp. 1970); N.Y. MENTAL HYGIENE LAW §§ 72 et seq. (McKinney Supp. 1970); CAL. WELFARE & INST'NS CODE §§ 6250 et seq. (West Supp. 1970); WISC. STAT. ANN. §§ 51.04-.05 (Supp. 1970); ILL. ANN. STAT. ch. 91 1/2, §§ 6-1 et seq. (Supp. 1970).

[2] MICH. COMP. LAWS ANN. § 330.21 (Supp. 1970). *Compare* the California statute, which subjects to potential judicial commitment the "mentally disordered sex offender . . . who by reason of mental defect, disease, or disorder, is predisposed to the commission of sexual offenses to such a degree that he is dangerous to the health and safety of others." CAL. WELFARE & INST'NS CODE §§ 6250, 6300 (West Supp. 1970). New York has adopted the standard that "any person alleged to be mentally ill and suitable for care and treatment" may be committed. N.Y. MENTAL HYGIENE LAW, § 72 (McKinney Supp. 1970).

the temporary and diagnostic detention of the alleged mentally ill person in a state or otherwise licensed mental hospital for a period of up to 240 days.[3] No such order, however, shall issue without certification of mental illness by two physicians, who, in the case of the diagnostic order, must be court-appointed;[4] the certificate authorizing admission to a mental hospital must show that it is the physician's opinion that the person is "actually mentally ill . . . and shall contain the facts and circumstances upon which the opinion of the physician is based."[5] Certification of mental illness is prohibited simply on the basis of senility, inferred from such signs of the "general deterioration of mental processes" as "disorientation, confusion, or impairment of memory,"[6] in the absence of "[p]sychotic implications."[7] Prior to the expiration of the diagnostic period, the superintendent of the regional diagnostic and treatment center to which the alleged mentally ill person has been sent is required to certify the results of such examinations, diagnoses, prognoses for future improvement, and recommendations as have been obtained.[8] If the person is then adjudged mentally ill by the trier of fact, a permanent order may be issued resulting in commitment to a mental hospital for an indefinite period.[9]

Thus, the Michigan civil commitment statute, like others, is replete with the language of mental illness, medical diagnosis,[10]

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[3] MICH. COMP. LAWS ANN. §§ 330.19-.21 (Supp. 1970).

[4] Persons incarcerated in state hospitals under "temporary detention" orders were generally examined by staff physicians, while court-appointed physicians eventually conducted examinations preparatory to hearings on diagnostic orders. MICH. COMP. LAWS ANN. §§ 330.20 (Supp. 1970). It was not clear how the hospitals assigned patients to examining physicians, but the author was informed that the probate judges assigned the physicians on a rotation basis or according to personal preference as to physician. Interview with Leonard Edelman, Wayne County Probate Court Registrar, Oct. 15, 1971.

[5] MICH. COMP. LAWS ANN. §§ 330.19-.21 (Supp. 1970). "Physician's Certificates" are provided by the court for this purpose. They are one-page forms allowing a space of about six inches for the physician's entire diagnosis. *Compare* the New York Statute, which authorizes, under various conditions, commitment on the certificate of one physician, two physicians, or the county health officer or commissioner, Physician's certificates must be accompanied by "a statement of the facts upon which the allegation of mental illness and need for care and treatment are based." N.Y. MENTAL HYGIENE LAW § 72 (McKinney Supp. 1970). The Wisconsin Law requires certification of mental illness by a physician; the physician's statement shall describe "the illness and reasons why the patient is considered irresponsible and dangerous." WIS. STAT. ANN. § 51.04 (Supp. 1970).

[6] *See* Table 3 *infra*, for the extent to which these "symptoms" are cited as signs of mental illness.

[7] MICH. COMP. LAWS ANN. § 330.20 (Supp. 1970).

[8] *Id.* § 330.21.

[9] *Id. Compare* the Wisconsin act, which provides that if the court or jury finds the patient "mentally ill or infirm," the court shall commit him to a mental hospital. WIS. STAT. ANN. § 51.05 (Supp. 1970).

[10] For a definitive exposition of the currently accepted psychiatric nosology, *see* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (2d ed. 1968). Mental illnesses are distinguished on the basis of whether they

and hospitalization. From start to finish, the sole justification for involuntary mental hospitalization is that a person is first alleged, and then determined, to be "sick." The propriety of the involuntary mental hospitalization process thus depends upon the reliability and validity of these determinations.

III. THE WAYNE COUNTY PROBATE COURT STUDY

A. Focus and Objective

The study concerned cases of civil rather than criminal commitment. In civil commitment proceedings, the alleged mentally ill person has either not been charged with violating a law, or has committed merely a petty offense; in criminal commitment proceedings, the alleged mentally ill person has either been charged with commission of a crime and is awaiting trial or has been found not guilty by reason of insanity.[11] *Criminal* commitment proceedings were deliberately avoided because they are generally afforded separate and distinct treatment statutorily, and because they involve theoretical considerations not within the scope of this comment. In contrast, *civil* commitment proceedings must be justified squarely on the basis of an inferred mental illness of sufficient magnitude to warrant hospitalization of the subject for his and society's welfare, whether the patient likes it or not.

Although the Michigan civil commitment statute provides that "all the proceedings relating to diagnostic hearings and care and intensive treatment shall also apply to persons . . . addicted to the excessive use of intoxicating liquors, or narcotics or noxious drugs,"[12] the study was restricted to cases involving persons certified as being "actually mentally ill." Proceedings officially designated as alcoholism or narcotic addiction cases, rather than mental illness cases, were avoided[13] because it was assumed that their separate classification denoted diagnostic considerations extraneous to those of primary concern here. With the exception of those proceedings involving mental retardation or alleged organic brain damage, the mental illness proceedings concerned conditions of undetermined physical origin.

The purpose of the study was to determine the reliability and

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are physiologically or organically derived, on the one hand, or non-organically (i.e., "functionally") derived, on the other. The distinguishing symptom-configuration of each disorder is described.

[11] T. SZASZ, LAW, LIBERTY AND PSYCHIATRY 40 (1963).

[12] MICH. COMP. LAWS ANN. § 330.21 (Supp. 1970).

[13] *But see* Tables 3, 4, and 5, for the degree to which drinking and drug use were cited both as symptom and as diagnostic label.

validity of the bases for involuntary mental hospitalization; essentially, the subject of the study was the reliability and utility of the diagnostic labels employed by the examining physicians. If persons adjudged mentally ill are in fact suffering from discrete, diagnosible diseases, then four consequences should follow: (1) sets of diagnosticians should be able to agree on the particular illnesses from which the patients are suffering; at least, instances of failure to agree should be exceptional or negligible; (2) such diseases should be inferable on the basis of discernible and reliable complexes of symptoms; (3) the symptom-complex of one disease should be relatively distinct from that of another; and, (4) each examining physician should make various diagnoses more or less in the same proportion as every other examining physician.

Unlike somatic illness, no offending organ or organ-system has been physically isolated as the cause of a strictly mental illness; thus, the only basis for inferring the existence of the psychological disease is the observable symptomatology.[14] The fact that physical or neurological bases, although undiscovered, *might* exist for these illnesses is essentially irrelevant to the problem of diagnosis; diagnosticians can employ only that information which they can observe directly or experimentally, and they cannot observe that which they have not yet discovered. Consistent failure of the diagnosticians to agree, or inconsistent diagnosis rates, would suggest an inappropriate primacy of the physicians' expectations and predispositions. If several diseases were indicated on the basis of precisely the same complex of symptoms, or, conversely, if a given disease were indicated by an overlapping multiplicity of symptoms, then there would be no basis for distinguishing among the diseases. Given these results, the utility, not to mention the validity, of the classification scheme would be called into serious question, thus casting doubt upon the propriety of judicial dependence on the physicians' diagnoses as a justification for involuntary civil commitment and raising fundamental considerations of due process.

B. Procedure

In an effort to obtain a representative and manageable sample, all the involuntary mental hospitalization proceedings registered

[14] *See also* W. MISCHEL, PERSONALITY AND ASSESSMENT 195 (1968).

> As long as there are no identified concrete pathologies that can be tied clearly to social behavior, speculations about them have little value for the assessor. On the contrary, adherence to medical analogies, and labeling people with the names of diseases whose disease properties and physiological bases are not established, can distract the assessor from concentrating on the psychological conditions controlling the behavior of concern.

in volume 600 of the Wayne County Probate Court calendar were selected;[15] volume 600, which was selected arbitrarily, catalogued all court proceedings in which hearings were initiated between December 19, 1969 and January 23, 1970. Subsequent hearings on the proceedings generally continued through April or May, 1970, with a few extending into August, but these did not concern the present study. Of the proceedings logged in volume 600, there were 113 involving involuntary mental hospitalization and reaching the point at which at least one certification examination was conducted.[16] One of the files was unavailable. The remaining 112 files were examined and provided the data for the study.[17] Particular attention was given to the physicians' certificates of mental illness contained in the files and provided for by the Act.[18] Thus, the study essentially focused upon the phase in the proceedings at which the diagnosticians gained initial access to the alleged mentally ill persons.

The following data was recorded from each file: (1) the presiding judge, (2) the certifying physicians, (3) the recommendations of the certifying physicians, (4) the diagnoses of the certifying physicians, (5) the symptomatology cited by the certifying physicians, and (6) the outcome of the case. It was suspected that there might be some variance among the rates at which the five probate court judges entered permanent commitment orders; as it happened, the judges, though charged with making independent decisions, followed the advice of the regional diagnostic and treatment centers in all but two cases, and the factor thus proved irrelevant. In all, eighty physicians conducted at least one examination, with eleven physicians making 251 of the 376 physician-diagnoses.[19] A total of twenty-eight recognizable diagnoses of distinct mental illnesses were made, in addition to that of "not mentally ill." The symptoms cited fell into nineteen categories,

[15] The Wayne County Probate Court serves the greater Detroit area.

[16] Of the 113 cases in the sample, "permanent orders" of indefinite commitment were entered in twenty-four cases. This outcome was a function of the recommendation of the superintendent of the regional diagnostic and treatment center to which the alleged mentally ill persons were sent for observation and further diagnosis. In none of the twenty-four cases did the superintendent recommend release. Of the eighty-nine cases in which petitions were ultimately dismissed, the superintendent recommended entering a permanent order in only two cases. *See* vol. 600, Wayne County Probate Court calendar.

[17] It should be remembered that these cases were not the court's entire civil commitment caseload for the period. In addition, the court processed alcoholism and narcotic addiction cases, as well as proceedings initiated during another month and thus listed in another volume of the court calendar.

[18] MICH. COMP. LAWS ANN. §§ 330.19-.21 (Supp. 1970).

[19] Two physicians collaborated on seventy-seven "physician-diagnoses." More than one illness was diagnosed in fifty-three "physician-diagnoses." This accounts for the discrepancy between the number of diagnosed illnesses and the number of "physician-diagnoses."

such as depression, delusional behavior or talk, and vague, disoriented, or confused behavior or talk. The results obtained are discussed in the following section.

TABLE 1
PHYSICIANS' RECOMMENDATION RATIOS, BY PHYSICIAN*

Physician	Physician-Diagnoses	Recommendation Ratio**
All Physicians	376	.95
Dr. A.	67	.90
Dr. B.	33	.94
Dr. C.	26	.92
Dr. D.	26	.96
Dr. E.	16	1.00
Dr. F.	15	1.00
Dr. G.	15	.67
Dr. H.	15	1.00
Dr. I.	13	1.00
Dr. J.	13	1.00
Dr. K.	12	1.00
69 Others	125	.99

* Recommendations of further hospitalization as a percentage of total recommendations.

** Of the eighty examining physicians, only six made even one recommendation that further hospitalization was not necessary.

C. Discussion and Results

Physicians certified mental illness and recommended hospitalization in ninety-five percent of the "physician-diagnoses."[20] Only six of the eighty examining physicians made even one recommendation that further hospitalization was *not* necessary in any given case. Recommendation ratios (i.e., the rate at which each physician recommended further hospitalization) varied from the seventy-four highs of 1.00 to a low of .67. Dr. G., who found his patient "not mentally ill to a commitable degree" five out of fifteen times, was the only physician to recommend further hospitalization in less than ninety percent of the physician-diagnoses rendered. No doubt the subject population processed in these actions was not a random sample of the population at large; they

[20] *See* Table 1.

had, at least, bothered someone sufficiently to prompt petitions for their commitment. Nonetheless, Table 1 suggests that virtually every alleged mentally ill person to whom the examining physicians gained access was found sufficiently "diseased" to require hospitalization.

TABLE 2
PHYSICIAN-PHYSICIAN AGREEMENT AS TO DIAGNOSIS*

Degree of Agreement	N	Rate of Agreement
Complete Agreement**	21	.20
Partial Agreement***	55	.51
No Agreement****	31	.29

* Diagnoses of "Mental Illness" and cases in which only one physician conducted an examination have been disregarded; they constituted neither agreement nor disagreement. Had "Mental Illness" been considered a discrete diagnosis, there would have been virtually no agreement, complete or partial.

** Complete Agreement = Complete identity of the diagnoses of all examining physicians.

*** Partial Agreement = Identity of diagnosis of all examining physicians as to one or more, but not all, diagnosed illnesses (instances of no or only one diagnosis exclusive of "Mental Illness" considered "Partial Agreement").

**** No Agreement = No identity as to any diagnosed illness by all examining physicians.

If the physicians are in general agreement as to the almost universal need for involuntary mental hospitalization manifested by their examined patients, they are nonetheless unable to agree among themselves as to *why* such hospitalization is necessary.[21] Agreement between and among examining physicians as to the proper diagnosis in a given case was very poor; in fact, complete consensus as to diagnosis could be reached in only one case out of five, and the physicians' examinations resulted in total diagnostic disagreement in almost three cases out of ten.[22]

[21] *See* Table 2.

[22] These findings substantiate the conclusions reached in Ash, *The Reliability of Psychiatric Diagnoses*, 44 J. ABNORM. SOC. PSYCHOL. 272 (1949). Seventeen subjects were interviewed for diagnostic purposes by two psychiatrists, and thirty-five were interviewed

TABLE 3

PERCENT OF CASES OF EACH DIAGNOSED ILLNESS MANIFESTING EACH SYMPTOM

Diagnosis	N	Symptom*	Aggressive, Hostile Behavior or Talk	Self-Destructive Behavior or Talk (attempted suicide)	Depression	Delusional Behavior (or hallucinations)	Affective Behavior	Phobic or Anxious Behavior	Criminal Behavior	Withdrawn (Affect "flat")	Response Deficits	Bizarre, Incoherent Behavior or Talk	Vague, Disoriented, Confused	Lack of Judgment or Insight	Uncooperative Behavior	Untidy Behavior	Excessive use of Alcohol	Inappropriate Behavior or Affect	Narcotic Addiction or use	Poor Impulse Control	Impairment of Memory
"Mentally Ill"	142		25	16	18	44	16	18	01	25	06	31	41	35	02	07	07	21	08	04	08
Schizophrenia, chronic undiff.	28		11	07	18	64	07	07	04	25		64	64	68		04	11	43	11		04
Schizophrenia, acute	16		13		25	44	19	13		31	13	44	69	75		13	06	63	13		06
Schizophrenia, paranoid	48		13	04	08	79	23	17	06	19		65	71	54	02	06	04	48	04		
Schizophrenia, catatonic	2									100		100	50	50							50
Schizophrenia, Adolescent adjustment react.	3		33		66			33		33		33	33	33			66	33			
Organic brain syndrome	21		24		05	24	10	10	05	10	05	52	67	33	05	05	19	43	10	05	29
Mental retardation	8		38	13	25	13	13		13	13		13	25	38				25	13	13	
Psychosis, organic basis	3		33		33	67				33			33	33				33	33		

Drug addiction or use	9	11		11	33	11					44	56	56			11	22	89		
Habitual excessive drinking	2	50				50											100			
Psychosis	9		11	33	33		33	11	11		33	44	56			22	56	56	11	22
Sociopathic personality	4	25		25	50			25				25	75			50	75	50		
Depressive reaction	20	05	45	80	20	20	25		35	05	10	45	50			05	20	05		
Pre-senile dementia	2	50								50	50	50					50			
Severe emotional disturbance	2		100	100				50					50						100	
Psychotic episode	1				100							100						100		
Manic-depressive	2					100					100		100							
Poor superego	1	100			100								100			100	100			
Basic character disorder	5	40		40	20			60	20		20	20	60		20	40	16	80	40	
Neurosis	2		100	100		50	50		50					50						
Inadequate personality	1	100																100		
Passive-aggressive personality	2	100		50	50			50			50					50	100	100	50	
Behavior, management problem	2	50							50				50				50			
Homosexuality	1												100							
Mentally handicapped	1				100												100			

* An average of 12.9 diseases were diagnosed from each symptom cited.

Theoretically, a diagnostic category is defined by a particular symptom-configuration which distinguishes it from other diagnostic categories. It might be expected that as the reliability of the categories decreases, the extent of overlap in the symptomatologies would increase correspondingly. This is precisely what occurred in the study.[23] There was little or no homogeneity in the classification of symptoms according to a diagnosed illness.[24] Thus, even though some symptoms were cited in a high percentage of cases of persons diagnosed as having particular illnesses, the same symptoms were nonetheless cited as evidence of from five to twenty-two different diseases; the average number of diseases eventually inferred from each symptom was 12.9. Conversely, the existence of a given disease was inferred on the basis of an overly broad and overlapping array of symptoms.

A few examples from Table 3 are illuminating. It should come as no surprise that while the symptom "narcotic addiction or use" was cited with regularity to support the diagnosis "drug addiction or use," the same symptom supported the inference of fifteen other diseases. In the same manner, such "symptoms" as hostility and aggressiveness, depression, delusions or hallucinations, bizarre talk or behavior, vagueness, disorientation, confusion, lack of judgment or insight, and inappropriate affect (the most frequently cited symptoms) were each indicative of the possibility of at least seventeen different diseases. Of course, the physicians may be employing symptomalogical labels such as *disorientation* or *bizarre talk* as shorthand for a variety of descriptively discrete phenomena. But that would only underscore the lack of homogeneity of the symptom-labels and the need for the diagnosticians to use language which does in fact "contain the facts and

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by three psychiatrists. The psychiatrists were asked to diagnose each subject according to five "major categories" and sixty specific subcategories. The seventeen psychiatric pairs agreed as to major category in fifty-eight to sixty-seven percent of the cases and as to specific subcategory in thirty-one to forty-four percent of the cases. The thirty-five triads agreed on forty-six percent of the major categories and on only twenty percent of the specific subcategories. *But see* Schmidt & Fonda, *The Reliability of Psychiatric Diagnosis: A New Look*, 52 J. ABNORM. SOC. PSYCHOL. 262 (1956) in which greater diagnostic agreement among pairs of psychiatrists was obtained.

[23] *See* Table 3.

[24] "Homogeneity of classification" refers to the uniformity, uniqueness, or distinguishability of behavior (symptoms) subsumed within a given diagnostic category. *See* Zigler & Phillips, *Psychiatric Diagnosis and Symptomatology*, 63 J. ABNORM. SOC. PSYCHOL. 69 (1961). The case histories of 793 patients admitted to a state hospital over a period of twelve years were studied; the diagnoses were divided into four major categories (manic-depressive, psychoneurotic, character disorder, and schizophrenia) and thirty-five different symptoms were catalogued. Thirty of the symptoms appeared in the cases "manic-depressive," thirty-four in those labeled "character disorder," and all thirty-five appeared in the "psychoneurotic" and "schizophrenia" cases. Zigler and Phillips concluded that the relationships between symptoms and diagnoses yielded by the diagnostic system were so minimal as to be without utility.

circumstances upon which the opinion of the physician is based," as the statute explicitly requires.[25]

By the same token, seventeen of the nineteen symptoms appeared in the diagnoses of paranoid schizophrenia, sixteen in acute schizophrenia, eighteen in organic brain syndrome, and fourteen in depressive reaction. Not surprisingly, all nineteen symptoms were eventually cited to substantiate the diagnoses designating only "mental illness." Thus, the inclusion of a patient within a particular diagnostic group conveyed only minimal information concerning the symptomatology of the patient; conversely, a particular set of symptoms did not allow a reliable prediction as to the diagnostic label that would ultimately be appended to the patient.

Because the judges assigned physicians on a rotation basis or according to personal preference as to physician,[26] it should follow that the court-appointed physicians should have made various diagnostic designations in more or less the same proportions. This, however, did not occur.[27] For example, Dr. A. made only twenty-five percent of the total diagnoses, but he accounted for fifty-six percent of the sixteen diagnoses of acute schizophrenia, fifty-four percent of the forty-eight diagnoses of paranoid schizophrenia, and forty-five percent of the twenty diagnoses of depressive reaction. Dr. B., who made fourteen percent of the total diagnoses, accounted for fifty-two percent of the diagnoses of organic brain syndrome and sixty-three percent of the diagnoses of mental retardation. Finally, Dr. D. made only nine percent of the diagnoses, but was responsible for twenty-one percent of the cases labeled chronic undifferentiated schizophrenia and thirty-five percent of those labeled depressive reaction. Thus, the diagnosis reached in a given case appeared, in part, to be a function of the hypothetical constructs and predispositions of the physicians.

These findings suggest that, to a substantial degree, the diagnoses and recommendations of examining physicians in involuntary civil commitment proceedings of the alleged mentally ill reflect a procedure where obscure and questionable labels are offered by diagnosticians and accepted by the court as conclusive of the underlying malady. Although many of those brought before

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[25] MICH. COMP. LAWS ANN. § 330.20 (Supp. 1970), and note 30 *infra*. For examples of statutes using similar language *see* N.Y. MENTAL HYGIENE LAW § 72 (McKinney Supp. 1970); WIS. STAT. ANN. § 51.04 (Supp. 1970).

[26] *See* note 4 *supra*.

[27] *See* Table 5. No inferences can be made regarding the staff physicians, since they virtually always designated their patients as being merely "mentally ill" on the court-provided physician's certificates.

TABLE 4
DIAGNOSES, FREQUENCY*

Diagnosis	N	% of total
All Diagnoses**	221	100
Schizophrenia, paranoid	48	22
Schizophrenia, chronic undifferentiated	28	13
Organic brain syndrome	21	10
Depressive reaction	20	09
Not mentally ill	18	08
Schizophrenia, acute	16	07
Psychosis	9	04
Drug addiction or use	9	04
Mental retardation	8	04
Twenty others	44	20

* As a percentage of total diagnosed illnesses.
** Exclusive of those merely designated "Mental Illness."

the court in civil commitment proceedings are undoubtedly suffering from such severe disorders that involuntary institutionalization might arguably be appropriate, it is clearly inappropriate to do so on the basis of grossly undescriptive labels rather than the specific conduct or data upon which the examining physician formulated his diagnoses. Those who choose to specify a diagnostic label beyond the general designation "mental illness" are often inclined to see particular illnesses in an inordinate number of cases (Table 5). All this is made possible by a diagnostic scheme which allows the inference of practically any disease on the basis of practically any symptom configuration (Table 3).

Much of the difficulty derives from the nature of the symptomatology which is employed. Theoretically, a symptom is an observable, objective datum,[28] which is taken as a sign of an under-

[28] Note that the data with which the diagnostician has to work includes the *verbal report* of the patient. Thus, for example, the physician may note that the patient *reports* (an observable) that a particular stimulus is accompanied by pain even though the pain itself is not observable. The distinction is crucial in relation to such symptoms as "delusions." The patient may *report* that he is a narcotics informer (an observable) but the transmutation of this symptom into a *delusion* requires an act of interpretation by the physician.

TABLE 5
DIAGNOSIS, FREQUENCY (BY PHYSICIAN)*

PHYSICIAN (% of diagnoses noted parenthetically) / DIAGNOSED ILLNESS** (N NOTED PARENTHETICALLY)	Mentally Ill (142)	Schizophrenia, chronic, undiff. (28)	Organic Brain Syndrome (21)	Alcoholic Psychosis (5)	Sociopathic Personality (4)	Psychosis (9)	Drug Addiction or use (9)	Basic Character Disorder (5)	Inadequate Personality (1)	Schizophrenia, Acute (16)	Depressive Reaction (20)	Not mentally Ill (18)	Schizophrenia, Paranoid (48)	Underlying (2) Schizophrenia	Pre-senile Dementia (2)	Mental Retardation (8)	Behavior or (2) Management Prob.	Psychosis, (3) Organic Basis	Schizophrenia, Adjustment react. of Adolescence (3)	Manic-Depressive (2)	Schizophrenia, Catatonic (2)	Poor Superego (1)	Homosexuality (1)	Passive-Aggressive Personality (2)	Severe Emotional Disturbance (2)	Neurosis (2)	Psychotic Episode (1)	Habitual Excessive (3) Drinking	Mentally Handicapped (1)
Dr. A (.25)		39	29	20	50	55	22	60	100	56	45	39	54		50	13	50	67	33		50		100	50					
Dr. B (.14)	01	18	52	20	25	33	44			13	20	11	15	50		63	50		33	50							100		
Dr. C (.09)	16		10	20								11				13												33	100
Dr. D (.09)		21			25		11	40		13	35	06	15	50						50		100		50	50	50			
Dr. E (.04)	10												04																
Dr. F (.04)	11																											33	
Dr. G (.04)	07											28																	
Dr. H (.04)	11																												
Dr. I (.05)		14	10	40		11	11			06			10						33										
Dr. J (.04)	08														50													33	
Dr. K (.03)	08																												
69 OTHERS (.15)	29	07								13		06	02			13		33			50				50	50			

* Percent of cases of each diagnosed illness diagnosed by each physician

** N=363; two physicians collaborated in seventy-seven physician-diagnoses, and more than one illness was cited in fifty-three physician-diagnoses

lying mental condition; since the underlying condition is not observable directly, as a ruptured appendix might be, for example, it must be inferred from the observable symptom. The only reliable basis for inferring the existence of the illness is that under particular circumstances, a consistent and homogeneous symptom configuration can be observed.

In practice, however, the symptomatology is treated in a quite different manner. Consider a typical example of one of Dr. A.'s certificates of mental illness:

> [Patient] . . . is *confused.* She answers questions in a rambling and *incoherent* manner. She is *hallucinated.* [Examples are quoted similar or identical to those quoted in other cases diagnosed by Dr. A.]. She is *delusional* with ideas of persecution. [Further examples cited, also in quotation marks, also similar or identical to others]. Her *affect is inappropriate.* Her *insight and judgment are lacking.* Patient has *schizophrenia-paranoid* type. Hospitalization and treatment are indicated.[29] [Emphasis added].

The aforementioned formula constituted a familiar recitation, consistently found in Dr. A.'s diagnoses. Vague, conclusory labels were treated as though they were symptoms, despite the theoretical objectivity symptoms are supposed to possess.[30] The "appropriateness" of "affect" (i.e., emotional demeanor, quality of responses) is a matter of subjective interpretation. Given the role of context and personal value judgment in determining "appropriateness," it is unlikely that any behavior is so inherently appropriate that deviation from it is a *per se* sign of literal and tangible disease. Furthermore, there are no objective, consistent standards by which it can be determined when "judgment" is lacking. Such determinations risk the injection of the diagnostician's personal values for comparative purposes. Thus, the validity of equating his value structure with a state of good health is dubious. Finally, it has been argued that "lack of insight" is really psychiatric

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[29] The symptoms and final diagnosis have been emphasized. The probate court would not permit reference to cases by name or file number and thus direct footnoting cannot be made.

[30] *But see* Hanneman v. Medical Superintendent of Mount Pleasant State Home and Training School, 336 Mich. 316, 58 N.W.2d 90 (1953), in which the Michigan Supreme Court held that pursuant to the statutory requirement of physicians' examinations and certification, facts, not mere *conclusions* must be set forth. In *Hanneman,* statements that an alleged mentally ill person was a "low grade type," could not answer simple questions, and would never be of greater mental capacity or be able to support himself or be safe without watching were all mere conclusions and therefore insufficient to support a commitment order. *See also In re* Opal, 360 Mich. 696, 104 N.W.2d 802 (1960), in which allegations of listlessness and apparent loss of memory were held to be "conclusory" and insufficient to support a commitment order.

shorthand for "refusal to accept the doctor's view."[31] In this context, "lack of insight" may well be the patient's refusal to accept the doctor's advice to volunteer for commitment. Failure of the patient to accept the physician's construct of the patient's condition is taken, in a markedly circular fashion, as further proof of the patient's disease.

Nor is it always clear when a patient's verbal report is "delusional." In one case, the certifying physician observed that the patient, drug addicted, thought that he was an informer for the Federal Bureau of Narcotics, commissioned to "infiltrate" the ghetto for the purpose of bringing to light addicts and pushers. Anyone familiar with the line of cases arising out of *On Lee*[32] would know that such an assertion is perfectly plausible. Yet the notion was apparently so foreign to the physician's experience that she labeled it "delusional," and on the basis of the label, inferred the existence of an underlying pathology. This is not to suggest that there do not exist persons who *are* delusional or that the examining physician *might* not have been correct in this case. The example is cited only to illustrate the extremely *interpretive* nature of the act of designating a verbal report as delusional and the danger of mistake as a result of the diagnostician's experience.[33] The circularity of the process is underscored by the fact that the more a hypothetical patient might protest that he is in fact a Narcotics Bureau informer, the more he would be deemed to lack "insight" into his true condition; this would be taken as a further "symptom" of the patient's illness.[34]

IV. CONCLUSIONS

The present study suggests that, under prevailing circumstances, involuntary mental hospitalization is at least the inevitable temporary outcome of a process which allows the inference of practically any conceivable mental disease on the basis of practically any conceivable symptom-configuration. It should follow, then, that involuntary civil commitment of the mentally ill,

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[31] T. SZASZ, IDEOLOGY AND INSANITY 132 (1970).

[32] On Lee v. United States, 343 U.S. 747 (1952).

[33] *See* A. BANDURA, PRINCIPLES OF BEHAVIOR MODIFICATION 3 (1969). "Since symptom labeling primarily reflects the evaluative responses that a given behavior evokes from others, rather than distinguishable qualities of the behavior itself, an identical response pattern may be viewed as a pathological derivative or as wholesome behavior by persons whose judgmental orientations differ."

[34] The questionable nature of what is characterized as "delusional" is further illustrated by another case, in which a young male patient's assertions that "the boys pick on me" and "the principal doesn't believe me" were taken, *per se*, to be delusional feelings of persecution.

premised on diagnostic labels of such questionable reliability and validity, is without sufficient legal justification and should be considered a deprivation of liberty without due process of law in violation of the Fifth and Fourteenth Amendments. The physicians' certificates of mental illness clearly do not live up to the statutory requirement that facts, rather than mere conclusions, shall be set forth to justify involuntary civil commitment. Moreover, one reading of the present study could support the position of those behavioral psychologists who maintain that abnormal behavior is a function of social learning experiences rather than mediating pathological agents within the individual.[35] Szasz argues that involuntary civil commitment is used, not as a means of according treatment to persons in need of it, but rather as a mechanism for socially isolating those members of society whose presence, for one reason or another, is highly upsetting or inconvenient, but for whose behavior no crime can be found.[36] It has been observed that

> [a] crucial consideration is the issue of social disturbance. If a person is old and cannot care for himself, he creates a social disturbance and may be committed. If a person threatens to kill himself—but does not do so—he too creates a social disturbance and, in a way, asks to be committed. If a person lays claim to ideas or beliefs or sensations that threaten society—for example, beliefs of being persecuted (called "delusions"), or sensations of seeing and hearing (called "hallucinations")—he too creates a social disturbance and may be committed. Finally, if a person commits acts which violate social rules—for example, by engaging in forbidden modes of sexual gratification—he too creates a social disturbance and may be committed.[37]

Society will not tolerate the incarceration of persons merely because they are annoying or disquieting, but will readily hospitalize "for his own good" a person upon whom it appends the label "sick." In this way, the incarceration of disturbing social deviators is legitimized. In general,

> that conduct tends to lead to commitment which appears abnormal to the layman. Such crudely offensive social behavior cannot, however, be readily correlated with psychiatric diseases. Nevertheless, psychiatrists tend to label this sort of behavior psychotic. Thus, the expressions 'psychosis' and

[35] *See* W. MISCHEL, *supra* note 14 and A. BANDURA, *supra* note 33; *Accord*, T. SZASZ, THE MYTH OF MENTAL ILLNESS (1961).

[36] T. SZASZ, *supra* note 35, and *supra* note 11.

[37] *Id. supra* note 11, at 47.

> 'behavior justifying commitment' overlap, and in effect often mean the same thing. Indeed, persons whom psychiatrists may consider psychotic are usually left undisturbed so long as they do not annoy others.[38]

Szasz thus contends that the problem is not merely the labels presently used by physicians in civil commitment proceedings, but rather the inadequate theoretical foundation which underlies these labels. Incarceration of persons solely because they are inconvenient or unwanted, or because their behavior is strange or offbeat, or because they are frightening and feared potentially dangerous has never been condoned.[39] It is incontestable that persons can be, and have been, constricted and debilitated by a bewildering array of fears, behavioral deficits, and inconvenient, time-consuming or inappropriate behaviors and thoughts; it has also been demonstrated that such persons can benefit from a variety of therapeutic procedures.[40] These behavioral psychotherapists, however, have for some time asserted that *consent* is vital to the therapeutic effectiveness of any program of behavior change.[41]

Thus, asserting that involuntary civil commitment of the mentally ill is grounded on a questionable and possibly invalid view of human behavior (i.e., that these behaviorally disturbed persons are "sick"), Szasz has proposed that involuntary civil commitment be abolished altogether.[42] There is, however, no reason why a hospital might not, under the proper circumstances, be the locus of a therapeutic program of behavior change voluntarily embarked upon by a disturbed individual and his therapist. Thus, hospitalization of adults in private and public mental institutions should be completely voluntary, and the patient should not suffer the loss of legal rights traditionally associated with the commitment process.[43] Moreover, a person convicted of a crime could be subjected to involuntary mental hospitalization for a period not

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[38] *Id.* at 46–47. *See also* Lee v. Alabama, 406 F.2d 466 (5th Cir. 1969) in which the Federal Court of Appeals for the Fifth Circuit held that the state could commit for observation those persons reasonably believed "to be suffering from mental disease, the result of which may be grossly antisocial behavior." *Id.* at 472.

[39] *See In re* Williams, 157 F. Supp. 871 (D.D.C. 1958). Even if a person is diagnosed as mentally ill, *potential* dangerousness was held not sufficient to satisfy a statutory dangerousness standard.

[40] A. BANDURA, *supra* note 33.

[41] *See, e.g.*, James, *Case of Homosexuality Treated by Aversion Therapy*, 1 BRIT. MED. J. part I, 768 (1962), for the proposition that therapy conducted involuntarily, particularly through court referral, presents the worst prognostic condition and least likelihood of fulfillment of therapeutic objectives.

[42] T. SZASZ, *supra* note 11, at 226-27.

[43] *Id.*

to exceed the maximum sentence for the crime involved,[44] since the alternative would be an equally involuntary confinement—imprisonment. But as discussed above, such modes of criminal commitment are to be distinguished from the types of civil commitment envisioned in the Michigan act and examined in the study.

It cannot be ignored that the likelihood of any state in the near future abolishing involuntary mental hospitalization is, to say the least, extremely remote. There has been, and most likely will continue to be, considerable pressure to retain a socially acceptable mechanism for the care and rehabilitation of those individuals who are determined by psychiatrists to have serious psychological disorders. It is the function of society and the law, however, to determine whether a particular type of illness or disorder is serious enough to warrant involuntary commitment.

This alternative, contrary to Szasz, reflects what is probably the more generally accepted view that serious psychological disorders susceptible of descriptive diagnostic analysis do exist, and in severe cases require involuntary hospitalization. The problem here is the need for the examining physician to articulate fully and clearly *the facts and circumstances* which support his diagnosis of an illness of sufficient gravity to warrant institutionalization.

An initially crucial step toward decreasing the number of innocuous but unwanted persons committed would be to require that an alleged mentally ill person be proven "dangerous to himself or others"[45] as a condition precedent to involuntary com-

[44] *See* the New Jersey Sex Offender Statute, N.J. STAT. ANN. § 2A: 164-6(b) (1953), which permits treatment of convicted sex offenders for a period of confinement not to exceed the maximum sentence for the crime involved.

[45] State statutes requiring dangerousness as a precondition to at least one variety of involuntary mental hospitalization include CAL. WELFARE & INST'NS CODE §§ 6250, 6300 (West Supp. 1970); HAWAII REV. LAWS § 81-31 (Supp. 1965) (for emergency hospitalization only); KAN. STAT. ANN. §§ 59-2902 (Supp. 1970); MD. ANN. CODE art. 59, § 12 (Supp. 1970); MINN. STAT. ANN. §§ 253A.01 et seq. (Supp. 1970) (for emergency hospitalization only); MISS. CODE ANN. tit. 25, §§ 6909-01 et seq. (1953); MO. ANN. STAT. §§ 202.803 (Supp. 1970) (for emergency hospitalization only); MONT. REV. CODES ANN. §§ 38-201 et seq. (1961); NEV. REV. STAT. §§ 433.653, 433.671 et seq., 433.685 et seq. (1969); N.C. GEN. STAT. §§ 122-58 et seq. (Supp. 1969) (for emergency hospitalization only); N.D. CENT. CODE §§ 25-03-07 et seq. (1970) (for emergency procedure only); OHIO REV. CODE ANN. § 5122.01 et seq. (Page 1970) (for emergency hospitalization only); TEX. CIV. STAT. ANN. tit. 92, § 5547-28 (1958) (for emergency procedure only); WASH. REV. CODE ANN. §§ 71.02.010 et seq. (1959); D.C. CODE ANN. §§ 21-522 et seq., 21-541 et seq. (1967); WIS. STAT. ANN. § 51.04-51.05 (Supp. 1969) (for emergency hospitalization only). A larger group of statutes excludes a dangerousness requirement altogether. *See, e.g.*, ALA. CODE tit. 22, § 324 (Supp. 1969); ARK. STAT. ANN. § 59-232 (Supp. 1969), ch. 186, §§ 71-1-4 et seq.; [1965] COLO. SESS. LAWS 739; CONN. GEN. STAT. ANN. §§ 17-176 et seq. (Supp. 1970); ILL. REV. STAT. ch 91 1/2, §§ 6-1, 7-1 (1965); IND. ANN. STAT. §§ 22-1201 et seq. (Supp. 1969); IOWA CODE ANN. §§ 229.1 et seq. (1969); LA. REV. STAT. ANN. §§ 28:52, 28:53, 28:57 (1969); MICH. COMP. LAWS ANN. § 330.21 (Supp. 1970); NEB. REV. STAT. §§ 83-325 et seq. (Supp. 1969); N.H. REV. STAT. ANN. §§ 135:15

mitment. The present procedure should be further changed so that the certifying physician or diagnostician would be required to set forth the *specific* reasons why the patient should be hospitalized rather than simply reciting labels which seem to be mere conclusions, at best vague and nondescriptive.[46] Such a requirement would presumably impose a greater evidentiary burden upon the petitioning party which would provide an additional safeguard against the possibility of institutionalizing persons who are not sufficiently disturbed to warrant involuntary commitment.

A statutory dangerousness requirement and an increased evidentiary burden would be empty, however, without the full panoply of procedural guarantees. Although the United States Supreme Court has not rendered a decision precisely on point, it has found the rights to notice, counsel, confrontation, and cross-examination applicable to juvenile delinquency proceedings.[47] Lower courts have, however, held that procedural due process must be observed in commitment proceedings,[48] and that denial of counsel[49] and lack of opportunity to cross-examine wit-

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et seq. (1964); N.J. STAT. ANN. §§ 30:4-23 et seq. (Supp. 1970); N.Y. MENTAL HYGIENE LAW, § 72 (McKinney Supp. 1970); OKLA. STAT. ANN. tit. 43A, §§ 3,51 et seq. (Supp. 1970); PA. STAT. ANN. tit. 50, §§ 4404 et seq. (1969); R.I. GEN. LAWS ANN. §§ 40-20-1 et seq. (1969); S.D. CODE §§ 27-1-1, 27-7-1 et seq., 27-8-1 et seq. (1967); VA. CODE ANN. § 37.1-67 (1970). A third group requires *either* dangerousness *or* lack of sufficient insight or capacity to make a responsible decision concerning hospitalization. *See, e.g.*, ALASKA STAT. §§ 47.30.030, 47.30.070 (1962); ARIZ. REV. STAT. ANN. §§ 36-501 et seq. (Supp. 1970); DEL. CODE ANN. tit. 16 § 5125 (Supp. 1968); FLA. STAT. ANN. § 394.204 (Supp. 1970); GA. CODE ANN. §§ 88-506-507 (Supp. 1970); IDAHO CODE ANN. §§ 66-317 et seq. (Supp. 1969); KY. REV. STAT. §§ 202.010 et seq. 210.280 (5) (1962); ME. REV. STAT. ANN. tit. 34, §§ 2331 et seq. (1965); MASS. ANN. LAWS ch. 123, §§ 1, 50 et seq. (1965); MINN. STAT. ANN. § 253A.07 (Supp. 1970) (for all but emergency hospitalization); N.M. STAT. ANN. §§ 34-2-1 et seq. (1954); N.D. CENT. CODE §§ 25-03-07 et seq. (1970) (for all but emergency hospitalization); OHIO REV. CODE ANN. §§ 5122.01 et seq. (Page 1970) (for all but emergency hospitalization); S.C. CODE ANN. §§ 32-911, 32-954 et seq. (1962); TENN. CODE ANN. §§ 33-602 et seq. (Supp. 1970); UTAH CODE ANN. §§ 64-7-33, 64-7-36 (1968); VT. STAT. ANN. tit. 18, §§ 7101, 7504, 7601 et seq. (1968), W. VA. CODE ANN. §§ 27-1-2, 27-5-1 (1966), WYO. STAT. ANN. § § 25-49 et seq. (1967).

[46] *See* cases cited in note 30 *supra*.

[47] *In re* Gault, 387 U.S. 1 (1967). It may be argued that involuntary hospitalization proceedings, like juvenile delinquency proceedings, are quasi-criminal in nature.

[48] *See, e.g.*, Holm v. State, 404 P.2d 740 (Wyo. 1965): Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968); Commonwealth v. Gomes, 355 Mass. 479, 245 N.E.2d 429 (1969).

[49] Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968), at 396, held that the Wyoming statute *permitting* representation of counsel at civil commitment proceedings did not adequately meet the demands of the Due Process Clause of the Fourteenth Amendment. The court declared that "Fourteenth Amendment due process requires that the infirm person, or one acting in his behalf, be fully advised of his rights and be accorded each of them unless knowingly and understandingly waived." *Heryford* thus appears to stand alone in holding that, unless knowingly waived, the right to counsel is guaranteed at civil commitment proceedings.

nesses or contravert the effect of evidence[50] violates due process. Scrupulously making counsel available to alleged mentally ill persons would insure that petitioners' evidentiary burden, factually based, would be met as a precondition to involuntary mental hospitalization. Hopefully, such guarantees would do much to prevent civil commitment on the basis of conduct whose only wrong is that it is bizarre, unsettling, inconvenient, frightening, or unpopular.

V. A POSTSCRIPT

On February 17, 1970, following a consultation with an alleged mental incompetent, the chief of staff of a Detroit area hospital sent the following letter to the former's attorney.

> I understand that Mr.____ is to appear at a hearing on ____ at which time a decision may be made to commit him involuntarily to an institution. I believe this would be a grievous error as well as a serious miscarriage of justice. If he is guilty of a crime then let him be prosecuted for that. Commitment to a mental institution would be tantamount to persecution.

The court-appointed examining physician subsequently labelled Mr.____ schizophrenic, paranoid type.

—Steven H. Levinson

[50] Holm v. State, 404 P.2d 740 (Wyo. 1965).