

The Right to Self-Harm:

Legal Issues Concerning Involuntary Psychiatric Commitment for Self-Injury

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I.

*Liberty means responsibility. That is why most men dread it.*¹

The concept of liberty is frequently invoked when discussing rights in the United States, both individual and constitutional. Less often brought up, however, is what exactly constitutes liberty. Is it delineated in the Constitution? Do we as humans possess some innate sense of what liberty is and what our rights are? No clear consensus has yet emerged. The dictionary definition states that liberty is “the freedom from control, interference, obligation, restriction, hampering conditions, etc.; the power or right of doing, thinking, speaking, etc., according to choice...[and] freedom from captivity, confinement, or physical restraint.”² Freedom from coercion is also implicit in the idea of liberty. However, there is much more involved in liberty than this simple definition suggests.

¹ Shaw, George Bernard. “Maxims for Revolutionists,” appendix 2 to *Man and Superman* in *The Collected Works of Bernard Shaw*. Vol. 10. Cambridge: The University Press, 1903. p. 218.

² “Liberty.” *Random House Webster’s Unabridged Dictionary*. 2nd ed. New York: Random House, 1998. p. 1108.

Responsibility goes hand in hand with liberty; there is a direct relationship between the two. They are often referred to as opposite sides of the same coin. With increased liberty comes increased personal responsibility, and vice versa. “Personal responsibility cannot exist without liberty, and liberty will not endure without responsibility.”³ In order to free ourselves from coercion by other individuals or organizations, we must be willing to be held accountable for our actions. Moreover, personal responsibility requires effort and determination. It is increasingly tempting to seek an easy solution to a problem and accept the security that reduced responsibility affords, even at the price of a proportionate decrease in freedom. Giving up control over one’s own behavior usually results in being deprived of liberty.

The Constitution of the United States provides that “no state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law.”⁴ Since our nation’s inception, liberty and property have been linked together. The right to own property is generally viewed as an intrinsic component of liberty. John Locke was an early proponent of property rights, positing that since they are one of the few tangible examples of rights, they are the foundation upon which all other rights are built. The most fundamental and essential property that a person can possess is his own body, and Locke advocated the right of every man to himself: “Though the earth and all inferior creatures be common to all men, yet every man has a ‘property’ in his

³ More, Max. “Liberty and Responsibility: Inseparable Ideals.” *The Freeman*. July 1996. Available online at <<http://www.theadvocates.org/freeman/9607more.html>>

⁴ Killian, Johnny H., ed. 14th Amendment, Section 1. *The Constitution of the United States of America: Analysis and Interpretation*. Washington: U.S. Government Printing Office, 1987. p. 1467.

own ‘person.’ This nobody has any right to but himself.”⁵ Personal liberty is dependent upon private property for Locke, because once a person owns property he can be autonomous within that space.

The right of freedom from coercion is considered a negative right rather than a positive one. Negative rights are rights *from* (murder, rape, etc.), while positive rights are rights *to* (education, welfare, and so on). Possession of a negative right indicates that a person is free to do as he wishes without interference from others. Negative rights confer freedom upon people, while positive rights create obligations; therefore, negative rights encourage personal autonomy and positive ones encourage dependence and helplessness. The right to injure one’s own body if so desired is a negative right, while the “right” to receive mental health care for self-harm, voluntarily or not, is a positive one.

In the clause cited above, the Constitution also establishes the right of due process; that is, how and why the laws are enforced. There are two components of due process, substantive and procedural. The “how” of law enforcement is reflected in procedural due process; in order to comply with this requirement of the Constitution, a law must be clear, fair, and contain a presumption of innocence on the part of the accused. Substantive due process is concerned with why, rather than how, laws are implemented. It is intended to guarantee that the restrictions which a proposed law seeks to impose are valid under the terms of the Constitution. This safeguard of liberty ensures that even if an unreasonable or unfair bill is passed and signed into law legally, it may be declared a violation of due process and therefore unconstitutional.

⁵ Locke, John. An Essay Concerning the True Original, Extent, and End of Civil Government. Available online at <<http://www.jim.com/2ndtreat.htm>> paragraph 26.

Being incarcerated, whether in a prison or mental institution, constitutes a deprivation of liberty. Both types of facilities are typified by Erving Goffman as “total institutions” in the sense that “their encompassing or total character is symbolized by the barrier to social intercourse with the outside that is often built right into the physical plant.”⁶ Goffman breaks his classification of total institutions into five categories, with mental hospitals as “places established to care for persons felt to be both incapable of looking after themselves and a threat to the community, albeit an unintended one” and prisons as institutions “organized to protect the community against what are felt to be intentional dangers to it.”⁷ Although he divides total institutions according to his own typology, Goffman points out that they are all more similar than different, in that “each exhibits to an intense degree many items in this family of attributes.”⁸

There are several unique traits that characterize total institutions. One of these is the physical barrier emphasizing a sense of being cut off from the outside world. Another, and perhaps the most definitive, aspect of total institutions is their integration of all aspects of life, negating the distinction formerly made between the public and private spheres.

First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member’s daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day’s activities are tightly scheduled...[and] finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution.⁹

⁶ Goffman, Erving. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Doubleday, 1961. p. 4.

⁷ Goffman pp. 4-5.

⁸ Ibid. p. 5.

⁹ Ibid. p. 6.

Total institutions also feature a distinct split between inmates and staff, with staff clearly positioned above inmates in the social hierarchy. There is a specific set of rules governing life in these institutions, with outside laws no longer applying; this, combined with the staff/inmate dichotomy, leads to the development of stereotypes and a tendency for each group to view both themselves and the other within the narrow confines of such stereotypes. Lastly, “there is an incompatibility...between total institutions and the basic work-payment structure of our society. [They] are also incompatible with another crucial element of our society, the family.”¹⁰

Before a citizen of the United States may be confined to prison for participation in a criminal activity, however, he or she inevitably receives some form of due process, including but not limited to the rights to a fair and speedy trial, legal counsel, and an impartial jury of that person’s peers. Those who are considered mentally ill and in need of treatment, on the other hand, are often denied these basic constitutional rights. In cases of involuntary psychiatric commitment, the consent of the patient is not necessary; in fact, commitment may be carried out even in the face of vehement protests and refusals of treatment. Such actions are justified on the basis that people may be dangerous to others or to themselves, or are unable to care for themselves. Involuntary psychiatric patients lack the authority to discharge themselves from the institution in which they are confined and are given little or no input into their treatment, to the point that in some jurisdictions they may be forcibly medicated despite their objections.

The conflict over involuntary commitment is, at its heart, a struggle between the individual’s innate desire for personal autonomy and bodily integrity and the government’s sense of responsibility for the health, safety, and happiness of its citizens.

¹⁰ Ibid. p. 11.

The government could best serve the people and ensure their health and happiness, however, by being reminded of the fact that the state has no compelling interest in what a legal adult does to or with his or her own body, as long as no direct harm is inflicted upon unwilling bystanders. There is no legitimate governmental interest in protecting people from themselves.

This is consistent with John Stuart Mill's harm principle, which establishes that individuals are sovereign over their own bodies and minds. The harm principle states

that the only purpose for which power can be exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right.¹¹

Self-injury is a perfect example of a situation corresponding to the harm principle; people make a conscious decision to inflict harm upon their bodies for a variety of reasons, usually as a coping mechanism for dealing with their emotions or environment. This behavior, although it involves no one but the person who chooses to engage in it and should be no one else's business, has nonetheless been deemed sufficient grounds for involuntary psychiatric commitment in the United States.

Involuntary commitment for so-called mental illnesses such as schizophrenia are beyond the scope of this paper. This type of commitment raises issues relating to the classification of mental illness as a disease in the same sense as, for example, cancer, literal versus metaphorical diseases, and the medicalization of socially deviant behavior, to name a few. Self-injury is not a "mental illness"; rather, it is a coping behavior, and thus traditional arguments in favor of involuntary commitment must be reevaluated

¹¹ Mill, John Stuart. On Liberty. Available online at <<http://academic2.american.edu/~dfagel/Mill.html>>

where self-harm is concerned, especially in light of the deprivation of liberty and lack of due process involved.

II.

So I took the nail file, found its sharp edge, and ran it across my lower leg, watching a red line of blood appear across my skin...I made a few more scratches, alternating between legs, this time moving the file more quickly, less cautiously. I did not, you see, want to kill myself. Not at that time, anyway. But I wanted to know that if need be, if the desperation got so terribly bad, I could inflict harm on my body. And I could. Knowing this gave me a sense of peace and power, so I started cutting up my legs all the time.¹²

What do actors Johnny Depp, Angelina Jolie, and Christina Ricci have in common with author Elizabeth Wurtzel, musicians Courtney Love and Fiona Apple, the late Princess Diana, and millions of Americans? The answer is one that few people expect to hear: self-injury, also commonly referred to as self-harm or self-mutilation. Current research suggests that almost two million Americans deliberately inflict some

¹² Wurtzel, Elizabeth. *Prozac Nation: Young and Depressed in America*. New York: Riverhead, 1994. pp. 46-47.

form of physical harm on their bodies each year.¹³ Despite its prevalence in society, self-injury remains a mysterious and little-understood phenomenon.

Until the late 1970's and early 1980's, conventional wisdom dictated that all forms of self-injury were "parasuicide," and those who engaged in this practice were performing a muted form of suicide. Although numerous groups in other societies routinely participated in self-injurious rituals for religious or healing purposes, the American view of the practice was one of revulsion and horror. Psychiatrist Armando Favazza, M.D. was one of the first modern researchers to delve more deeply into the cultural and psychological explanations for self-injury. In 1987, the first edition of his book *Bodies Under Siege* was published, sparking the current interest in self-injury as a topic of study.

The definition of self-harm now used in medical circles relies in large part on Dr. Favazza's work in the field. For the purposes of this paper, I will use his characterization of self-injury as well: "Self-mutilation [is] the direct, deliberate destruction or alteration of one's own body tissue without conscious suicidal intent. This definition does not include bona fide suicide attempts, indirect methods of self-harm (such as starvation), or swallowing objects (glass, nails) or substances (drug overdoses)."¹⁴ Under this broad heading of self-injury fall two major categories: culturally sanctioned self-harm and deviant-pathological self-harm.¹⁵

¹³ Strong, Marilee. *A Bright Red Scream: Self-Mutilation and the Language of Pain*. New York: Penguin, 1998. p. 25.

¹⁴ Favazza, Armando, M.D. *Bodies Under Siege: Self-mutilation and Body Modification in Culture and Psychiatry*. Baltimore: Johns Hopkins U.P., 1996.

¹⁵ Terminology note: I will generally refer to the practice discussed here as either self-harm or self-injury; other terms used, such as self-mutilation, self-inflicted violence, or self-abuse, have a more derogatory connotation that I find rather offensive. However, when a direct quote is indicated, I will not change the term that the original author uses to refer to the behavior.

Culturally sanctioned self-harm consists of rituals and practices, the latter of which tend to be more common in modern American society. Although clear distinctions between the two are sometimes difficult to draw, rituals generally “imply activities that are repeated in a consistent manner over at least several generations and that reflect the traditions, symbolism, and beliefs of a society.”¹⁶ Practices, on the other hand, often have less cultural significance and are not as deeply rooted in tradition; they might be described as fads or trends. Body piercing is an example of a culturally sanctioned and socially acceptable self-harm practice, while the circumcision of male infants in Jewish culture is a ritual.

Self-harm rituals are an integral part of many societies around the world and serve to promote healing, spirituality, and social order. Americans rely on science to prevent and cure diseases, but other cultures turn to various forms of self-injury to achieve the same goals. The Hamadsha, a sect of Muslim healers in Morocco, are believed to have special medicinal powers in their blood, so they slash open their foreheads and allow the sick or injured to dip pieces of bread into the blood. Once the patient eats the blood-soaked bread, the healing magic passes into them and cures their ailments. The ancient practice of trephination was intended to heal by cutting a small hole in the skull to let out the evil spirits that caused headaches.

Modern Christianity generally appears to avoid directly addressing the self-mutilative aspects of some spiritual practices; however, throughout history people have believed that harming themselves is pleasing to the spirits and will ensure prosperity and happiness both in this world and in the afterlife. Many of the saints canonized by the Catholic Church were involved in the practice of mortification of the flesh in order to

¹⁶ Favazza p. 226

facilitate their eternal salvation. Saint Ammonius burned himself all over his body with a red-hot iron, while Saint Elizabeth, the 14th-century queen of Portugal, was reported to have whipped herself at the age of eight.¹⁷ The Hindu culture worships lingam stones representing Shiva's self-castrated phallus. In addition to placating the spirits, these injurious rituals are also reputed to aid human beings in reaching religious ecstasy and gaining deeper insight.

The social order component of culturally sanctioned self-harm accounts for many of the practices that the Western world views as being oppressive to and exploitative of women. Many societies consider female sexuality a threat to the natural social order, and fear that if it were not controlled, chaos would ensue. Adolescents in other cultures must undergo self-injury in order to signal their readiness to accept the responsibilities of adulthood, and still other groups signify genealogical and kinship bonds through such means as scarification or skull molding. In general, "the alteration or destruction of body tissue helps to establish control of things and to preserve the social order."¹⁸ The community is physically and emotionally preserved by perpetuating self-injury rituals through the generations.

Culturally sanctioned self-harm, although interesting, is not the focus of this paper. This type of self-injury is not seen as a psychological problem because of its deep roots in tradition and the fact that the entire community both accepts it and participates in it. Deviant-pathological self-harm, on the other hand, is a very individual practice and, despite the growing awareness of and interest in it, is not socially acceptable.

Conventional wisdom still holds that people who deliberately cut or burn their own

¹⁷ Owen, Mark. "Mortification." Extract from the *Encyclopedia of Human Cruelty on CD-ROM*. Available online at <<http://www.felicity.com.au/mortification.htm>>

¹⁸ Favazza p. 231.

bodies are suicidal and sincerely want to die. In the mid-1980's, Pattison and Kahan developed a system of classification for self-injury that helped greatly to “eliminat[e] the linguistic and conceptual confusion that surrounded self-mutilation.”¹⁹

Pattison and Kahan's taxonomy is composed of three variables. The first concerns time and awareness and is referred to as the direct/indirect variable. Direct self-harm takes place in a short period of time with awareness of the effects of the behavior and conscious intent to injure. Indirect self-harm appears to occur with no awareness of the consequences of the behavior and no conscious intent to harm; it also takes place over a much longer period of time. Examples of indirect self-harm include starvation, excessive drinking or drug use, and compulsive overeating.

The second variable is lethality, or the likelihood that death will result from the behavior in which a person is engaged. A low probability of death means that the behavior is considered low lethality. The final variable that Pattison and Kahan suggested is repetition, referring to the frequency with which the self-injurious behavior occurs. Classifications of self-harm can thus be made in terms of these three variables. “A low lethality, multiple episode, direct behavior such as repetitive skin cutting is classified as a deliberate self-harm syndrome.”²⁰ This is the type of self-injury with which this paper is concerned.

Deviant-pathological self-injury can be further subdivided into three categories: major, stereotypic, and moderate/superficial. Major self-harm is commonly associated with psychosis, including schizophrenia and depression, and “refers to infrequent acts – such as eye enucleation, castration, and limb amputation – that result in the destruction of

¹⁹ Ibid. p. 233.

²⁰ Favazza p. 233.

significant body tissue.”²¹ This type of self-injury often has some underlying connection to religion, sexuality, or both. The Bible directs its adherents, “And if thy right eye offend thee, pluck it out and cast *it* from thee: for it is profitable for thee that one of thy members should perish, and not *that* thy whole body should be cast into hell. And if thy right hand offend thee, cut it off and cast *it* from thee...” – a command that some self-injurers take literally.²² Others identify with Christ’s suffering on the cross, wish to atone for their perceived sinfulness, or feel that they are being commanded by either a divine or demonic influence to harm themselves. Fear of homosexuality, the desire to be rid of one’s genitals or to change genders, and the control of one’s sexuality have also been cited as explanations for major self-injurious acts.

Stereotypic self-harm is far more monotonously repetitive than other forms of self-harm and is more likely to be performed when others are present. “It is usually impossible to ascertain any symbolic meaning, thought content, or associated affect with the behaviors...stereotypic self-mutilators seem to be driven by a primarily biological imperative to harm themselves shamelessly and without guile.”²³ This type of self-injury is generally observed in people with severe mental retardation, especially those who are institutionalized, or in conjunction with certain genetic disorders such as Lesch-Nyhan syndrome (an inborn enzyme defect found only in males that may result in mental retardation, involuntary muscle movements, and self-aggressive behavior), Retts disorder (an associated feature of profound mental retardation, occurring only in females and “characterized by the persistent, progressive loss of hand skills and of the ability to

²¹ Ibid.

²² *The Bible: Authorized King James Version*. New York: Oxford U.P., 1997. Matthew 5:29-30. pp. 7-8.

²³ Favazza p. 237.

interact socially”), autism, and Tourette’s syndrome.²⁴ Stereotypic self-harmful acts include head banging, eyeball pressing, and tongue and lip biting.

Moderate/superficial self-injury is the sort that has received the most attention in the medical community and popular culture recently. Skin cutting and burning are the most common forms of this type of self-harm, although hair pulling and other forms of skin injury such as picking, scratching, and carving also fall into this category. A survey of undergraduate college students conducted by Favazza revealed that approximately 12% had engaged in moderate/superficial self-harm at some point. The number of cases of such behavior is currently estimated to be around 1,400 per 100,000 people.²⁵ This category is further broken down by Favazza into compulsive, episodic, and repetitive self-injury.

Hair pulling and skin picking are by far the most prevalent forms of compulsive self-injury. These behaviors occur repeatedly, up to several times a day, and are highly repetitive and ritualized. Hair pulling, or trichotillomania, is an impulse control problem that generally worsens under stress and is often performed unconsciously, according to conventional psychiatric wisdom. Psychodermatological conditions, a categorization that encompasses many kinds of skin picking, scratching, and squeezing, are also compulsive. These behaviors are most frequently seen in people with delusions of parasites under their skin (caused by either medical disorders or drug use). In addition, excessive perfectionism and obsessive-compulsive disorders can compel people to pick at their skin to eliminate real or imagined imperfections.

²⁴ Ibid. p. 239.

²⁵ Favazza p. 240.

Episodic and repetitive self-injury encompass the same types of behaviors with the same motivations; the major difference between the two lies in the frequency with which self-harming actions are performed. “Episodic self-mutilators do not brood about this behavior, nor do they have a self-identity as a ‘cutter’ or ‘burner.’ They deliberately harm themselves to feel better, to get rapid respite from distressing thoughts and emotions, and to regain a sense of self-control.”²⁶ When self-injury becomes an “overwhelming preoccupation” and the person identifies himself as a cutter or burner, then episodic self-injury has become repetitive. “Unlike episodic self-mutilation, which is best considered a symptom or associated feature of a mental disorder...the repetitive type is best considered a separate disorder of impulse control.”²⁷

From his extensive studies of self-injury, Favazza, along with his colleague Dr. Richard Rosenthal, developed a schematic describing what they termed “repetitive self-mutilation syndrome,” or RSM.²⁸ This specific subset of the broader category of self-harm is the one with which this paper is concerned. Favazza and Rosenthal’s characterization of RSM is modeled after the format of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*. The DSM-IV, as it is commonly referred to, is the main diagnostic reference used by mental health professionals in the United States. Although self-injury as a separate syndrome is not included in the DSM-IV, it is mentioned in association with other disorders, most notably borderline personality disorder. Favazza and Rosenthal group RSM in the category of impulse control disorders, along with kleptomania, pyromania, and trichotillomania.

²⁶ Ibid. p. 243.

²⁷ Favazza p. 251.

²⁸ When referring to Favazza’s work, I will use the terms “RSM,” “self-harm,” and “self-injury” interchangeably. In all other instances, I will use only “self-harm” and “self-injury,” since RSM is unique to Favazza’s work.

“The essential feature of RSM is recurrent failure to resist impulses to harm one’s own body physically without conscious suicidal intent.”²⁹ This type of self-injury is more often observed in females and generally begins in late childhood or early adolescence, and continues for several years. The onset of chronic self-harm has been linked in numerous studies to abuse in early childhood, particularly sexual abuse. “In a study of all patients admitted to the University of California at San Francisco’s adolescent psychiatry unit during a six-month period in 1988, 83 percent of those who reported being victims of sexual abuse engaged in cutting.”³⁰ RSM also frequently occurs in conjunction with borderline personality disorder and post-traumatic stress syndrome. In addition, those who repetitively injure themselves often exhibit a tendency toward other forms of impulsive behavior, including anorexia, bulimia, alcohol and drug abuse, and kleptomania.

Favazza and Rosenthal proposed a set of diagnostic criteria for RSM as a separate and distinct disorder, rather than an associated symptom of some other problem. They suggest the following criteria for diagnosing RSM:

1. preoccupation with harming oneself physically;
2. recurrent failure to resist impulses to harm oneself physically, resulting in the destruction or alteration of body tissue;
3. increasing sense of tension immediately before the act of self-harm;
4. gratification or a sense of relief when committing the act of self-harm; and
5. the act of self-harm is not associated with conscious suicidal intent and is not in response to a delusion, hallucination, transsexual fixed idea, or serious mental retardation.³¹

This schematic attempts to remedy the fact that self-injury is often examined not as a disorder in its own right, but rather as a manifestation of another syndrome such as

²⁹ Ibid. p. 253.

³⁰ Strong p. 64.

³¹ Favazza p. 256.

borderline personality disorder. However, Favazza cautions against such an interpretation: “Self-mutilation is one of eight diagnostic criteria for BPD but by itself is neither necessary nor sufficient to establish a diagnosis.”³²

The most pressing question that people have about self-injury is: why? Why would anyone deliberately inflict pain and scarring upon their own body? In the past, those who purposely cut or burned themselves were deemed suicidal, and episodes of self-harm were considered to be failed suicide attempt. This misunderstanding of the phenomenon was furthered in part by some of Sigmund Freud’s early work. As an extension of his concept of eros, the life instinct, he theorized that humans also have thanatos, a death instinct. “Suicide and self-mutilation were regarded as manifestations of an instinctive push toward death and were qualitatively identical for Freud.”³³ Although his ideas about eros and thanatos have been discounted by many psychiatrists, Freud’s notion of self-harm as potential suicide still lingers; even today, laypeople and medical professionals alike regard self-injurers as suicidal.

The acts of suicide and self-harm, no matter how similar their physical manifestations may appear, are very different, however. “Suicide is an exit into death, but self-mutilation is a reentrance into a state of normality. Suicide is an act of escape, but self-mutilation is a morbid act of regeneration. A person who attempts suicide seeks to end all feelings, but a person who self-mutilates seeks to feel better.”³⁴ Self-injury is a coping mechanism or a form of self-help for those who engage in it. When they are overwhelmed with a strong emotion such as anger, sadness, or fear, or when they dissociate from the real world and are too numb for emotions, self-injurers deal with their

³² Ibid. p. 257.

³³ Favazza p. 270.

³⁴ Ibid. p. 271.

feelings and bring themselves back from a dissociated state by harming their bodies. Other people may exercise, talk to a friend, smoke marijuana, or drink a beer when they experience similar feelings. For the self-injurer, cutting, burning, scratching, and so on are the preferred coping mechanisms.

The most common emotional states that prompt episodes of self-injury are anger, tension or anxiety, and depersonalization or dissociation. Harming oneself is often perceived as a safer and more effective way of dealing with anger, since direct confrontation with the source of that anger could provoke retaliation or the dissolution of an important relationship with family or friends. In the case of anxiety, “when tense patients cut themselves, they...often describe the results in words such as ‘It’s like lancing a boil’...the implied metaphor is clear: in cutting their skin they provide an opening through which the tension and badness in their bodies can rapidly escape.”³⁵ The physical sensation is often extremely important to the self-injurer in cases of depersonalization, during which the person may feel detached from his or her body and from the real world. Self-harm, especially cutting, is often the only way that the sufferer can end this dissociative episode.

Self-injurers generally lack other coping mechanisms that are sufficient to deal with the strength of their emotions.

The self-mutilator is someone who has found that physical pain can be a cure for emotional pain. It is someone who, for one reason or another, has absolutely no outlet for her emotional pain, and therefore no relief from it. All she has is that short period of time when it is temporarily overpowered, “drowned out,” by physical pain...self-mutilating behavior means the mind has slipped away from its ordinary context or perspective, losing sight of the impracticality of pain and

³⁵ Favazza p. 272.

danger in order to commit an act that will bring an immediate solution (however unrealistic or temporary in nature) to emotional pain.³⁶

They experience emotions that are unbearably intense to them, and must mute or diffuse these feelings somehow. Self-harm may be the only way, or simply the most effective way, they have of managing strong emotions.

Researchers have speculated that a strong correlation exists between childhood abuse and self-injury, and studies seem to substantiate this hypothesis. In one major study of female self-injurers conducted by Favazza and Karen Conterio, 62% of the subjects reported some form of childhood abuse.³⁷ In addition to outright abuse, neglect and poor parenting, as well as early trauma such as separation from a parent due to death or divorce, have been related to self-harmful behaviors later in life. Although abuse or inadequate parenting in early childhood may be one cause of self-injury, not all self-injury can be explained away as a result of these findings. Since the psychological interest in self-harm is still relatively new, many facets of this behavior remain unexplored. In general, “self-mutilation is a multidetermined behavior and can be understood only by attention to interactions among psychological and biological functioning, the environment and social setting, and the overarching web of culture.”³⁸

³⁶ Levenkron, Steven. *Cutting: Understanding and Overcoming Self-Mutilation*. New York: Norton, 1998. p. 45.

³⁷ Of the number reporting abuse, 29% reported both sexual and physical abuse, 17% reported only sexual abuse, and 16% reported only physical abuse. Favazza p. 266.

³⁸ *Ibid.* p. 282.

III.

For some time now I have maintained that commitment – that is, the detention of persons in mental institutions against their will – is a form of imprisonment; that such deprivation of liberty is contrary to the moral principles embodied in the Declaration of Independence and the Constitution of the United States; and that it is a crass violation of contemporary concepts of fundamental human rights...in short, I consider commitment a crime against humanity.³⁹

Involuntary psychiatric commitment, more often referred to as involuntary civil commitment, is “the practice of using legal means or forms to commit a person to a mental hospital, insane asylum, or psychiatric ward against the will or over the protests of

³⁹ Szasz, Thomas. *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man*. Syracuse: Syracuse U.P., 1970. p. 113.

that person.”⁴⁰ People may also admit themselves to the same types of institutions of their own accord, but voluntary psychiatric commitment is outside the scope of this paper. According to the Bazelon Center for Mental Health Law, 27 states and the District of Columbia currently permit the commitment of so-called mentally ill individuals for treatment against their will. This action is justified if the person is considered to be a danger to himself or to others, and is “offered as a solution to the problem of people with mental illnesses in jails, homeless on the streets, or acting out disruptively or violently in society.”⁴¹

The advocacy and usage of commitment or hospitalization for mental illnesses has been recorded in history as far back as the ancient Greek and Roman empires. Hippocrates, considered the father of medicine, believed that mental illness should be treated in asylums far from the pressures and stress of city life. Soranus, a Greek physician who lived in Rome during the second century A.D., advocated similar practices. Both points of view marked a departure from more common treatments of the era such as forced drugging with opium and alcohol, starvation diets, and public whippings.

However, it was not until 450 B.C. that the concept of civil commitment with which we are familiar was introduced. “Aristotle...not only defined the legal principle of informed consent which is essentially unchanged to this day, but also defined the two essential powers of a democratic government which are found in our own culture and law

⁴⁰ “Involuntary commitment.” Wikipedia: The Free Online Encyclopedia. Available at <http://en.wikipedia.org/wiki/Civil_commitment>

⁴¹ “Studies of Outpatient Commitment are Misused.” The Judge David L. Bazelon Center for Mental Health Law. 3 July 2001. Available online at <<http://www.bazelon.org/issues/commitment/ioc/studies.htm>>

and underlie the two legal justifications for civil commitment of certain persons.”⁴² The notion of informed consent is crucial to the legality of psychiatric commitment, and refers to “a person’s ability to receive and absorb the relevant knowledge, intelligently evaluate the risk and benefits of the decision, and to be free from any coercion.”⁴³ The Supreme Court’s decision in *Zinermon v. Burch* is one of the most influential legal cases dealing with informed consent.

Aristotle’s conception of the two basic governmental powers in society has also endured for centuries and has been incorporated into both the Declaration of Independence and the Preamble to the United States Constitution. He envisioned the government as serving the functions of both police and parents for its citizens. Under its police powers, the government protects citizens from danger and harm inflicted upon them by outside sources. Aristotle’s idea of the parental role of the government, which came to be known as *parens patriae*, made it “the government’s responsibility to act as the ultimate parent of all citizens of the country who have no family or friends to help them in times of need.”⁴⁴ Together, these two powers form the basis and justification for involuntary psychiatric commitment.

Civil commitment as a formal government policy was virtually nonexistent until the beginning of the 16th century. However, once its popularity increased, civil commitment was seen as a cheap and convenient way to rid society of so-called undesirables; not only those diagnosed as mentally ill, but also alcoholics, drug users, the

⁴² Stavis, Paul F. “Civil Commitment: Past, Present, and Future.” Address given at the National Conference of the National Alliance for the Mentally Ill. Washington D.C., 21 July 1995. First published in the *Quality of Care Newsletter*. Issue 64, August-September 1995. Available online at <http://www.cqc.state.ny.us/counsels_corner/cc64.htm>

⁴³ Ibid.

⁴⁴ Stavis.

homeless, military deserters, and prostitutes were either institutionalized against their will or conscripted into forced labor. This took place throughout Europe for decades, leading to that century's being referred to as "The Great Confinement."⁴⁵ England and France especially made use of these tactics. For example, in 1532 the Parliament of Paris began arresting beggars on the streets, then forcing them to work in the city sewers while chained together in pairs. In England, a 1575 act of Parliament confined the poor or otherwise socially deviant to institutions known as "houses of correction," a practice which eventually spread throughout the rest of Europe.

Throughout the Middle Ages and as late as the 19th century, it was common to place the inmates of such facilities on public display, allowing observers to peer in through windows at those inside, sometimes for a nominal fee. Inmates were subjected to severe overcrowding, deprived of food, and often beaten or humiliated as "treatment." No distinctions were drawn between the mentally ill, the physically ill or disabled, the poor or unemployed, and the social deviants in these institutions; all were treated with the same brutality. "At this time in history, madness or mental illness was not considered an illness; rather, it was...caused by sin and social deviance...Those who were mentally ill were [seen as] very similar to animals who did not feel pain, nor cold, nor severe punishment, but rather thrived under such conditions."⁴⁶ At the end of the 18th century, approximately one out of every 100 Parisian citizens was incarcerated in one of these facilities. Separation of those deemed mentally ill from other types of so-called social deviants did not occur until years after the Renaissance.

⁴⁵ Ibid.

⁴⁶ Stavis.

During this era, the situation in colonial America was similarly problematic. “Supporting an indigent, incompetent person was not considered...a matter of government responsibility.”⁴⁷ Due to their low populations and fledgling economy, the colonies often lacked facilities such as schools, fire departments, or jails; institutions such as the European “houses of correction” certainly did not exist. Thus, the supposed social deviants and mentally ill often formed groups which wandered from town to town, leading a nomadic existence rather than being incarcerated. If institutionalization did occur, it generally followed the European trend of categorizing all social deviants as criminal and thus placing them in the few existing jails or in poorhouses. These practices persisted until the mid-18th century, when the first general public hospitals were established in the United States thanks in large part to the efforts of Benjamin Franklin and others.

During the 19th century, social reformers became concerned about the plight of the mentally ill and advocated for the creation of asylums, places of rest and retreat much like those described by Hippocrates and Soranus centuries earlier. At this time, “commitment was predicated simply on a mentally ill person’s requiring care...entry was designed to be as simple as possible, and...coercion was viewed as essential if needed treatment was to be obtained.”⁴⁸ However, following the Civil War, “mental hospitals degenerated into snake pits. They were no longer asylums, but places of disorder and distress,” once again proving fertile ground for the reform movement.⁴⁹ One notable

⁴⁷ Ibid.

⁴⁸ Appelbaum, P.S. *Almost a Revolution: Mental Health Law and the Limits of Change*. Oxford: Oxford U.P., 1994. p. 20.

⁴⁹ Slovenko, Ralph. “Commentary: Reviewing Civil Commitment Laws.” *Psychiatric Times*. Vol. XVII, Issue 10. October 2000. Available online at <<http://www.psychiatrictimes.com/p001001b.html>>. Mrs. Packard’s case was also discussed at an earlier date by Thomas Szasz, especially in *Ideology and Insanity*, pp. 116-117.

advocate for such reforms was Mrs. E.P.W. Packard, a former mental hospital patient herself. She was institutionalized by her husband under a state statute allowing the involuntary commitment of married women by their husbands, without any of the procedural safeguards applied in other civil commitments. After her discharge,

Mrs. Packard fought for the adoption of mental health codes; these became the foundation of our modern codes. She claimed that sane people were illegally incarcerated and maltreated. Her efforts, along with exposes by other former patients, resulted in the passes of legislation that allegedly safeguarded patients' rights more effectively and circumscribed the powers of hospital officials.⁵⁰

The trend of reforms in civil commitment procedures followed the general social reform trends of the times, and fluctuated in response to the political climate and popular culture as well.

By the early decades of the 20th century, conditions in and usage of mental hospitals had reverted to their pre-reform state. They were once again viewed as the remedy for many forms of socially deviant behavior, including poverty and crime as well as mental illness. Law enforcement assumed an integral role in the process of involuntary commitment; by the 1930's, approximately "64% of patients were transported to state hospitals by law enforcement personnel" and such patients could be detained by police and hospitalized for as many as 140 days without any sort of pre-commitment hearing or due process.⁵¹ Such conditions persisted throughout the 1940's and 1950's. In the 1960's, the first antipsychotic drugs such as Thorazine were introduced, leading to charges that patients were forcibly medicated to make them docile and easily controlled. Such accusations arose in the era of the civil rights movement, when the government and courts were beginning to notice violations of individual rights, including segregation and

⁵⁰ Slovenko.

⁵¹ Appelbaum p. 21.

women's rights. This led to the current state of mental hospitals and commitment procedures, where an increasing emphasis is placed on respecting the constitutional rights of patients; however, since incidents such as those involving Kendra Webdale (discussed in the next section), many groups have been advocating the stricter commitment policies popular in past decades.

The popularity of involuntary psychiatric commitment has waxed and waned in this cyclical fashion over the decades, as had the authority of the government to enforce that commitment. Since the Supreme Court's 1975 *O'Connor v. Donaldson* decision, the trend in some states has been away from involuntary civil commitment and more toward a new phenomenon known as involuntary outpatient commitment (IOC), or simply as outpatient commitment. IOC is "a statute authorizing courts to require an individual to accept outpatient mental health treatment or hospital release conditioned on treatment compliance," and is touted as the next great reform in mental health care, since it is widely viewed as less invasive than traditional inpatient commitment.⁵²

Many states, however, still rely on involuntary civil commitment on an inpatient basis. Statutes and requirements vary by jurisdiction, but many have included a "less restrictive alternative" clause in their involuntary inpatient commitment laws. Oftentimes, IOC becomes this less restrictive alternative. In general

there are three places of commitment for persons with mental illness: 'inpatient' commitment (to an institution); 'outpatient' commitment (to the community with close monitoring by a government agency, private agency, or individuals); and 'criminal' commitment, i.e., where a person is either found not guilty of criminal responsibility, yet mentally ill and in need of care and treatment, or found guilty and mentally ill and who will receive psychiatric services in a prison.⁵³

⁵² Bazelon.

⁵³ Stavis.

Involuntary commitment is often used on individuals who are considered dangerous to others, which is a valid governmental concern; however, those who are only a danger to themselves, specifically, those who self-harm, are also subjected to involuntary commitment.

Statutes outlining the requirements and procedures for involuntary psychiatric commitment vary by state. A review of all 51 jurisdictions in the United States (50 states plus the District of Columbia) reveals that 43 require “that the risk of self-harm be the result of a mental illness. Seven others merely stated concurrent danger and mental illness but did not specify that the risk arose from the mental disorder and the last one gave contradictory requirements.”⁵⁴ Self-injury in itself is neither a mental disorder nor indicative of one, assuming that such a thing as mental illness actually exists (a question that is beyond the scope of this paper). However, since the inclusion of self-injury as a diagnostic criterion for borderline personality syndrome in the two most recent editions of the DSM, it has become the popular assumption that everyone who self-harms must have a borderline personality disorder.⁵⁵ Therefore, involuntary commitment for self-injury, whether any other evidence of a so-called mental illness is present or not, is statutorily permissible in many jurisdictions.

There are four major methods through which a person may be detained and subjected to involuntary civil commitment. The first of these is emergency detention, which is “the fastest and easiest method of commitment and is used most often because it

⁵⁴ Werth, James L., Jr. “U.S. Involuntary Mental Health Commitment Statutes: Requirements for Persons Perceived to be a Potential Harm to Self.” Available online at <http://www.usd.edu/dmhi/gr/Invol_MH_Commit.pdf>

⁵⁵ DSM refers to the *Diagnostic and Statistical Manual of Mental Disorders*, now in its fourth edition. It contains diagnostic criteria for the most commonly identified mental illnesses and is published by the American Psychiatric Association.

circumvents the judicial process and thereby deprives the person of nearly all rights.”⁵⁶ In 1984, a survey of involuntary commitment practices in 20 states showed that emergency detention was the favored method of commitment. This technique may also be used to convert voluntary patients to involuntary ones, often when they seek to discontinue medications or leave the hospital and return home. The second method, semi-judicial commitment, requires less immediate action than emergency detention but is otherwise very similar. “A psychiatrist examines the person and certifies, in writing, that hospitalization is required. A judge then reviews the paperwork for authenticity and signs the authorization for involuntary detainment. The individual is not present at this transaction and therefore has no right to defend him- or herself.”⁵⁷

Judicial commitment is yet another means of involuntary hospitalization. It requires the filing of legal documents explaining why a person should be committed against his or her will, and the court must have jurisdiction before any detainment may occur. “Judicial commitments are more adversarial than the first two methods. Some states give victims the right to an attorney. However, while the outcome may be decided by a judge, it rarely involves a jury.”⁵⁸ The final method of commitment is predicated upon guardianship or conservatorship laws. These involve the psychiatric commitment of a person who was previously judged “incompetent” by a court procedure and thus assigned a legal guardian. Such a guardian may then commit his or her charge involuntarily.

⁵⁶ “Involuntary Psychiatric Commitment: A Crack in the Door of Constitutional Freedoms.” Citizens Commission on Human Rights. Available online at <<http://www.cchr.org/issues/commitment/publications/involuntary/index.htm>> p. 2.

⁵⁷ Ibid.

⁵⁸ “Involuntary Psychiatric Commitment” p. 2.

Although each state defines the criteria for involuntary commitment differently in their statutes, they are all similar in that the only form of due process a patient is guaranteed before being hospitalized is that his or her case will be reviewed by a judge. Those who are accused of crimes receive far better protection under the law; they are provided with legal counsel and the chance to appear before the judge and often a jury before they are found guilty or innocent and incarcerated. People subjected to involuntary commitment rarely receive such treatment, and almost never get the opportunity to plead their case before a jury of their peers. “Those who have taken the time to investigate have found that judges who hear civil commitment cases without a jury always or almost always automatically and routinely commit everyone doctors recommend for commitment without a real attempt to use their own judgment to determine the appropriateness of the incarceration.”⁵⁹

Involuntary psychiatric commitment deprives people of their liberty to move about freely, to engage in activities of their choosing, and to lead their lives as they see fit. In accordance with the rights guaranteed to all citizens in the U.S. Constitution, such a deprivation of freedom should be preceded by due process of law. However, involuntary commitments are carried out in a way that rarely provides this due process, especially where self-harm is concerned. Mill’s harm principle established that individuals have the right to do as they please with their bodies, provided that they injure no one else in the process, and that the government should not interfere with this. Self-injury is a perfect illustration of a behavior that complies with all the terms of the harm principle, yet those who engage in it are punished for their actions by being confined in mental institutions

⁵⁹ “Do You Have a Right to Jury Trial in Psychiatric Commitment?” The Antipsychiatry Coalition. Available online at <<http://www.antipsychiatry.org/jury.htm>> Also contains a summary of state statutes regarding the right to trial by jury.

against their will, and they are denied their fundamental constitutional rights in the process.

IV.

*It is quite obvious that there is nothing in the world to which every man has a more unassailable title than to his own life and person.*⁶⁰

Although Schopenhauer was referring to suicide in the epigraph to this section, his fundamental point is also applicable to situations of involuntary civil commitment for self-injury. The most basic property which any person possesses is his or her own body. Within this sphere, that person is autonomous and has complete freedom to do as he or she wishes – theoretically. Involuntary commitment laws for self-harm, however, infringe upon this right. The term “self-harm” explains it all; a person makes a conscious decision to inflict harm upon himself. No one else is involved in this decision or is hurt by it

⁶⁰ Schopenhauer, Arthur. “On Suicide.” Available online at <<http://comp.uark.edu/~mpianal/schopenhauer.htm>>

except for the self-injurer, and therefore it should not be a matter of concern for anyone else. Taking away a person's liberty simply because they choose to injure themselves violates the Due Process Clause of the U.S. Constitution.

The Supreme Court has ruled in the past that this clause ensures more than just due process and freedom from actual physical restraints. It also protects the rights to bodily integrity, to marry, to have children, to use contraception, to have an abortion, and to refuse unwanted medical treatment, even if it would save the person's life. However, the Court is very careful whenever it considers expanding the protection of the due process clause to new subjects. "By extending constitutional protection to an asserted right or liberty interest, we, to a great extent, place the matter outside the arena of public debate and legislative action" and so the justices must be cautious that their own biases and preferences do not influence their decisions.⁶¹ This, combined with public opinion on civil commitment following such highly publicized incidents such as the one involving Kendra Webdale, may contribute to the fact that the Court's last significant decision on involuntary psychiatric commitment was in 1975, with O'Connor v. Donaldson, 422 U.S. 563.⁶²

⁶¹ Washington v. Glucksberg, 521 U.S. 702 (1997) at 721.

⁶² Kendra Webdale was a 32-year-old woman who was pushed into the path of a New York City subway train by 29-year-old Andrew Goldstein on January 3, 1999. Goldstein had been diagnosed as schizophrenic after suffering an alleged psychotic break in 1989 while a student at SUNY-Stony Brook. He spent the next 11 years in and out of psychiatric hospitals while sporadically taking medication. He also had a recorded history of attacking doctors, nurses, and social workers, and was institutionalized in June 1998 after allegedly assaulting a woman on the subway. In November, a few weeks before he pushed Webdale, he sought treatment at Jamaica Hospital but was turned away after assaulting a doctor. Goldstein's mother had also repeatedly sought treatment for her son in a supervised residence, but he was released after three weeks. "Goldstein time after time sought to commit himself to a hospital. He was denied repeatedly and sent away. Goldstein told subway motorman Jacques Louis, 'I'm sick. I need a doctor.' [shortly after pushing Webdale]." Ackerman, Dan. "Goldstein Lawyers Put Mental Healthcare System on Trial." Available online at < <http://dackman.homestead.com/files/GoldsteinTrial.htm>>. This incident and Goldstein's trial resulted in a media frenzy and the passage of "Kendra's Law," which established forced outpatient commitment for those with so-called severe mental illness and a history of treatment refusal.

The Supreme Court uses a two-pronged test when determining whether an alleged right falls under the protection of the Due Process Clause. First, any prospective right must be “so rooted in the traditions and conscience of our people as to be ranked as fundamental”⁶³ and must be so deeply embedded in the cultural and common-law traditions of the United States that “neither liberty nor justice would exist if they were sacrificed.”⁶⁴ Second, the potential right in any substantive due process case must be carefully and completely described, as established in Reno v. Flores, 507 U.S. 292 (1993), Collins v. Harker Heights, 503 U.S. 115 (1992), and Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990). Significant precedent exists to support the Court’s use of this two-pronged test when examining the constitutionality of involuntary psychiatric commitment.

O’Connor v. Donaldson remains the seminal case on involuntary psychiatric commitment in the United States. It involves an action brought by Kenneth Donaldson, a mental patient at the Florida State Hospital in Chattahoochee, against the hospital’s superintendent, Dr. J.B. O’Connor. Donaldson was civilly committed in January of 1957 and remained in custody against his will until he filed this lawsuit in February of 1971. “Throughout his confinement Donaldson repeatedly, but unsuccessfully, demanded his release, claiming that he was dangerous to no one, that he was not mentally ill, and that, at any rate, the hospital was not providing treatment for his supposed illness.”⁶⁵ His initial suit was brought in the United States District Court for the Northern District of Florida and alleged “that O’Connor, and other members of the hospital staff named as defendants, had intentionally and maliciously deprived him of his constitutional right to

⁶³ Snyder v. Massachusetts, 291 U.S. 97 (1934) at 105.

⁶⁴ Palko v. Connecticut, 302 U.S. 319 (1937) at 325-326.

⁶⁵ O’Connor v. Donaldson at 566.

liberty.”⁶⁶ The jury assessed both compensatory and punitive damages against O’Connor, a judgment that was affirmed by the Court of Appeals for the Fifth Circuit. The Supreme Court granted O’Connor’s certiorari petition “because of the important constitutional questions seemingly presented.”⁶⁷

Donaldson was initially committed by his father, who felt that his son was delusional. A county judge in Pinellas County, Florida conducted hearings, and it was eventually decided that Donaldson suffered from paranoid schizophrenia. He was then

committed for ‘care, maintenance, and treatment’ pursuant to Florida statutory provisions that have since been repealed. The state law was less than clear in specifying the grounds necessary for commitment...[this is], however, irrelevant, for this case involves no challenge to the initial commitment, but is focused, instead, upon the nearly 15 years of confinement that followed.⁶⁸

During the trial, the evidence clearly demonstrated, without challenge, that Donaldson at no point in either his life or his hospitalization posed a danger to others; both O’Connor and his codefendants admitted that they had never witnessed Donaldson commit a dangerous act and that he could have earned a living and cared for himself outside the hospital. Additionally, “the hospital staff had the power to release a patient, not dangerous to himself or others, even if he remained mentally ill and had been lawfully committed.”⁶⁹ O’Connor repeatedly denied this power in Donaldson’s case, claiming that he felt Donaldson could not have made a “successful adjustment” to life outside the hospital, a fact contradicted by the testimony cited above.

In addition to Donaldson’s frequent requests for his own release, the hospital was also contacted numerous times by outside parties on his behalf. In 1963, “a representative

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ O’Connor v. Donaldson at 567-568.

⁶⁹ Ibid. at 568.

of Helping Hands, Inc., a halfway house for mental patients, wrote O'Connor asking him to release Donaldson to its care...O'Connor rejected the offer, replying that Donaldson could be released only to his parents. That rule was apparently of O'Connor's own making."⁷⁰ Donaldson was 55 years old at this point, and his parents were far too elderly and unwell to assume responsibility for him, a fact that O'Connor was well aware of. Furthermore, although O'Connor maintained correspondence with Donaldson's parents to keep them informed on their son's treatment, he never mentioned the Helping Hands offer. Also, "on four separate occasions between 1964 and 1968, John Lembcke, a college classmate of Donaldson's and a longtime family friend, asked O'Connor to release Donaldson to his care. On each occasion O'Connor refused."⁷¹

Overwhelmingly, the evidence in this case demonstrated that

Donaldson's confinement was a simple regime of enforced custodial care, not a program designed to alleviate or cure his supposed illness...O'Connor described Donaldson's treatment as 'milieu therapy.' But...in the context of this case, 'milieu therapy' was a euphemism for confinement in the 'milieu' of a mental hospital.⁷²

O'Connor's defense was that he believed he had been following a valid state law permitting "indefinite custodial confinement of the 'sick,' even if they were not given treatment and their release could harm no one."⁷³

In the Supreme Court's view, the Court of Appeals dealt sufficiently with many of the legal issues presented in the case's early forms, so that they were left with "a single, relatively simple, but nonetheless important question concerning every man's

⁷⁰ Ibid. at 569.

⁷¹ O'Connor v. Donaldson at 570.

⁷² Ibid.

⁷³ Ibid. at 571.

constitutional right to liberty.”⁷⁴ They held that a state may not, in accordance with the Constitution, confine a nondangerous person who is able to survive outside an institution either alone or with the help of willing caretakers. “A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely...assuming that the term can be given a reasonably precise content and that the ‘mentally ill’ can be identified with reasonable accuracy, there is still no constitutional basis for [confinement].”⁷⁵ The Court also held that, although the state has a reasonable interest in assisting the “unfortunate,” a diagnosis of mental illness and the desire to raise a person’s living standards are not adequate grounds for denial of freedom to those who can survive safely without being incarcerated.

This decision has been interpreted by some lawyers and lower courts as combining the police power and the *parens patriae* power discussed in the pervious section. The Court’s holding that a “nondangerous” person may not be confined indefinitely “has been interpreted, or perhaps misinterpreted, by certain lawyers and courts as a constitutional requirement that in every case of involuntary civil commitment, the patient must be proved...a danger to someone else or himself.”⁷⁶ If this were indeed what the Court actually meant, the *parens patriae* power would be greatly undermined, if not completely eliminated. Some scholars argue that, since the Supreme Court has never before challenged the government’s power to care for those it deems incompetent, this conclusion must be false.

The literal definition of *parens patriae* is “parent of his country,” referring to the power of the state to act on behalf of certain people. There are three conditions under

⁷⁴ *Ibid.* at 574.

⁷⁵ *Ibid.* at 576.

⁷⁶ Stavis.

which treatment without consent is acceptable and in which the state may legitimately assume the role of the parent, in the context of literal diseases such as pneumonia or leukemia. These include: when the patient is literally unconscious and thus incapable of giving or refusing consent; when the patient is a child, and assumed to lack the capacity to fully comprehend the consequences of refusing treatment; and when the patient is highly contagious and therefore dangerous to others, who might contract the disease from the patient without engaging in contact.

Extended to encompass the theory of mental illness, there are three analogous conditions which are used to justify the involuntary commitment of an adult. The first of these occurs when a person is said to be lacking insight into his or her illness, a situation of metaphorical unconsciousness. An adult who acts childish and seems neither willing nor able to care for him- or herself in a manner that society deems sufficient may also be institutionalized. The final condition involves metaphorical contagion; the patient is judged to be a danger to others or to him- or herself.⁷⁷ Essentially, involuntary commitment enables the state to arrest and hold those who it believes may potentially perpetrate a crime, before any crime has committed and without any concrete evidence. This is accomplished through mental hospitalization and psychological treatment, rather than through the criminal justice system

The standard of proof currently used for involuntary civil commitment was established in 1979 with the Supreme Court's decision in Addington v. Texas, 441 U.S. 418. This case involved a man, Addington, whose mother attempted to have him committed against his will after he was arrested for threatening her. He had previously

⁷⁷ Schaler, Jeffrey. Class lecture. Deprivation of Liberty. American University, Washington D.C. 28 August 2002.

been temporarily hospitalized on seven separate occasions between 1969 and 1975, and had been committed indefinitely to Austin State Hospital three times. While the man was in police custody following his arrest, he was interviewed by a psychiatric examiner, who then issued a Certificate of Medical Examination for Mental Illness recommending that Addington be hospitalized. Addington objected to this conclusion and retained counsel to challenge the statutory provisions allowing for his involuntary commitment.

The state of Texas provided evidence that Addington “suffered from serious delusions, that he often had threatened to injure both of his parents and others, that he had been involved in several assaultive episodes while hospitalized, and that he had caused substantial property damage both at his own apartment and at his parents’ home.”⁷⁸ On the basis of these facts, two psychiatrists opined that Addington suffered from psychotic schizophrenia with paranoid tendencies and that he was “probably dangerous to himself and others.”⁷⁹ Addington did not dispute the evidence and in fact agreed that he was mentally ill. Instead, what he intended to prove was that no substantial basis existed for the conclusions made about his dangerousness, either to himself or others.

The jury in the trial court ruled that Addington was indeed mentally ill and required hospitalization, and issued an order committing him to Austin State Hospital yet again. He appealed to the Texas Court of Civil Appeals, “arguing, among other things, that the standards for commitment violated his substantive due process rights and that any standard of proof for commitment less than that required for criminal convictions, i.e., beyond a reasonable doubt⁸⁰, violated his procedural due process rights.” The Court of Civil Appeals agreed with this assessment and reversed the trial court’s ruling, while the

⁷⁸ Addington v. Texas, 441 U.S. 418 (1979) at 420-421.

⁷⁹ Ibid. at 421.

⁸⁰ Ibid. at 422-423.

Texas Supreme Court, on appeal, reversed the appeals court's decision. The Texas Supreme Court "declined to adopt the criminal law standard of 'beyond a reasonable doubt' primarily because it questioned whether the State could prove by that exacting standard that a particular person would or would not be dangerous in the future" and ruled that a "preponderance of the evidence" standard in civil commitment cases was sufficient to satisfy the requirements of due process.⁸¹ The United States Supreme Court ruled that no appeal was warranted in this case and so dismissed that aspect of the case, but assumed that the papers filed counted as a writ of certiorari and decided to grant the petition.

The Supreme Court reaffirmed the existence of three separate levels of proof used in different types of cases. The most lenient standard, preponderance of the evidence, is typically applied in civil cases, such as those involving a dispute over money between two private parties. "Since society has a minimal concern with the outcome of such private suits, plaintiff's burden of proof is a mere preponderance of the evidence. The litigants thus share the risk of error in roughly equal fashion."⁸² This is the standard of proof which the Texas Supreme Court held adequate to guarantee due process in civil commitment proceedings.

At the opposite end of the spectrum lies the standard of evidence imposed in criminal cases. In such instances, "the interests of the defendant are of such magnitude that historically and without any explicit constitutional requirement they have been protected by standards of proof designed to exclude as nearly as possible the likelihood of

⁸¹ Ibid. at 423.

⁸² Addington v. Texas at 424.

an erroneous judgment.”⁸³ This standard calls for the evidence to prove the defendant’s guilt beyond a reasonable doubt, and imposes the entire burden of proof upon the prosecution.

The more moderate standard has no clear-cut definition and no real name either. It is sometimes referred to as the “clear, unequivocal, and convincing” standard and tends to be used in civil cases involving quasi-criminal offenses. “The interests at stake in [such] cases are deemed to be more substantial than mere loss of money and some jurisdictions accordingly reduce the risk to the defendant of having his reputation tarnished erroneously by increasing the plaintiff’s burden of proof.”⁸⁴ Generally, this standard is applied in civil cases where interests judged to be especially important are at stake, such as denaturalization and deportation.

In deciding the appropriate standard of proof to employ in civil commitment cases, the Supreme Court had to strike a balance between the individual’s interest in freedom and not being committed versus the state’s desire to hospitalize those it feels would benefit from it, all while keeping in mind the need to minimize the risk of incorrect decisions. The Court acknowledged that

civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection...[however,]the state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.⁸⁵

Since the preponderance of the evidence standard advocated by the Texas court could potentially increase the chances of wrongful commitment and thus serve the interests of

⁸³ Ibid.

⁸⁴ Addington v. Texas at 425.

⁸⁵ Ibid. at 426-427.

neither the individual nor the state, the benefits of applying this standard of proof were unclear to the Supreme Court. Therefore, “the individual’s interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence.”⁸⁶

Addington petitioned the Court to adopt the “beyond a reasonable doubt” standard, arguing that the loss of liberty and stigma attached to incarceration in a mental institution are equal to those that go along with imprisonment. The Court declined to accept this rationale for several reasons. The first of these concerns the historical application of this standard. “This unique standard of proof, not prescribed or defined in the Constitution, is regarded as a critical part of the ‘moral force of the criminal law’ and we should hesitate to apply it too broadly or casually in noncriminal cases.”⁸⁷ The Court also felt that in civil commitment cases, the ultimate goal is treatment rather than punishment, and so the same standard of proof is not required.

In addition, the liberty interest at stake in civil commitment is not as great as that in a criminal case and neither is the risk of erroneous incarceration, according to the Court.

The heavy standard applied in criminal cases manifests our concern that the risk of error to the individual must be minimized even at the risk that some who are guilty might go free. The full force of that idea does not apply to a civil commitment. It may be true that an erroneous commitment is sometimes as undesirable as an erroneous conviction. However...the layers of professional review and observation of the patient’s condition, and the concern of family and friends generally will provide continuous opportunities for an erroneous commitment to be corrected.⁸⁸

⁸⁶ Ibid. at 428.

⁸⁷ Addington v. Texas at 429.

⁸⁸ Ibid. at 429-430.

The Court also declared that those who are diagnosed as mentally ill are neither totally free of stigma or at liberty, due to their so-called disease.

Finally, the Supreme Court held that the different factual aspects in a criminal case as opposed to one dealing with mental illness preclude the application of the most stringent standard of proof to civil commitment cases. In a criminal case, the dispute centers on the facts themselves, while a commitment case revolves around the meaning of the facts presented. The evidence in criminal proceedings consists of specific, empirical facts, but civil commitments are based on psychiatric diagnoses. “The subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations...within the medical discipline, the traditional standard for ‘factfinding’ is a ‘reasonable medical certainty.’”⁸⁹ This standard provides a compromise between what can be proven and what safeguards individual rights, since the state should not be “required to employ a standard of proof that may completely undercut its efforts to further the legitimate interests of both the state and the patient that are served by civil commitments.”⁹⁰

Since the “beyond a reasonable doubt” standard was deemed too stringent for civil commitment cases and the “preponderance of the evidence” standard not stringent enough, the Supreme Court concluded by process of elimination that the intermediate standard of evidence was the appropriate one to apply in such cases. This standard may be “clear and convincing” or “clear, unequivocal, and convincing,” depending on the preference of the state enacting the statute. The only requirements imposed by the Supreme Court are that “to meet due process demands, the standard [of proof] has to

⁸⁹ Addington v. Texas at 431.

⁹⁰ Ibid. at 431.

inform the factfinder that the proof must be greater than the preponderance-of-the-evidence standard applicable to other categories of civil cases.”⁹¹ Thus, states must neither apply the “beyond a reasonable doubt” standard nor include the term “unequivocal” in their standards.

The Supreme Court’s reasoning concerning psychiatric commitment as opposed to incarceration in a correctional facility seems slightly flawed. First, the Court assumes that mental hospitalization is not punitive. It may not be intended as such, but for many people it certainly proves to be more of a punishment than a treatment. There are also far more similarities between mental hospitals and prisons than the Court acknowledges, as noted in the discussion of Goffman’s work in the introduction to this paper. The Court also takes for granted that, in cases of erroneous commitment, patients will have family and friends to check up on them, and that the system will function properly so that checkups and observations will occur as they should, and the patient will eventually be released. The case of O’Connor v. Donaldson discussed earlier proves that none of these assumptions are necessarily true; this suggests that perhaps the Court should not rely so heavily on them when making decisions about involuntary commitment.

In cases of self-injury, there is neither the clear nor convincing evidence necessitated that those who engage in such behavior are a danger to themselves, to others, or in need of any sort of treatment. Self-injurers harm only themselves, and their psychopathology implies that they are strongly disinclined to ever injure others in any way. They may desire treatment if they no longer feel that self-injury is an appropriate coping mechanism for them, but they by no means require it. Self-injurers are also not a

⁹¹ Ibid. at 433-434.

danger to themselves; they are not suicidal, and the overwhelming majority do not sustain life-threatening injuries from their actions.

The Supreme Court has established that adult citizens of the United States have a general right of “self-sovereignty” and a right of autonomy over their own bodies with their decisions in Planned Parenthood v. Casey, 505 U.S. 833 (1992) and Cruzan. In Casey, the Supreme Court reaffirmed its Roe v. Wade decision concerning abortion; they held that women have the right to have abortions before the fetus is viable, without unnecessary government interference, and that the state has a legitimate interest throughout pregnancy in protecting women’s health and the lives of their unborn children as well. They noted that the Due Process Clause protects specific rights and “personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education” which are some of “the most intimate and personal choices a person may make in a lifetime.”⁹²

The Cruzan case concerned a woman who had received severe injuries in a car accident which left her in a permanent vegetative state and whether she “had a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment.”⁹³ According to the common law, even touching another person without consent qualifies as battery; in addition, any medical treatment usually requires informed consent from the person to be treated. The Court interpreted the requirement of informed consent to mean that people have a right to refuse medical treatment, even if it would save their lives. Their decision in this case was based largely on the common-law

⁹² Planned Parenthood v. Casey at 851.

⁹³ Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990) at 269.

tradition that forced medication constituted battery, and the legal history protecting the right to refuse unwanted treatment.

These cases combined to create a right to bodily integrity. Adults may have abortions, use birth control, refuse feeding tubes, and bear children with a partner of their own choosing. All these activities fall under the protection of the 14th Amendment's Due Process Clause and have met the requirements of the Supreme Court's two-pronged test. Self-injury should be treated no differently. The established right to bodily integrity encompasses the right to harm oneself, since such behavior involves no one but the person taking part in it, and also causes direct physical harm to no one but that person. Therefore, the right to engage in self-injury without fear of involuntary psychiatric commitment is a constitutionally protected right, since it is directly related to a right already established as a protected liberty interest under the Due Process Clause. In Casey, the Court stated that "at the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of personhood."⁹⁴ Self-injury is an integral part of these definitions for some people, and thus they deserve the right to engage in it free from the fear of repercussions.

⁹⁴ Planned Parenthood v. Casey at 851.

V.

*It wasn't a suicide attempt. It was an escape from everything awful. When we cut, we're in control – we make our own pain, and we can stop it whenever we want. Physical pain relieves mental anguish. For a brief moment, the pain of the cutting is the only thing in the cutter's mind, and when that stops and the other comes back, it's weaker. Drugs do that too, and sex, but not like cutting. Nothing is like cutting.*⁹⁵

The adjectives used by the general population to describe the phenomenon of self-injury are overwhelmingly negative in character: crazy, insane, disgusting, bizarre, mentally ill, attention-seeking, psychotic, grotesque, repulsive, and suicidal are just a few

⁹⁵ Stoehr, Shelley. *Crosses*. New York: Doubleday, 1991. p. 27.

of the most common. The popular perception, however, disguises the fact that, for those who engage in self-harming behavior, these acts are almost always positive in nature.

‘Cutters’ are people who use their own skin to change their moods, to achieve a little-understood state of psychological awareness through intense pain, and to communicate a message that until recently has seemed indecipherable...they hurt themselves not really to inflict pain by, astonishingly enough, to *relieve* themselves of pain – to soothe themselves and purge their inner demons through a kind of ritual mortification of the flesh. Rather than a suicidal gesture, cutting is a symbol of the fight to stay alive.⁹⁶

Self-injury is an affirmation of life and a coping mechanism for dealing with unpleasant or overpowering emotions or environments, not a death wish.

The rise of the public health movement in the United States, however, has brought a disturbing new trend along with it. Many forms of socially deviant behavior, including self-injury, are being classified as mental illnesses. This forces those who engage in self-harm to assume the role of patients who can then be cured by a doctor, whether they consent to such treatment or not. Involuntary psychiatric commitment for self-injury represents the apotheosis of this phenomenon; adults who are exercising their right to personal autonomy are coerced into psychiatric treatment because their behavior is not socially acceptable. This involuntary treatment is presented as beneficial and as being in the person’s best interest, but in reality, it deprives those who are subjected to it of their constitutional rights and liberties, takes away their responsibility, and stigmatizes them as crazy or psychotic.

The first recorded instance of self-injury in literature comes from the New Testament of the Bible, in the Gospel of Mark. Throughout history, self-injury has occurred in many cultures, in many different contexts. It is not until the past few decades, however, that people have been punished for it by means of involuntary psychiatric

⁹⁶ Strong pp. xvii, 18.

commitment. Self-injury “has been largely ignored or misdiagnosed for all but the past few decades [and] it is little understood even by most mental health professionals,” despite a recent surge of interest in it as a topic of psychological research.⁹⁷

A phone call to a major psychiatric hospital in Washington, D.C. revealed that this institute will commit those who admit to harming themselves, whether they desire such commitment or not, and this incarceration will take place with none of what the law has recognized as due process. In the name of medical treatment, an individual may be deprived of his or her liberty and constitutional rights, without consent and even without being ill, simply because his or her actions flout social norms. The rights contained in the United States Constitution are guaranteed to all adult citizens, not only to those whose behavior is socially acceptable. Self-injury is neither a mental illness nor a disease nor anything of the kind; it is simply a coping mechanism. To deprive individuals of their liberty for engaging in self-injury is to deny them their constitutional rights, most egregiously the right to the due process that should occur before such commitment may take place.

⁹⁷ Strong p. xvii.

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