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Trauma From Involuntary Hospitalization and Impact on Mental Illness Management

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Involuntary admission and treatment are methods used to deliver safe and effective care against a patient's will and prevent adverse outcomes in those with mental illness who may be a danger to oneself or others. These modalities are justified on the basis of rationale such as the person involved is thought to be incapable of making rational decisions about treatment, the person involved will appreciate the intervention once symptoms abate, coercive measures are effective, and risk assessment of danger to oneself or others is reliable and valid.[1] However, these arguments are now being challenged by studies[2–4] showing that patients suffering from mental illness have decision-making capacity in most instances, and it is unknown whether these risk assessments are beneficial.[5]

Valenti et al[6] examined the principles that are important to patients during involuntary treatment and found that patients value freedom of choice and the feeling of being safe in the hospital, as well as nonpaternalistic and respectful behavior from the staff. Therefore, it is imperative for the staff to be familiar with the values of patients with illnesses resulting in frequent rehospitalizations so that they can be incorporated into treatment. This incorporation of values may promote better engagement of patients with the treatment plan and prevent repeat hospitalizations.

From an ethical standpoint, use of involuntary admission and treatment revolves around the core principle of respect for autonomy. It means that patients should not be manipulated or coerced into treatment if they are capable of making autonomous decisions about their care. However, coercive measures such as compliance to medication as a discharge criterion are often used in mental health care. These measures violate the patient's freedom of choice and are against the individual's liberty and autonomy and can be deemed as a humiliating and even traumatic experience.[7,8] One cannot assume that the status of a person who has been hospitalized against their will coincides with complete loss of self-determination. These individuals have a right of decisional freedom and autonomy, which is also emphasized in the United Nations Convention on the rights of persons with disabilities.[9] However, a Norwegian study[10] examined clinicians' interpretation of criteria for involuntary commitment and found that they often have a paternalistic perspective and that patients were assumed to lack decision-making capacity. The decision for involuntary treatment was also influenced by several extra-legislative factors such as patients' functioning, experience, resistance, networks, and follow-up options.[10] A Swedish study[11] examined the ethical issues related to involuntary treatment by interviewing a Swedish psychiatrist and found that although involuntary treatment was in line with the Swedish laws, it also left room for individual judgments when making decisions about involuntary treatment. The psychiatrist focused on the consequences of involuntary treatment and weighed risk of harm to the therapeutic alliance against assumed good consequences of ensuring that patients received needed treatment.[11]

This case report investigates the impact of involuntary hospitalization on the treatment of mental illness in a patient who endured trauma during a previous involuntary admission in her home country. We discuss the barriers to care and methods used to reform a therapeutic alliance and ensure compliance with medication.

Case Report

Ms A was a 37-year-old woman who was transferred to the psychiatric inpatient unit from the medical unit where she had been admitted for hypoglycemia with unknown psychiatric history. She was initially admitted under a false identity, which was discovered later when her parents were interviewed.

During the initial days of presentation, Ms A was noted to refuse food and medications, stating that she was fasting and waiting to meet her "Messiah" who told her not to eat. Her urine toxicology result was positive for cannabis. She had previously left her home, had subsequently become homeless for the first time, and had started living in a shelter but was

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Prim Care Companion CNS Disord 2022;24(4):21cr03122

To cite: Sareen A, Mitra S, Wadhwa A, et al. Trauma from involuntary hospitalization and impact on mental illness management. *Prim Care Companion CNS Disord.* 2022;24(4):21cr03122.

To share: https://doi.org/10.4088/PCC.21cr03122

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disturbed by the living circumstances, especially the presence of the LGBTQ community, which she felt "conflicted" with her values of following Judaism.

The patient was engaged in regular interviews, and psychoeducation and counseling were provided about the need to eat and the importance of medication. Initially, she was very guarded and would not allow the treatment team to gather any collateral information, although she eventually provided consent for the treatment team to involve her boyfriend and parents in the treatment planning. A family meeting was held on the unit, which revealed her true identity. She was a musician who had performed internationally. Ms A eventually became more cooperative and better engaged with the treatment team. She was noted to be more forthcoming about her clinical history and reported previous hospitalization in her home country. She stated that she was treated on the psychiatric inpatient unit against her will with involuntary administration of medications. She was treated with haloperidol, which had led to severe dystonic reactions. Given these traumatic experiences, she avoided psychiatric treatment in the United States.

Ms A was provided supportive therapy for her trauma and was encouraged to take her medication. She gradually demonstrated insight into her diagnosis and about the need to take her medication. As she was a musician, she was concerned about the common belief that psychiatric medications could impact her creativity in a negative way. Thus, she was provided evidence of studies that disproved these assumptions and was motivated to take the medication. She was discharged with outpatient follow-up at a clinic and by our mobile crisis team.

Discussion

Historically, treatment of individuals with mental illness transitioned from indefinite commitment to deinstitutionalization in the 1960s. In 1963, President Kennedy signed an act to facilitate the transition from asylums to community mental health centers.[12] Subsequently, the judicial system evolved from a depository of power over the custody of the mentally ill to a guarantor of their rights. Since then, there has been a shift toward deinstitutionalization, which involves moving the patients from hospitals to less restrictive settings in the community. However, people with mental illness are detained in prisons far more frequently in the United States compared to other countries, and, thus, the prison has become a substitute for the "mental health asylum."[13]

The law of the Russian Federation "On Psychiatric Care and Guarantees of Citizens' Rights During Its Provision" is the legal act that regulates psychiatric care in Russia. As per the law, a mentally disturbed individual may be hospitalized in a psychiatric hospital against his/her will or the will of his/her legal representative and without a court decision having been taken if the individual's examination or treatment can only be carried out by inpatient care and the mental disorder is severe enough to give rise to (1) a direct danger to the person or to others or (2) the individual's helplessness (ie, an inability to take care of himself) or (3) a significant impairment in health as a result of a deteriorating mental condition if the affected person were to be left without psychiatric care.[14] However, failure to monitor compliance with mental health law is not exercised, leading to gross violations of involuntary psychiatric examinations, involuntary hospitalization, involuntary treatments, and the hospitalization of patients for indefinite periods of time.[15]

Similarly, the People's Republic of China is infamous for its political abuses of psychiatry. The abuses there are more extensive and involve the incarceration of followers of the Falun Gong movement, trade union activists, human rights workers and "petitioners," and people complaining about injustices by local authorities.[16] The new mental health law does not give involuntary patients the right to refuse treatment.[17] The duration of the involuntary treatment is not specified, and there are no set intervals for reevaluation. There is no form of mandatory outpatient treatment specified in the law, so it is not possible to require treatment in the "least restrictive environment."

Involuntary treatment is concerning due to the breach of the self-determination principle and the risk of a breakdown in the therapeutic relationship, as at the onset, there is often an environment of hostility and confrontation. Since mental illness is the only area in which refusal of treatment is often identified as the symptom of the disease itself, one needs to have a more comprehensive view of the patient's decisional capacity and the need for such treatment. Individuals subjected to such treatment often have a sense of loss of power and autonomy, as well as a feeling of loss of dignity and self-respect.[18]

However, empowering patients in making their own health care decisions, with support by the legal framework of the country, can lead to substantial benefits such as increased adherence, clinical stability, and prevention of relapsing illness.[19] Therapeutic alliance building, empowerment of patients, and a collaborative treatment plan may form the cornerstones of a successful inpatient stay.

Our case is important from the standpoint that timely, routine, scheduled interviews and sessions with Ms A with a nonjudgmental and patient-centered interview technique encouraged her to consider treatment. She was very guarded at the beginning, but with regular sessions, came to inform the team about her true identity, fear of medication affecting her creativity, history of traumatic hospitalization, and barriers in maintaining medication compliance. Each question was addressed in an empathetic and informed manner, she was always encouraged to bring up any new questions, and a collaborative and autonomy-driven discharge plan was developed with the patient.

Our study also highlights a unique aspect of creative individuals, especially those who pursue creative arts professionally, who find that they are most creative when they are in an acute episode of hypomania. These patients try to avoid treatment, as they fear that they will lose their creativity. However, studies[20] have demonstrated evidence to the contrary. It is also important to help patients understand

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that although they may find their creative niche in a hypomanic phase, it is difficult to prevent that situation from becoming a full-blown manic episode.

Conclusion

In conclusion, the team would like to reinforce that although involuntary hospitalization does exist for patients with mental health illness, a supportive and collaborative treatment plan that empowers the patient and encourages patient autonomy may pave the way to ensure greater medication compliance and fewer readmissions.

Published online: August 9, 2022.

Relevant financial relationships: None.

Funding/support: None.

Patient consent: Consent was received from the patient to publish the case report, and information has been de-identified to protect anonymity.

REFERENCES

1. Feiring E, Ugstad KN. Interpretations of legal criteria for involuntary psychiatric admission: a qualitative analysis. *BMC Health Serv Res*. 2014;14(1):500.
2. Owen GS, Szmukler G, Richardson G, et al. Decision-making capacity for treatment in psychiatric and medical in-patients: cross-sectional, comparative study. *Br J Psychiatry*. 2013;203(6):461–467.
3. Okai D, Owen G, McGuire H, et al. Mental capacity in psychiatric patients: systematic review. *Br J Psychiatry*. 2007;191(4):291–297.
4. Lepping P. Overestimating patients' capacity. *Br J Psychiatry*. 2011;199(5):355–356.
5. Singh JP, Fazel S, Gueorguieva R, et al. Rates of violence in patients classified as high risk by structured risk assessment instruments. *Br J Psychiatry*. 2014;204(3):180–187.
6. Valenti E, Giacco D, Katasakou C, et al. Which values are important for patients during involuntary treatment? a qualitative study with psychiatric inpatients. *J Med Ethics*. 2014;40(12):832–836.
7. Sibitz I, Scheutz A, Lakeman R, et al. Impact of coercive measures on life stories: qualitative study. *Br J Psychiatry*. 2011;199(3):239–244.
8. Kogstad RE. Protecting mental health clients' dignity: the importance of legal control. *Int J Law Psychiatry*. 2009;32(6):383–391.
9. Mandarelli G, Tatarelli R, Ferracuti S, et al. Il consenso informato e il trattamento sanitario obbligatorio. *Nóos*. 2012;18(1):43–56.
10. Feiring E, Ugstad KN. Interpretations of legal criteria for involuntary psychiatric admission: a qualitative analysis. *BMC Health Serv Res*. 2014;14(1):500.
11. Sjöstrand M, Sandman L, Karlsson P, et al. Ethical deliberations about involuntary treatment: interviews with Swedish psychiatrists. *BMC Med Ethics*. 2015;16(1):37.
12. Testa M, West SG. Civil commitment in the United States. *Psychiatry (Edgmont)*. 2010;7(10):30–40.
13. Williams AR. Opportunities in reform: bioethics and mental health ethics. *Bioethics*. 2016;30(4):221–226.
14. Sakharova O, Gurovich I, Wahlbeck K. *Mental Health Care Indicators in Russia: A Study of the Availability of European Indicators for the MINDFUL Project*. Helsinki: STAKES; 2007:116.
15. Gushansky E. Preface. In: Prokopenko A. *Mad Psychiatry. Punitive Psychiatry*. Moscow/Minsk, Russia; 2005:35.
16. Munro R. Judicial psychiatry in China and its political abuses. *Columbia. J Asian Law*. 2000;14:1.
17. Phillips MR, Chen H, Diesfeld K, et al. China's new mental health law: reframing involuntary treatment. *Am J Psychiatry*. 2013;170(6):588–591.
18. Chambers M, Gallagher A, Borschmann R, et al. The experiences of detained mental health service users: issues of dignity in care. *BMC Med Ethics*. 2014;15(1):50.
19. Hotzy F, Jaeger M. Clinical relevance of informal coercion in psychiatric treatment: a systematic review. *Front Psychiatry*. 2016;7:197.
20. Cruz TND, Camelo EM, Nardi AE, et al. Creativity in bipolar disorder: a systematic review [published online ahead of print July 20, 2021]. *Trends Psychiatry Psychother*. 2021.

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