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THE LEARNER'S VOICE

A Dilemma in Coercively Treating a Patient

Alison Liss[1]

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In my second year of training, I was on an overnight call in our psychiatric emergency department when a man presented involuntarily following a suicide attempt. He was uncooperative in triage, insisting that he wanted to leave. After the intern and I spent half an hour trying to convince him to go through the triage process, I activated a behavioral emergency. When the behavioral techs arrived, they also attempted to talk him into cooperating with the triage process, and when he would not, they tried to walk him to the quiet room in the back. But he refused to walk with them, and ultimately, the techs carried him to the quiet room where he was chemically restrained. As he was being carried to the back, he cried for his mother. For weeks, this haunted me — his cries of "Mommy!" reminded me of George Floyd, who called for his mother with his last breaths. I have spoken about the incident with multiple supervisors and in my personal psychotherapy, but I cannot reconcile my actions with my personal commitment to anti-oppressive, anti-carceral movements.

In the introduction to their book *Liberatory Psychiatry: Philosophy, Politics, and Mental Health*, Drs. Carl I. Cohen and Sami Timimi note that "psychiatry can help people to be both 'free from' and 'free to'" [1]. By this, they mean that we as psychiatrists can not only help people escape their mental anguish, but can also empower and encourage people's autonomy, growth, and self-determination. I believe that we as psychiatrists are in a unique position to enable people to live lives that are not merely symptom-free but rich, meaningful, and satisfying. Indeed, in my classes at the local psychoanalytic institute, the latter is seen as the primary goal of treatment, and the lessening of symptomology is a happy by-product. But how can someone be "free to" when they are tied to a hospital bed? How can they retain their right to self-determination when they are hospitalized involuntarily?

I am white, and in the past fifteen years with the police murders of Sean Bell, Michael Brown, Eric Garner, Tamir Rice, Breonna Taylor, and too many others, I have become acutely aware of the dangers of the criminal justice system. Yet I joined a profession in which, as in the criminal justice system, I have the legal right to detain and restrain individuals. This weighs heavily on me, especially given that the majority of patients I treat are people of color. So why do I continue to work in psychiatry?

In part, it is because I have seen the benefits of involuntary hospitalization in certain circumstances. I have seen the person with mania, spending away her life savings, who is immensely grateful at the end of her hospitalization after being stabilized despite protesting forcefully while acutely ill. Or the person with psychosis, unable to care for himself independently, who is discharged with a new case manager and supportive residence. My fear, however, is that the non-therapeutic, trauma-inducing hospitalizations outweigh these success stories. We are all familiar with patients who are caught in a cycle of repeated hospitalizations, who are discharged without a strong plan in place because the resources simply are not there and who later return with the same set of symptoms because they did not have the necessary outpatient support to enable them to be both "free from" and "free to."

Risk factors for involuntary hospitalization include limited contact with outpatient treatment, suggesting that more robust outpatient care options may reduce the need for coercive treatment [2]. The concept of procedural justice, which originated in the legal literature, can also be helpful in conceptualizing what involuntary treatment, when necessary, should look like. Research shows that people perceive that they are being treated more fairly, regardless of the outcome, when they are treated with respect, politeness, and dignity and when their rights are acknowledged [3]. In the psychiatric setting, this is achieved by listening to the patient's wishes, validating their views, and explaining the rationale of decisions. Data show that when patients being

✉ Alison Liss
alison.liss@tuhs.temple.edu

[1] Temple University Hospital, Philadelphia, PA, USA

treated involuntarily believe that they are being afforded procedural justice they have lower levels of perceived coercion and higher levels of satisfaction with their treatment [4]. Satisfaction with treatment is associated with low levels of perceived coercion independent of coercive measures documented in the medical record [5].

Ultimately, the patient who was restrained was hospitalized for several days. Looking back, I do believe the hospitalization was necessary. But was it necessary to activate the behavioral health emergency when he refused to go through triage? I do not know what would have happened had I not. If the behavioral health emergency was not activated, it is possible the patient could have become aggressive and threatened the safety of the staff and milieu. The incident highlights the bind that we as psychiatrists are placed in when called upon to practice this type of psychiatry. To refrain from doing so can threaten the safety of patients, but restraining and involuntarily admitting patients can itself be trauma-inducing for the patient. I doubt I will ever forget this patient because he taught me a hard lesson about my own ideas of what is an acceptable way to practice. As painful as it was and continues to be, this episode is a reminder of my hope for a future of psychiatry where coercive treatment is rare and, when necessary, practiced using the tenets of procedural justice.

Declarations This essay contains a clinical vignette. Identifying details of the patient have been changed to protect their privacy.

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