Forced Into Treatment

The Role of Coercion in Clinical Practice
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Introduction

Conventional wisdom holds that psychiatric treatment must be voluntary to work. It seems obvious that one cannot engage the mind of the unwilling patient. Nevertheless, our clinical experience, supported by the psychiatric literature, contains many examples of successful outcome when treatment was initiated through coercion. Schizophrenic patients have been restored to family and job after involuntary commitment to hospital or outpatient treatment. Sullen adolescents, brought unwillingly by their parents, can become engaged in therapy and emerge able to move forward into the developmental tasks ahead of them. Child molesters, sentenced to treatment as a condition of probation, have used hormonal and behavior therapy to stop their previously uncontrollable actions. When threatened with losing their jobs, alcoholic patients may become successful at maintaining abstinence despite many previous failures. These examples illustrate that the presence of coercion does not necessarily preclude successful treatment.

Webster’s dictionary defines coerce as “to force” or “to compel.” When we attempted to define “voluntary” and “coerced” treatment, we realized that these terms lie at either end of a continuum along which may be found instances containing both coercive and voluntary elements. We have no problem calling the injection of medication into a resisting involuntary patient a coerced treatment. We call it voluntary treatment when a depressed patient seeks therapy to find relief from the inner pain of sadness and inability to enjoy life. But how do we label the treatment offered as a condition of probation to the exasper whose only alternative is going to jail? What about the 50-year-old foreign service officer who seeks treatment because he must demonstrate control over his alcoholism before he can be cleared for overseas duty? Do we call it voluntary or coerced when a woman comes to treatment after her husband threatens to leave unless she stops raging and cutting herself? What if the husband does not threaten to leave, but instead confronts her with the effect of her behavior on their children? There is obviously a degree of coercion in each of these situations.
Situations that can be described as coercive can also be viewed as containing external pressures that strengthen the patient's motivation for treatment. Psychiatrists and mental health professionals are taught to ask why a patient decided to come to treatment at this particular time. Sometimes the cause is purely internal; however, the patient's motivation for treatment has often been increased by some external event. For example, the middle-aged engineer whose job is finally in jeopardy because of his drinking has a powerful motive to pursue abstinence.

There seems to be a kind of embarrassment about situations in which the patient did not enter treatment entirely on his or her own initiative. The idea that forced treatment not only can be successful, but also can sometimes be more successful than voluntary treatment (for example, to retain a job) contradicts the conventional belief that psychiatric treatment must be voluntary to succeed. That position is further jeopardized when we consider that we generally accept the idea that discipline of the young, as by the imposition of external control, is necessary for the development of internal controls and, eventually, freedom and autonomy. This concept is central to the socialization and education of children; the consequences of inadequate or inappropriate discipline are commonly seen in disturbed children.

But what constitutes coercion? When consequences are inflicted to secure compliance? When treatment is sought to end or avoid pain? Is this pain external, such as potential loss of job, spouse, or children, or internal, such as despair, self-hatred, or shame? Is treatment considered voluntary when the patient seeks help with the goal of maintaining or achieving external security rather than pursuing inner change? What degrees of coercion qualify as "forced treatment"? Why is the imposition of external controls in the absence of internal controls considered discipline in children and coercion in adults?

The element of coercion may be found not only in the referral process, but also in the physician-patient contract and in treatment. Just as the referral process may be defined along a continuum between the poles of mandated treatment and self-initiated treatment, the therapeutic process ranges from overly coercive approaches to self-actualizing, growth-promoting approaches. The range covers psychological and biological treatments; individual, group, and family therapy; behavioral, dynamic, supportive, insight-oriented, and hypnotherapy approaches; and milieu and social approaches. An insightful study of the different treatment modalities must note that the chosen treatment for each patient is delivered in a specific clinical setting within a particular context and that these elements may be as relevant in determining outcome as the more specific effects created by the treatment intervention itself (Beavers 1977).

The operative component of psychiatric treatment is often as elusive as it is fascinating. How the identified patient comes to treatment, remains in treatment, and benefits from treatment are intrinsically related and central to understanding the essence of therapy. The use of power in each therapeutic process is definable, legitimate, and necessary; and many astute clinical theorists have compellingly addressed the question of therapeutic power (Frank 1973).

To stimulate further thought, investigation, and discussion of these issues, this report explores coercive aspects of psychiatric intervention from a variety of perspectives. It makes an effort to shed light on the nature of coercion in initiating psychiatric treatments, as well as on its effect on the treatment process and outcome.

The members of this committee are clinicians and/or are in positions of administrative responsibility in dealing with the clinical needs of patients. Thus, we are biased toward the perspective of treating which is treatable in the suffering of mentally ill patients. We recognize, however, that other values exist, are valid and important, and need to be weighed and balanced. Rather than starting the report with an examination of traditional court-ordered treatment, we first introduce three areas of clinical practice in which the issue of coercion is less often considered to provide the reader with a different viewpoint from which to approach court commitment. We end with a discussion of two situations in which the culture itself (i.e., the military and prison environments) is perceived as coercive.

In Chapter 1 we discuss the legitimate role of coercion, power, and authority in socializing children and in enhancing the internalized controls that lead to freedom and autonomy. This chapter includes illustrations demonstrating how the reality of parental pressure is used to engage initially resistant disturbed children in collaborative treatment. In Chapter 2 we describe the use of coercive social pressures, including the threat of job loss, to motivate employees whose substance abuse problems are affecting their job performance to seek help. In Chapter 3 we address the coercion of court-ordered treatment for sex offenders, child abusers, and others who often avoid treatment until they are in trouble with the law.

In Chapters 4 and 5 we examine the more traditional areas of civil commitment and involuntary hospitalization. Included are a historical overview of commitment, a review of the legal basis for involuntary treatment, and a discussion of the impact of the current structure and commitment process on patients and others. In Chapter 6 we describe outpatient commitment, a newer form of coercion where the courts order a patient to receive psychiatric treatment in an outpatient setting. Chapter 7 looks at prisoners, some of whom can be engaged in treatment
that is both needed and beneficial despite the coercive nature of the prison environment. Chapter 8 presents the special aspects of coercion within the authoritarian military environment.

We hope to demonstrate that there are patients who are appropriately forced into treatment and who can move from initial defiance through reluctant compliance to a successful therapeutic alliance and an ultimately successful outcome.

References


Understanding the role of control and power is essential in clinical work with children, who generally must be coerced into psychiatric treatment. Here is an example:

Susie's parents brought her for evaluation against her will (after they suffered through three runaways, each lasting over 48 hours). They had threatened, without effect, to take away her allowance, telephone, weekend activities, and slumber parties with friends. Susie came to the session quietly, but she was furious.

Although legal pressures may dominate the treatment context at times, even routine daily treatment efforts with children immediately and often palpably immerse the clinician in the conundrum of developing therapeutic power, as illustrated in the dilemma of establishing an alliance with Susie.

In practice, the use of power and control is as ubiquitous in the treatment as it is in the parenting of children, so that the implications of power and control may be easily overlooked. Because authority is central to growth and development (as well as to treatment), clinicians trained to work with children quickly learn to appreciate its role.

The Developmental Perspective

Because children need so much from their environment—nurturance and warmth, safety and security, emotional resonance and attunement, limits, structure, education, and socialization—those responsible for
their development need to exercise their authority sensitively and benevolently. The developmental process, the organization and functioning of family systems, the various psychopathologic configurations, and the process of treatment all involve power and authority. Descriptions of family systems and therapy (Beavers 1977; Haley 1965, 1976; Lewis et al. 1976; Minuchin 1974; Selvini-Palazzoli et al. 1978) address power, limits, and boundaries; and psychopathology, especially when viewed as developmental arrest or regression, can be described as a disorder of power or control. Therapeutic endeavors always demand consideration of limits, control, and safety, especially with dangerously out-of-control adolescents. Collaborative work with parents often aims at providing children with what they require at various developmental levels in terms of structure and limits.

The initial request for treatment, the early formation of an alliance, and even the logistics of subsequent sessions rest substantially with parents or guardians, who may impose their desires on the child to obtain treatment. Rarely is this imposition questioned or viewed as disturbing in early phases of treatment. Although forcing a child to attend an assessment often results in a tense interaction, getting the child to treatment is the parent’s responsibility, and such pressures are validated by professionals. As treatment continues, however, clinicians do well to reevaluate any continued need for the parents to coerce the child to attend sessions. Understanding such a need can be fruitful in generating a clinical formulation that allows the development of more effective therapeutic leverage. Despite its potential value as grist for the therapeutic mill, the need for continued coercion is also a troublesome clinical dilemma. Coercion, persuasion, suggestion, and direction are legitimate dimensions of both parenting and treatment, but they require careful scrutiny, and their use demands that the clinician be scrupulously reflective.

Child Treatment—Use of Power

Clinicians are more comfortable with coercion when 1) a clearly dangerous clinical situation exists; 2) there are achievable, defined, proximal goals (as in an acute psychotic episode or after a suicide attempt); 3) there are specific effective treatments (such as antidepressant medication for major depressions); 4) treatment is short term, cost-effective, and available; and 5) the identified patient is a child.

Along the continuum of referrals described earlier, adults tend to be distributed with greater frequency toward the self-initiated pole, whereas children and adolescents generally experience greater pressure and direction from parents and other authorities. The greater direction and coercion in referrals of youths is accepted as a parental responsibility by society, mental health professionals, and the children themselves. How might the exercise of parental coercion become an intrinsic part of treatment?

Example

Treatment intervention with Ann hinged on the leverage created, at least in part, by her parents’ determination to get her well—a resolve demonstrated through their persistent pretreatment attitude. Ann, a 12-year-old, markedly emaciated, irritable, anorexic seventh grader, was seen in evaluation because her parents and pediatrician were frightened about her continued weight loss. Although she was usually submissive, her parents had to use physical force to bring her to the first evaluation session. During this interview, Ann experienced significant separation anxiety and panicked when her mother left the office to sit in the waiting room. In the ensuing hours of her twice-weekly therapy, this extremely resistant and silent girl would say only that she did not wish to take part in treatment in any way. When the derivatives of a variety of dynamic issues related to anorexia nervosa were explored aloud by the therapist, Ann remained nearly mute. Her core conflict around control evidently had been displaced from her relationship with her parents to her struggle around eating.

Ann was placed on a behavior management program that made her privileges contingent on weight gain. Her parents were actively involved in marital therapy with a collaborative therapist and slowly reduced their intense preoccupation with their daughter’s weight. Meanwhile, Ann’s struggle around food shifted to resistance to treatment. She could never define anything around which her therapist could help her. But, despite her negative, insolent, and defiant attitude about treatment, she slowly gained weight and became more involved with peers, more productive in school, and generally happier. In therapy, Ann remained silent, but became more attentive and less depressed. Despite her parents’ description of her as being an overly compliant child, Ann remained extremely oppositional about attending and taking part in therapy sessions and repeatedly attempted to talk her parents out of making the next appointment.

The conceptual framework offered in the treatment of Ann suggests that the treatment relationship had allowed her to displace her battle for control from her parents to her therapist. Despite the therapist’s discomfort about a year’s work during which Ann was silent, data from parents and school indicated progressive improvement in all areas, and earlier termination of therapy because of Ann’s resistance would have been
Inpatient Treatment of Children and Adolescents

In their involvement in long-term residential and inpatient treatment, child psychiatrists have had to deal with power, coercion, and control in a number of contexts. The clinical treatment context is totally different in a parent-initiated hospitalization of a 14-year-old boy, who has little emotional, social, legal, or financial recourse, and the treatment of a 30-year-old man, voluntarily admitted, who remains in treatment because of his own pain and wish for healing. The approach to resistance is a major focus of long-term inpatient work with children and adolescents. This resistance presents in many forms, including stubbornness, mistrust, rebelliousness, detachment, and all varieties of manipulation, as well as ingratiating compliance (Rinsley 1980).

The treatment of youths, especially in an inpatient setting, requires careful attention to how power is employed by the patient, family, and treatment team. Children need considerable external support because they are almost helpless in the social, economic, and legal world of adults. Their lack of psychological autonomy mirrors their genuine inability to function in the social world; they are weak and ineffective in many spheres in which adults negotiate relatively easily. Children often present clinically with little capacity to tolerate or express pain, and they employ defenses that generate pain in others. Because the important figures in a child’s life are called on to respond with limits, directives, discipline, and treatment decisions, clinicians must find ways to use these responses in establishing an alliance with the child.

There is the clear risk that many inpatient adolescents will remain angry both while in treatment and after discharge because they experience hospitalization as unfair. Hospitalization is perceived as the loss of a major power struggle with other family members. In addition, they feel overwhelmed and guilty. Each of these potential responses must be addressed to develop a strong treatment alliance. Nevertheless, follow-up treatment assessment findings suggest that adolescent inpatient treatment can be effective, even with severely disturbed youths (Gossett et al. 1983).

A number of predictable themes can lead to entrenched resistance, limited improvement, and premature termination. The first theme arises when a clinician, patient, and family cannot embrace the same goals. Most children and adolescents do not share their parents’ goals for treatment, so these goals regularly require careful work and reframing. Second, patients may perceive the psychopathology treatment model as control, retribution, or brainwashing. In truth, disordered behavior is brought into systematic and distinct focus during the inpatient treatment of youths, and the therapist clearly tries to change the way the youth thinks, feels, and behaves. Patient complaints are named “resistance,” and a whole armamentarium of techniques are employed against the patient’s opposition to change. Third, patients who struggle with a vulnerable sense of autonomy, as most inpatients do, resent as intrusive and controlling all attempts to help them conform to society’s expectations.
In studying coercion and power maneuvers used in treatment, the number of similarities between the techniques used in long-term inpatient treatment and those used in thought reform or religious cults is startling. Lifton (1969) described these techniques as

1. Separation from social contacts
2. Idealization of the program
3. Charismatic leadership
4. Promise of a better life
5. Creation of a sense of belonging to something special
6. Intense group process
7. Imposition of values

Effective therapists who are intellectually and emotionally honest examine these issues regularly (Johansen and Gossett 1981). To wonder truly collaboratively with the patient is a central therapeutic process (Margulies 1985), and one that offers some protection in differentiating growth-promoting and other altruistic, ethical, patient-based treatments from the risks of thought control.

Clinical Context, Therapeutic Alliance, and Implications for Treatment

What can be generalized from the experience of child psychiatry concerning treatment endeavors with people coerced in various ways to be patients? What have child psychiatrists learned about what enhances the treatment process and improves outcome, and what detracts from that process and contributes to more negative outcomes? The bedrock of treatment is a treatment alliance. If child psychiatry has learned anything at all, it is the centrality of that alliance to the entire process. Meeks (1971) defined adolescent treatment itself around maintaining the alliance in the face of the realization that it is often fragile and easily disrupted. Therapists must make every effort to elicit from the patient and then to define and negotiate shared goals around which a treatment alliance can be established, regardless of how the patient first comes to treatment and regardless of what external motivating or coercing factors are operative during the treatment course. Ann’s clinical presentation challenged the therapist’s efforts, who made every effort to establish an alliance. Ann’s only consistently expressed goal was to discontinue treatment. The alliance was thus explicitly with her parents, whereas she only implicitly worked in treatment as evidenced by her careful listening (at times) to her therapist’s remarks and her occasional but cogent arguments.

Conceptualizing the influences of coercive interventions on treatment is made easier after one recognizes the context of treatment of children in general.

Example

Mrs. A brought her eldest daughter, Jan, for evaluation after several conferences with school counselors and teachers, who noted her deteriorating behavior, concentration, and mood. Jan, almost 15 years old, had gradually become more withdrawn over the last 2 years after her family moved from a distant city. She spent increasing time with her dog and less time with peers, and during each of the last 2 school years she had caused teachers to contact her parents about her lack of industry—a real change for a previously energetic, achieving, bright girl.

Mr. and Mrs. A minimized these concerns and resisted seeking help. Jan was resentful that anyone questioned her lack of complete control, responsibility, and emotional stability, and each year the issues were dismissed. In ninth grade, however, her performance was so poor that a conference of teachers and counselors prevailed on Mrs. A to seek consultation. She felt pressured herself, and she in turn persuaded Jan to take part in an evaluation or lose her stereo and telephone. Jan attended her first session sullen, pouty, and unavailable.

The kind of clinical context in which the child comes, essentially against his or her will, to avoid adverse consequences with parents and even the clinical context in which parents are pressured by school personnel or other family members are so standard as to be an expected clinical starting point. No one argues that this is a preferred beginning compared with Jan’s asking for help with something she herself finds uncomfortable. But, similarly, no one should dismiss such a beginning as inevitably boding a poor outcome or suggesting untreatability. Jan eventually disclosed deeply shrouded concerns about losing control, described in terms of partying too much, getting lost in rock and roll, and not attending to her school work. She made good use of outpatient therapy after developing a trusting working alliance; however, she never could acknowledge as correct her mother’s decision to seek treatment despite their warm and close relationship.

Formation of an alliance is fostered by therapists explicitly defining their role as the agent of the patient, in contrast to working for the patient’s parents, the hospital, or another institution that might be perceived by the patient as being in conflict with his or her own needs. The therapist works in the patient’s interest through listening carefully in both empathic and observing modes. This posture, however, emphasizes the child’s responsibility for conveying his or her concerns, hopes,
dreams, and expectations of therapy to the therapist.

At times, clinical reality demands attention to extreme external pressure. The best example may be a situation in which legal contingencies are prominent, such as the threat of juvenile detention by the authorities in correctional institutions. In such cases, the therapist and the patient, working through the alliance, must define goals related to dealing with those requirements in a way similar to that in which the patient deals with the expectations and demands of school, friendships, and parents. For the child therapist this definition of goals is a familiar consideration. Routinely he or she will deal with adolescents whose parents have grounded them or asked them to leave home if they do not improve grades, give up lovers or drugs, or quit getting traffic tickets. Such work demands careful attention to the child’s own needs while negotiating with external demands on the patient and therapist. When the therapist has a conflicting interest, such as an institutional allegiance, this must be made explicit.

Example

James, 19 years old, first entered psychiatric treatment at age 12 after being dragged into his first of nearly a dozen therapists’ offices. By the time he entered long-term hospitalization at age 16, he had argued, conned, threatened, eloped from, and exhausted numerous mental health professionals. James’s mental functioning fluctuated widely, so that he seemed at times more than coherent—actually insightful and brilliant. He spoke at length of free will, each man’s right to live his own way, and of the existential meaning of life. He framed his LSD usage, his deteriorating grades, his solitary existence, and his defiance of parental and social authority in such philosophical terms. His paranoid grandiosity failed to integrate the reality of his inability to live independently on the streets, his discomfort at being jailed when caught shoplifting, and his recurring need to be both literally and figuratively bailed out by his parents.

His current therapist met him shortly after admission to the long-term inpatient setting and was well advised to have taken an empathic, patient approach directed at building an alliance—not at confronting him with reality, with consequences, or with his current predicament. Material flowed in a seemingly tireless and endlessly hypnotic pattern that begged one to intervene with educative, reality-based confrontations. A central focus became “the stupidity of staff, an incompetent lot!” Like his parents, they were easily fooled by him whenever he chose. In fact, James often derided staff’s misjudgments or errors at times when they were most vulnerable because they often agreed with his points. But they were provoked to rage and intolerance of even his presence after he repeatedly tortured them with their human fallibility.

At last, James was friendless and alone, and except for his therapist, there was no one he wished to be with.

The hospital program used a therapist-administrator split. By avoiding the obvious confrontations that James’s behavior invited, his therapist established an alliance. “How awful it must be to live in a hospital where you feel so mistreated!” and “How terrible to have to deal with staff who make mistakes” set the tone of the therapeutic responses until James could work within the alliance. Only then could therapeutic gains be made. “How can you deal with this predicament of having your privileges restricted for not keeping your room clean? Whether right or wrong, you said your parents won’t let you leave this locked unit, and you see how furious you are with staff each time this happens. You feel so bad. What can you do?”

Responses that ask the patient to deal with his external circumstances (hospitalization, parents, staff), his symptoms, or his internal dynamics become helpful when offered in the context of a sturdy alliance in which the patient trusts the therapist to operate in his best interest. Beyond that, the alliance keeps the patient grounded in the perspective of the observing ego rather than being swayed by superego or drives. Such therapeutic work often may not begin until extensive preparatory work has established a firm foundation.

Preparation for this growth-promoting work required James to address with his therapist whether the therapist’s allegiance was to James’s parents, to the hospital, or to some societal values alien to James. Was the therapist working for money only? Was he exploiting James to gain admiration from colleagues as the best therapist? Was his intent to transform James into an ideal son? Was the therapist brainwashing James and removing his free will—one of James’s most cherished personal attributes? After having dealt with each of these themes with forbearance, the therapist was able to help by establishing James’s first really effective treatment alliance, which now has weathered many storms.

James currently works part-time and attends a community college. The focus of therapy now wanders between his conflicts with professors and friends, the nature of his dubious need for relationships (especially with his parents), the meaning of life, and on occasion, the nature of his relationship with his therapist. As an outpatient, James became more amenable to treatment when he finally realized through several dangerous episodes of acting out just how much personal responsibility he actually had for his own functioning.

The clinical dilemma with James is stark. Had he been left to his own devices in mid-adolescence, he was destined to deteriorate or die. Yet when he was coercively hospitalized, he felt threatened because his
sense of autonomy was undermined. By projecting and externalizing, he
gquickly gave up any personal responsibility for resolving his situation.
James’s attempts to engage the therapist in defending his parents, the
staff, or society had to be parried and either responded to with empathy
or exposed as an attempt to induce the therapist to become an adversary
rather than an ally.

Other factors that the therapist needs to recognize and sensitively
acknowledge to improve the formation of an alliance and to foster a
successful treatment outcome include the following:

1. The possible disparity in the child’s, the parent’s, and the therapist’s
goals
2. The child’s negative perceptions regarding treatment
3. The child’s overwhelming sense and fear of loss of control
4. The child’s lack of perspective about what treatment is about and
   mistrust of adults
5. The defensiveness of youth about the self-defeating nature and
dangerousness of their behavior (e.g., truancy, substance abuse,
delinquency, chaotic life-style, risk-taking, thrill-seeking behavior,
and social isolation)
6. The child’s paranoid, defiant, rebellious posture induced by forced
therapy, which may present clinically in a variety of ways including
silence, defiance, evasiveness, deceit, refused appointments, omis-
sion of relevant information, and ingratiating. All of these must be
recognized as forms of resistance
7. The characteristics of certain types of psychopathology (e.g., para-
noid disorders, highly projective disorders, and psychosis)

**Coercion Requires Caution**

In some clinical situations, it is important to advise parents not to coerce
their child into treatment. These cases are clinically characterized by
milder symptoms and pathology, less potent and immediately effective
treatments, and situations in which the coercion itself may worsen the
psychopathology or in which the outcome of the treatment is uncertain.

**Example**

Nine-year-old Andy was brought for evaluation by his parents, who
were concerned that he was as painfully shy as they both had been
themselves as children. All information available suggested that Andy
was happy, maturing, achieving in school, enjoying friends, and play-
ing soccer. Both parents felt he was well adjusted, but felt “he could be
doing better if he were more outgoing.” Andy was very clear that he
had no problem, wanted no help, and furthermore, felt intimidated and
demeaned by the consultation.

Clinical assessment, however, did reveal a moderately shy boy
with some mild anxiety and inhibitions. Although some help may have
been possible over a long course of play therapy, the wiser recommenda-
tion was made that his parents not push him into therapy but “watch
and wait,” see if he continued to function well, and have him reevalu-
ted if he developed compromised adaptation, depression, increased
anxiety, or other dystonic symptoms. Here, coercion was clinically
contraindicated because his disorder was mild, therapy was lengthy,
improvement resulting from the therapy was unclear, and finally, his
oppositional attitude would have required his parents to force him to
attend each therapy session.

**Summary**

It is clear to students of child development that setting limits and using
parental power are necessary in promoting the maturational process. In
fact, family systems theory addresses the issues of power and power
coalitions as paramount. Forcing a child into treatment initially is a
legitimate role for parents or guardians and is validated by mental health
professionals, who feel that this must be accepted as part of their regular
clinical work—especially in the case of school-age children, who only
rarely can initiate requests for help. Further, the clinical use of power
and persuasion has been addressed by a number of authors at both
theoretical and pragmatic levels. Child psychiatrists deal with issues of
coercion systematically and successfully in clinical practice. Although
children often come into treatment against their will—sometimes be-
cause of physical pressures or threats and sometimes because of eco-
nomic or emotional threats—they often can make use of a therapeutic
relationship that is negotiated over time and gives careful attention to
the child’s identified needs and wishes.

This experience leads one to recognize that many seemingly overtly
coercive treatment contexts may be turned into effective treatment in-
terventions. Exploration of the use of power and coercion as they relate
to children—whether in normal development or in treatment—is help-
ful in the study of the psychopathology of adults who require limit
setting, persuasion, or coercion in their treatment, often quite possibly
because their childhood developmental experience regarding issues of
power was dysfunctional.
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Coercion by Employers to Combat Substance Abuse

The most obvious example of coercion of adults into seeking mental health treatment, outside of court orders and commitment, is in the workplace. There, employers have solid economics as well as humanitarian reasons for maintaining the health and productivity of their work force.

Recently, for reasons of security and threatened productivity, some employers have attempted to coerce employees to take urine tests for illicit drugs to identify drug users in the work environment and either refer them for treatment or terminate their employment. Winch (1988) reported that drug testing initiatives were in use in more than 35% of the largest companies in the United States, with the number increasing rapidly. In contrast, the American Management Association conducted a nationwide survey of 1,690 human resource directors and found that almost 80% of firms did not conduct drug testing, and of those that did, only 55% found drug testing effective in fighting drug abuse in the workplace (Masi 1987). A more recent study by that organization, however, reported that 58% of its 6,080 member firms test employees for illegal drug use (Reubeorne 1990). The legality as well as effectiveness of such a requirement is still being debated.

Jacobs (1987) argues against drug testing initiatives that only test for drugs and impose penalties, favoring additional educational and awareness programs that involve all employees in creating an addiction-free workplace. He would use educational techniques similar to those that have resulted in increasing numbers of smoke-free work environments. Employee assistance programs (EAPs) have been a more accepted and established approach by industry to address employee substance
abuse. EAPs are company-sponsored programs that offer a variety of supportive services to employees, either directly or through contract services. These services may include programs on handling stress, money management, family or marital problems, child care, or health care management; but the primary focus has been on designing effective interventions for substance-abusing employees. Industry loses $40 billion to $100 billion a year as a result of alcoholism and drug abuse on the job (Ackerman 1988; Jacobs 1987). The Occupational Program Division of the National Institute of Alcoholism and Alcohol Abuse reported that the number of EAPs with some type of occupational alcohol program grew from 499 in 1974 to over 5,000 in 1980 (Kolben 1982), providing access to treatment to about 12% of the nation’s work force (Kurtz et al. 1984). Stackel (1987) estimated that there were between 9,000 and 12,000 EAPs by 1986.

EAPs were originally developed by employers who wanted to retain experienced employees whose alcoholism was impairing their work. Programs were generally managed and staffed by recovering alcoholic patients and human service professionals (Kolben 1982). Mandatory referrals for treatment as the only alternative to dismissal from work have often represented a significant portion of the caseload. Management realized from the beginning that keeping one’s job is a powerful motivation. When a supervisor says to someone, “Look I’ve taken this as long as I can. You’re either going to improve or go out the door,” there can be dramatic changes and, if the supervisor continues to have that expectation, the changes often continue (Leavitt 1983, p. 29).

**Do EAPs Work?**

Berman (1988) reported that substance abuse therapy reduced medical care costs by amounts ranging from 26% to 69% for each treated employee and also reduced the number of sick days per treated employee by 36%-47%. In a review article measuring the effectiveness of occupational alcoholism programs, Kurtz and colleagues (1984) noted testimony from industry that such programs are “a resounding success” (p. 27). Actual outcomes and definitions of success differ widely. In one of their examples, rehabilitation was defined as “remaining sober, affiliated with an alcoholism rehabilitation group and performing satisfactorily on the job for at least 18 months.” Illinois Bell preferred measuring job performance only and reported that, before using the alcoholism programs, 90% of program users were rated as poor or fair in job performance; after the program, 66% were rated as good (Leavitt 1983b).

Certainly, from the point of view of employers, the EAP concept has been most rewarding. Yet Kurtz and colleagues (1984) pointed out that none of the many outcome studies they reviewed met rigorous criteria such as adequate sampling of the at-risk population, matched control groups, uniform definition of successful outcome or of cost-effectiveness parameters, accurate records, sufficient follow-up, or definition of the numbers of potential employees actually reached. Thus, although their impact on management is profound, one can question the validity of most published studies from a scientific point of view.

**Role of Coercion in EAPs**

Even accepting the success of the programs, do they contain elements of coercion? Accurate information is difficult to obtain. On the one hand, industry seeks to protect its investment in a trained work force by ensuring that employees seek help when it is needed and by knowing whether the treatment works; on the other hand, industry seeks to foster a benevolent, supportive image by emphasizing the voluntary nature of the referral and the confidentiality of the counseling process.

In fact, confidentiality is stressed almost to the exclusion of the coercion issue. A typical EAP claim (Leavitt 1983a) states, “The services provided are entirely confidential. No one from the company is notified when an employee seeks consultation. If an employee is referred by a supervisor because of unsatisfactory work performance, the company is notified if the employee keeps the appointment. No other information about the individual’s personal problem is released” (p. 40). EAP policies regarding confidentiality, however, range from the above to a more forceful statement: “no disciplinary action is taken against an employee who cooperates in rehabilitation, makes progress and maintains a satisfactory record.” The issue of confidentiality has become important enough that the trend is for businesses to contract out for EAP services rather than provide them in-house (Stackel 1987).

Thus mandatory referrals may be disguised as “administrative,” “personnel or health service,” or only reluctantly, “disciplinary” referrals. Self-referrals to the EAPs are reported to range from 40% to 80% of the total. These figures may be inflated, however, by including self-referrals to the less controversial EAP services such as managing money or stress, or child care.

To those of us who assume that self-referral is a good prognostic sign, the discovery by Beaumont and Allsop (1984) that self-referral was associated with poor outcome is surprising! Conversely, clients forced into treatment did better than those who were self-referred. A correlation analysis within their study of several variables revealed that age was the
most powerful individual variable, accounting for 19% of overall variance. Self-referral, significantly correlated with failure, was also negatively related to age and length of service, suggesting that self-referred clients were younger and had less investment in the job. In a similar study by Heyman (1976), prior treatment for alcoholism was significantly associated with self-referral.

Salmon and Salmon (1983), in a controlled outcome study of people addicted to drugs, concluded that coercion, generally in the form of probation or parole, appeared to facilitate treatment success only for certain population groups, for certain treatment modalities, and for certain success criteria. In particular, coercion was found to facilitate success for older, longer-term heroin addicts using the criteria of subsequent arrests and continued abstinence in drug-free treatment settings. Thus, for some substance abusers coercion is associated with success in treatment.

Coercion and Motivation

How can we integrate these data that show a positive effect of forced treatment in the workplace with what we know generally about treating alcoholic and substance abuse patients? For most addicted people who come to our attention, all self-directed efforts to break the habit have been futile. Despair from the repeated failures has led some to suicide and many others to profound resignation. For most, the stronger the drive to “do it myself,” the greater the risk of repeated failure; this experience lies beneath the paradoxical statement that “you have to give up before you can win.” In the rehabilitation process, optimism is said to be the opposite of hope (Deegan 1987). Such optimism implies the kind of denial or superficial “positive thinking” that does not acknowledge the depth of illness, disability, and destructiveness generally accompanying an addicted life-style. Until the worst has been faced, there is no foundation for hope or recovery. Thus, a motivation driven by “willpower,” before the disease is fully acknowledged, is not likely to succeed.

It takes time for most addicted people to understand the distinction between a good intention to quit versus a total commitment to take responsibility for one’s life and stay abstinent no matter what the circumstances. Pride, resistance to change, fear of loss of control, fear of rejection, and many external factors can interrupt the process at any time. For some, the very thought of giving up drugs or the bottle “forever” is so frightening that they panic and run. This fear is the basis of the “one day at a time” approach.

A life-threatening medical illness that rudely breaks through denial is often sufficient motivation for some addicted individuals to take action. A physician’s persistent, nonjudgmental advice to seek help for addiction can turn the tide for others. One role for staff at a detoxification or rehabilitation treatment center is to create motivation by confronting patients with the effects of their addiction on their lives and the lives of others. Legal pressures stemming from arrests for driving while intoxicated, writing bad checks, or stealing to cover the costs of drug use, as well as financial irresponsibility in other areas, are part of the panoply of outside pressures that may increase motivation.

Peer pressure is also a strong motivator; it has long been acknowledged as a factor for teenagers starting to smoke, use drugs, drink excessively, or engage in other behaviors considered unacceptable by the general population. Peer groups as a positive motivator have been used by a wide variety of self-help groups since Alcoholics Anonymous came into being. Other self-help groups, therapeutic communities focusing on addiction recovery, and many other treatment programs use peer pressure and peer identification positively (Van Stone 1972). Although most adults like to consider themselves independent thinkers about personal habits such as drug or alcohol use, the alternative threat of rejection and the pull of acceptance by the consensus of peers are powerful social forces. Yet the systematic use of peer pressure in the workplace to motivate addicted workers has been relatively neglected by management. A prominent exception is the successful effort to make cigarette smoking “not OK” in many public and private areas. Referral by a supervisor for drug abuse treatment may be seen as part of a similar process to promote drug-free zones in the workplace.

The enormous capacity of addicts (including people who are alcoholic) to deny, connive, manipulate, deceive themselves and others, and behave in the service of their addiction is generally unappreciated by many clinicians and employee supervisors. Addicted workers will manipulate to avoid self-confrontation, to play for time, or just to try to stay one step ahead of the game. Self-referral may allow an addicted worker to escape a potential problem without any substantial intention to change. With a mandatory referral by a job supervisor, however, the game is over.

In summary, people with alcoholism and other addictions are often said to have to “hit bottom” before they will quit. Although we try to simplify the complexity of behavior, motivation leading to action is usually a combination of many factors, the clustering of which tips the balance toward recovery. The threat of imminent job loss may serve to force a patient to confront reality, break through denial, and sustain the motivation that can lead to recovery.
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3

Treatment as a Condition of Probation: The Need for Consequences

Many people are first brought into psychiatric treatment because of their contact with the criminal justice system. People suffering from depression or anxiety may seek treatment on their own because of intense subjective discomfort. Schizophrenic patients are usually brought to doctors by their frantic families. Alcoholic persons may contact Alcoholics Anonymous or treatment facilities because of pressure from employers. But sexual offenders, child abusers, or people who are involved in incest or family violence seldom seek treatment unless they are in trouble with the law.

When brought to trial, these offenders may be sentenced to serve time in prison. Many offenders, however, receive a suspended sentence and are placed on probation, with treatment imposed by the judge as a special condition of probation.

What happens when the judge orders someone into treatment? Are there situations where it works well? Is it a waste of time and money? We will first examine how the system currently works, using one jurisdiction as a framework.

The Current System—Judge’s Viewpoint

Judge Peter Messitte of the Circuit Court for Montgomery County, Maryland, described a system in which each judge has considerable latitude in using psychiatric treatment as part of his or her sentencing (P. Messitte, personal communication, February 1988). The judge can
sentence an offender to a longer period in a state prison or a shorter period in a county jail, and can suspend any part of the sentence. He or she can impose unsupervised probation ("don't get in trouble") or supervised probation. Supervision can include many different conditions. A standard probation order requires that the probationer report to his or her probation officer, work or attend school as directed, get permission before moving or changing his or her job, obey all laws, notify the officer or her probation officer if arrested, permit the officer to visit his or her home, avoid illegal drugs, pay a fine if ordered, and obey any special conditions. The special conditions may include mental health treatment.

Judge Messitte considered that treatment is sometimes effective and that it is appropriate to require treatment in some cases. In ordering such counseling, he usually leaves the details of treatment arrangements to the discretion of the probation department. He may, however, order treatment in a particular facility (for example, a residential drug treatment center) or even by a particular therapist, when the offender has already started treatment.

He usually orders treatment as a condition of probation in sex offenses (child molesting, exposing, incest, child sexual abuse), for people with a known psychiatric history (except with a long history of treatment efforts that failed), for drug and alcohol abusers (drug counseling, urine checks, Alcoholics Anonymous), and in various other puzzling cases, such as fire setting. During the period of probation the offender can be sent to prison if treatment is not maintained.

The judge's authority ends when the probation period ends. He or she is not usually aware of the success or failure of treatment, nor of recidivism. When asked to describe treatment that seemed to work, Judge Messitte recalled a case of a man in his late 30s who had had many sexual contacts with young boys. The man was ordered into a program for sex offenders that used behavior modification techniques and was able to refocus his sexual attention onto adult males.

The Current System—Therapist's Viewpoint

When receiving a new probationer with "mental health counseling" ordered by the judge, probation officers in Montgomery County usually have discretion about where to refer. They may refer the probationer to a particular clinic, residential drug treatment center, or practitioner (P. Pie, personal communication, March 1988). Pedophiles are often referred to the Johns Hopkins Sexual Disorders Clinic or the Special Offenders Clinic at the University of Maryland; drug abusers, to the Treatment Alternatives to Street Crimes program. Wherever they refer, the probation officers have the probationer sign a release of information form. "We call the facility, ask if they're attending, how are they getting along, general information. We hear if they're kicked out of the program. If they're not complying, we write it up as a probation violation" (R. Silverman, personal communication, March 1988).

Three experienced probation workers (Division of Parole and Probation, Maryland Department of Public Safety and Correctional Services) interviewed by a member of our committee seemed to be hopeful about the effect of treatment on incest offenders (L. Carlton, personal communication, March 1988; P. Pie, personal communication, March 1988; R. Silverman, personal communication, March 1988). They saw men who beat their wives change in programs that teach alternatives to violence; one worker saw pedophiles as amenable to hormone treatment, although not to psychotherapy alone (R. Silverman, personal communication, March 1988). They also recalled other kinds of offenders who made a good response to treatment, such as the case of a shoplifter, a woman who had sacrificed herself for her family and for whom her arrest had been the classic "cry for help" (L. Carlton, personal communication, March 1988). Overall, however, the probation officers had no systematic feedback on the results of their efforts. The Maryland Department of Public Safety does not compile statistics on the association between psychiatric treatment as a special condition of probation and recidivism or even on successful completion of probation.

The Current System—Therapist's Viewpoint

Dr. Margery Calhoun, a psychologist at the Community Psychiatric Clinic in Montgomery County, Maryland, has treated over 30 exhibitionists referred from the Montgomery County Courts during 18 years (M. Calhoun, personal communication, February 1989). For those who started treatment at their attorney's insistence after arrest and before going to court, Dr. Calhoun recommended continued treatment, and the court so ordered. In other cases, the judge ordered treatment as a condition of probation, and the probation officer arranged it.

Clinically, Dr. Calhoun considered that the treatments were successful with all but one patient. That one continued to expose, kept stealing, and was returned to the court. One other exposed himself again during a crisis with his girlfriend and returned to treatment. All others apparently stopped exposing after treatment started and did not resume after treatment finished. The treatment program focused first on teaching the
relationship between feeling angry and impotent and exposing and then on learning some assertive ways of handling anger. Although the patients would not have started treatment without being forced into it, they were compliant and cooperative. They did not seem to need the tight, ongoing control that has been reported to be essential with drug abusers.

David Lanham, M.D., for many years head of Legal Psychiatric Services in the District of Columbia and currently Medical Director, Mental Health Clinic, Charles County, Maryland, was optimistic about certain types of coercive treatment situations (D. Lanham, personal communication, March 1988). He noted, for example, that psychotic patients who can be treated with medication probably benefit most. He found rapists and homosexual pedophiles too risky to treat as outpatients, but would see exhibitionists. Child abusers, incest offenders, and spouse beaters all can be treated effectively, in his experience, with the use of appropriate adjunctive therapy and tight controls. Using protective services, for example, to check on child abusers at home can promote the success of couples treatment, drug treatment, Alcoholics Anonymous, and so forth. He believed that the usual recidivist antisocial offender cannot be treated successfully, whether in jail or in the hospital.

Dr. Lanham emphasized the need for evaluating the offender before sentencing, so that inappropriate referrals can be identified before the judge sentences them to treatment as a condition of probation. Most important, however, he emphasized tight control as a crucial factor leading to successful treatment.

Dr. Jonas Rappeport, with long experience as a forensic psychiatrist in Baltimore, Maryland, similarly emphasized positive outcomes with forced treatment. In describing his optimistic view of treating sex offenders, he stated, "When close probation supervision forces patients to attend, very satisfactory results can be obtained by outpatient treatment of those with repeated offenses. Those clinics that have no means of enforcing attendance at treatment sessions have repeatedly reported poor results" (Rappeport 1974, p. 150). He added, "I am convinced that it is generally not possible to treat 'acting-out' patients unless an external force requires that the patient attend treatment sessions regularly for an extended period of time. ... I personally will not treat any court-ordered patient in my private office unless the court requires me regularly to report three items: 1) whether the patient is regularly attending treatment sessions, 2) whether he pays his bills regularly, and 3) whether he is doing the best that can be expected of him in treatment. The patient must understand these conditions" (p. 152).

Dr. Rappeport emphasized the usual course of treatment failure that ensues when a private psychiatrist agrees to see a patient under court-ordered treatment but without a clear understanding that the psyciatrist will report back to the probation officer when the patient misses appointments or is otherwise not cooperating.

Finally, Dr. Saleem Shah, also experienced with Legal Psychiatric Services in Washington, D.C., and at the National Institute of Mental Health, stated that "although many believe that treatment must be free of coercion to work, I think that is nonsensical. Medication, for example, works though coerced. I think psychotherapy is probably analogous. Most of the patients of Legal Psychiatric Services were under compulsion and wouldn't have started treatment without that. I think we saw change, supported by the before-and-after psychological test profiles that I gave" (S. Shah, personal communication, March 1988).

**Treatment of Sex Offenders**

Sex offenders are prominent among those ordered into treatment by the court. Among sex offenders, the child molester and the exhibitionist are most often treated while on probation. The convicted rapist is usually incarcerated.

The overwhelming proportion of people referred for treatment can be classified as paraphiliacs, people with characteristic compulsive thoughts and urges to carry out sexually aggressive behaviors. It should be noted, however, that a small number of offenders may commit the same offenses because of psychosis, mental retardation, or antisocial personality disorder (Abel et al. 1986).

Many different treatment approaches have been used with these patients, with few controlled outcome studies. The older literature reports on psychodynamically oriented psychotherapy, an approach not used as often today with this population (Dietz et al. 1986). Hackett (1971) reported on a more directive, behaviorally oriented form of psychotherapy with a group of exhibitionists sent by the court for treatment as a condition of probation. Hackett treated 45 such patients with a program that he gradually shortened to about 6 months of weekly therapy. The patients first had to admit their history of exposing. Treatment then focused on becoming aware of anger as the precipitant for the urge to expose, on learning ways to avoid succumbing to the impulse by using self-inflicted pain (e.g., bite cheek, burn finger), and gradually on finding alternative ways of handling the anger. Hackett followed up the patients 2-14 years later by obtaining self-reports and checking arrest records. Thirty-four of the 37 reported no subsequent exposures; the self-reports were supported by the absence of subsequent arrests.

Behavior modification therapies that use various aversive stimuli or
programmed modification of sexual fantasy have been reported to be helpful with both pedophiles and exhibitionists (Abel et al. 1986; Dietz et al. 1986); however, there is concern about the ethical implications of such techniques when they are forced on patients (Group for the Advancement of Psychiatry 1977).

A newer form of treatment, used with many pedophiles and with some exhibitionists and other sex offenders, is the antiandrogen medroxyprogesterone acetate (Depo-Provera) given by depot injection every 7–10 days. This treatment leads to a reduction in plasma testosterone and in sexual drive (Bradford 1983). Berlin and Meinecke (1981), reporting on results of antiandrogen treatment at the Johns Hopkins Sex Disorders Clinic, noted the high frequency of genetic, hormonal, or neurologic anomalies in their population of chronic paraphilic patients, suggesting the possibility of a biologic factor predisposing to paraphilia. They reported preliminary results with 20 patients treated with Depo-Provera for up to 5 years and 9 months. These patients had previous histories of very frequent sexually deviant behavior (e.g., homosexual pedophilia twice weekly for decades). There were three relapses while patients were taking the medication; however, almost all patients who stopped the injections relapsed.

Use of this treatment has been restricted by ethical concerns and by public opposition. The voices of these patients, however, are seldom heard: A poignant, anonymous letter to Ann Landers describes one man’s experience (Landers 1989).

As far back as I can remember, I have had a problem with sexual feelings toward little girls. For 40 years I managed to keep it under control through willpower and prayer, but last year, after some extremely traumatic and stress-producing experiences, I observed that I was powerless when this urge came upon me... The day I was released on bond, I signed up for professional counseling. After three months of intensive therapy, I realized that the “beast” was still inside me. Terrified of what I might do next, I sought medical help. For three months, I have been receiving weekly injections of the hormone progesterone... The change in me since I have been taking these shots is remarkable. For the first time in years, I am in control not only of my actions, but my thoughts as well. I am not impotent; I am just in control.

For sex offenders, then, many different treatment modalities have been used with various reports of success. All the methods, however, have been used with patients who would not have been in treatment at all if not for some degree of external pressure. Ethical concerns about consent being affected by legal pressure have been addressed by giving special attention to the consent process. This includes exploration of the patient's understanding of the pressures, as well as disclosure of the risks and whether the treatment is experimental.

**Treatment of Family Violence Offenders**

Another large group of people who enter treatment programs because of pressure from the legal system are the family violence offenders, whether spouse beaters or child abusers. Estimates are that 2 million people annually are beaten by their spouses and that 2 million children are abused by their parents (Dickstein 1988; Rosenbaum 1986).

The many programs that have been developed in the last decade to change these violent behavior patterns share certain emphases (Dickstein 1988). They focus initially on holding the batterer accountable for his or her actions, using confrontation to attack the characteristic denial, minimization, and externalization. They use psychoeducational techniques, mainly in group settings, to teach increased awareness by the batterer of his or her own emotions and alternative, nonviolent ways of dealing with those emotions.

One such program, the Harborview Anger Management Program, won the Gold Award from the American Psychiatric Association's Institute on Hospital and Community Psychiatry in 1987 (Anonymous 1987). About 70% of the patients in this program are referred by courts because of domestic violence, general assault, or other anger control problems. The initial phase of treatment emphasizes confronting the patient's resistance to admitting that he or she has a problem controlling violent behavior and teaching the patient to monitor his or her own emotions. The staff has found the patient group to include varied diagnoses, often alcohol or drug abuse and sometimes unrecognized depression.

The main treatment consists of a specialized form of weekly group therapy, lasting for at least 20 weeks. The emphasis is on psychoeducational techniques of lessening arousal (deep breathing, progressive relaxation), problem-solving tips, reenacting scenes that trigger violence, and learning nonviolent ways to cope with stress and conflict.

The staff maintains tight control over attendance, with the patient having to start over if he or she misses more than two sessions. The dropout rate is reported to be as high as 30–40%. The director of the program, Dr. Roland Maiuro, reported that those who complete the program have significantly lower levels of anger, depression, and aggression than a matched control group, with changes persisting for at least 1 year of follow-up (R. Maiuro, personal communication, February 1988).

Looking directly at the issue of motivation in family violence pa-
tients who have been court-ordered into treatment, Ganley (1987) de-
scribed a way to cut through the initial denial that the patient has a
problem: "One way of responding to this is to clarify for the client that
while he is court-ordered into treatment, the program is not court-
ordered to treat him. Consequently, the client’s role at this juncture
in the process is to convince the counselor that he does indeed batter.
Otherwise, he will not be accepted into the program and will have to
accept other consequences for his crime" (pp. 169–170).

We may conclude that in this mixed group of family violence
offenders, specialized treatment programs have been developed that
do not shrink from using coercion as a positive force in enhancing motiva-
tion and treatment success.

Treatm ent of Incest Offenders

As awareness has grown in recent years about the prevalence of sexual
abuse of children (estimates are that one-fifth to one-third of women had
a childhood sexual encounter with an adult male) and of incest (esti-
imated at 1%), efforts to create effective treatment programs have in-
creased (Becker and Shah 1986). In dealing with incest, professionals
disagree about the need to involve child protection systems and courts.
One program that strongly supports court involvement is the Child
Sexual Abuse Treatment Program of Santa Clara County, California
(Kiersh 1980). In this multidimensional program, the mother and girl are
first treated individually. The father admits his guilt in court and is
convicted, given a suspended sentence, and ordered into treatment by
the judge.

The father must admit his guilt in a group of incest offenders and
detail how he abused his child. In addition to group therapy for the
abuser, the program also uses marital counseling, family therapy, and a
self-help group founded by mothers in this situation called Parents
United. Although this program has been criticized by some for its use of
coevision and for instances of repeat molestation, others have found it to
be extremely effective. Roland Summit, prominent in this field, empha-
sized that “incest does not have to be decriminalized or penalized. There
can be a compromise. It’s only necessary to get a probationary control.
You have to control an offender’s movements, and to make his probation
dependent on cooperation” (Kiersh 1980, p. 36).

The essence of this approach to treating incest offenders is remark-
ably similar to that described above for family violence offenders, and it
shares important elements with the previously described treatment
approach for exhibitionists.

Special Problems in Court-Ordered Treatment

The programs described here mostly work well and demonstrate how
court-ordered treatment can, indeed, be effective. However, cautious
should be noted. In the initial court assessment of the offender, the court
may send someone to an inappropriate program. For example, the
occasional sex offender who attacks a stranger on the street because of
psychosis rather than paraphilia will not receive proper treatment if this
diagnosis is missed. When the court or probation officer does not clarify
with the therapist what the reporting expectations are, or if the probation
officer has too large a caseload to exert effective control, the requirement
of treatment may remain indefinite and “fall between the cracks.” When
the therapist is not truly committed to this cooperation with the court or
probation office, he or she may collude with the patient and withhold
relevant information. The patient may, of course, lie to everyone and
may not be found out. This can happen in any treatment situation,
however, and may in fact be somewhat less probable with tight external
control.

We have not addressed in detail the issue of careful diagnosis of each
patient to improve the probability of appropriate treatment. In an inter-
esting analysis of the interaction among treatment variables and patient
variables, Woody et al. (1985) analyzed the effect of either drug counsel-
ing alone or drug counseling plus professional psychotherapy on pa-
tients with either opiate dependence alone or opiate dependence plus
antisocial personality disorder and/or depression. Their results showed
that antisocial personality disorder was a negative predictor of improve-
ment, but this negative outcome could be overcome when depression
was also present. In short, the uncomplicated sociopath showed little
response to psychotherapy, but the sociopath who was also diagnosed
depressed showed a positive response. This more precise diagnosis,
then, may provide a way to better outcomes, even with the most inac-
cessible offender, the one with antisocial personality disorder.

Summary

Court-ordered treatment has been shown to be successful when there is
tight probation control to ensure compliance; when treatment with
medication is appropriate for the clinical situation (e.g., treatment of
psychotic patients with neuroleptics, treatment of pedophiles with
Depo-Provera); when programs are specialized with a focus on specific
behavioral disorders (incest, wife beating); and when behavioral, psy-
choeducational, and group confrontation and support techniques are
used. These results contradict an attitude prevalent in some psychotherapy quarters that "ordered" participation in treatment will not succeed.

References


Civil Commitment and Involuntary Treatment: Historical and Legal Trends

The issue of involuntary or coercive psychiatric treatment is exemplified most overtly and publicly by the process of civil commitment. This issue touches on an array of factors that have an impact on psychiatry as a profession, on psychiatric patients and their families, and on society's perception of both groups. Public perception that involuntary treatment is used prudently, thoughtfully, and caringly is of crucial concern to clinicians.

Coercion Can Be a Necessary and Desirable Part of Effective, Humane Psychiatric Treatment

Most clinicians have seen examples of the clear need for involuntary treatment of certain patients whose illness has distorted their judgment and insight to a degree that their interests and those of their families are jeopardized.

Example

Mr. B was an 84-year-old married man of Middle Eastern heritage. His mother died when he was 12, and his father then left the children and returned to his native land. Mr. B, as the eldest, took over the responsibility of raising his siblings. He eventually married and raised three children of his own, all of whom have had successful professional careers. He retired about 10 years before admission, but remained
physically vigorous until he was found to have inoperable lung cancer. He was doing well with his cancer through chemotherapy and radiation treatments, but after a bout with pneumonia, he developed a severe melancholic depression and attempted suicide. Over the next several weeks he exhausted his wife, who had to keep constant watch over him as he wandered about the house looking for means to commit suicide. He rejected psychiatric attention because of his belief that “nothing will help.” Eventually, the family reluctantly and painfully overcame their own extreme resistance to defying his wishes and obtained a detention order.

After involuntary hospitalization, he and his family eventually accepted the option of electroconvulsive therapy after he was unable to tolerate an adequate trial of medications. He responded well and has continued to do well, addressing the issues of his cancer and terminal condition with his children and grandchildren.

Legal and Medical Models of Commitment

There are two broad justifications for the involuntary hospitalization and treatment of patients defined as needing but being unwilling to accept medical attention—a group that historically has been composed primarily of persons with either communicable diseases or mental illness (Towes et al. 1980). The first of these justifications is a *police powers doctrine* based on a society’s perception of its need and right to protect its members, both individually and collectively, from the dangerous actions of people who will not or cannot exert self-control. The second is a *pares patriae doctrine*, or the concept of benevolent paternalism, under which society accepts an obligation to protect its incapacitated members from the consequences of their incapacities (Perlin 1983). J. Shemo (“Involuntary Treatment and Commitment,” unpublished manuscript, 1992) reviewed the data and concepts surrounding the struggle between legal models (police powers) and medical models (pares patriae) in detail.

According to Peszke (1984), all societies have some form of civil commitment. Even Plato, in his utopian law, stipulated such provisions. The formalization of commitment procedures in Western society, however, was probably derived from the constitutional crisis that developed in the setting of King George III’s (1775–1820) mental illness (Peszke 1984). Appelbaum (1985a) demonstrated that since the inception of such laws in the United States in the 1850s, there has been a regular pattern in which legislative intent has swung between tightening and then loosening the restrictiveness of the commitment process. This legal pendulum effect has led Shuman (1985) to describe the history of commitment as being a “200 year old multi-dimensional see-saw” (p. 284).

The Advent of Coercive Treatment Is Associated in Time With the Concept of Treatment Optimism

By the turn of the century there was a hodgepodge of schemes within the states tending toward loosening the previously passed restrictive legislation that followed the demise of the moral treatment movement in the mid-1800s. The trend reversed itself again by the 1930s, at which time there were no specific biologic treatments for those disorders conceptualized as mental illness. During this period, when only custodial care was generally practiced, police powers (and countervailing legislation to curb their potential abuse) were invoked. This situation began to change with the introduction of electroconvulsive therapy in the late 1930s, penicillin for the prevention and treatment of neuropsychilis in the 1940s, and chlorpromazine (Thorazine) in the 1950s (Houken 1986). Parentis patriae thus arose with the beginning of treatment optimism (Peszke 1984) and was accompanied by efforts during the post–World War II period to scale down the statutes against involuntary hospitalization, because these restrictive laws were now being viewed as nontherapeutic.

In the late 1960s, however, the police powers doctrine reemerged (Roth 1980) and gained predominance. Legislation tended toward increased use of a legal model for the process of involuntary treatment and forced a decrease in the use of the medical or treatment model of decision-making (Lonsdorf 1983). This process is thought by many to have been first codified in the Lanterman-Petris-Short Act enacted in California in 1969 (Lamb and Mills 1986). Although only five states had previously limited civil commitment to the “dangerously” mentally ill (Shuman 1985), within 10 years every state and Puerto Rico had modified its commitment code.

The 1972 Wisconsin case of *Lussard v. Schmidt* is often considered of landmark importance in the move toward greater restrictiveness in commitment laws. In its detailed opinion, the state supreme court enumerated the following requirements (Lonsdorf 1983):

1. The risk of violence to self or others must be established, with such dangerousness being demonstrated by a recent overt act plus the substantial probability of recurrence.
2. There must be a preliminary hearing within 48 hours after the patient is detained.
3. There must be a neutral judge and legal counsel.
4. Notice of the hearing must be provided to the person being detained as well as to family or close friends.
5. Attendance by the detainee cannot be waived, nor can the person be incapacitated by medications.
6. The criterion of "beyond a reasonable doubt," the criminal standard of proof, must be applied, rather than the civil standard of "preponderance of the evidence."
7. Legal representation must be as an advocate for the patient's wishes, not as a guardian ad litem attempting to ensure the patient's "best interest."
8. The burden of excluding less restrictive alternatives to involuntary hospitalization is on the state.

Three major effects were common among these legal changes (Lamb and Mills 1986; Schwartz et al. 1984). First, the laws changed the substantive criteria, the "why" of commitment, from general ones embodying concepts of mental illness and need for treatment to specific criteria of dangerousness or inability to care for oneself. Second, the "how" of commitment, the procedural requirements, were changed to ensure rapid access to the courts, public defenders, and even jury trials, with due process guarantees. Third, the laws tended to change the duration of commitment toward briefer hospitalization, with the time limits shaped more by libertarian than clinical concerns (Lamb and Mills 1986). These laws resulted in denial of treatment to many who would previously have received it.

Reinforcing this trend and leading some mental health professionals to lend their support to increased restrictions on access to coercive treatment were two intraprofessional forces, based on either a reconceptualization or denial of mental illness, which converged to support the latest round of restrictive laws. The first force was a belief, based on 1960s community and social psychiatry theory, that mental illness was largely the result of social stress and economic disadvantage, despite research evidence available even then that the major psychoses are qualitatively different. The second force was the antipsychiatry movement supported by writings of such professionals as Szasz, Goffman, and Laing (Lamb and Mills 1986). Of these, Szasz probably took the strongest position (Hoaken 1980), exemplified by his best seller *The Myth of Mental Illness* (Szasz 1961). Szasz (1982) maintained that "mental illness is a metaphor and a myth" (p. 763) and that "since there are no mental diseases, there can be no treatments for them" (p. 763). He did exempt patients with cognitive dysfunction due to organic etiologies—but in a very restrictive sense. He thus contended that any person has the right to commit suicide, whatever the reason and whatever the consequences, and that harming others should be controlled entirely by the criminal justice system, whatever the circumstances.

A third set of factors—perhaps the most powerful—leading to the wave of legal restrictiveness were outside the direct auspices of psychiatric or mental health thinking. Among these factors was the development of the "mental health bar" growing out of the civil rights movement of the late 1960s and 1970s. This self-defined group of lawyers, who shared a strongly libertarian ideology, coalesced during this era of social activism, which was characterized by distrust not only of the state's police powers but also the power and motivation of all authorities, including physicians. Another factor was the availability of federal Medicare money (Pinzer et al. 1981) to get patients out of the state-financed mental hospital system and into nursing homes. Unfortunately, the federal Medicare system does not provide these mentally ill patients with adequate care once the deinstitutionalization occurs. Funding for such care falls to localities, which may or may not accept the burden.

Denial of Effective Treatment Is Not in the Patient's Interest

The available data reveal several effects of these restrictive trends:

1. The denial of commitment requests and increased discharges against medical advice led to a high rate of recidivism and outpatient failure, and a need for more emergency care—the "revolving door" phenomenon (Haupt and Ehrlich 1980).
2. More mentally ill patients were arrested and diverted to the criminal justice system (Bonowitz and Guy 1979) as "competency to stand trial" statutes began to be used to hospitalize patients who could no longer be civilly committed (Urmere 1971).
3. More commitment requests were denied, and eventually, in response, there may have been a decrease in the number of petitions filed. Thus, many who would previously have been eligible for commitment at earlier stages of their mental illness still ended up in the hospital, only in a more deteriorated and less treatable condition.
4. Clinicians prefer to use "need for treatment" rather than "dangerousness" criteria as a basis for commitment when allowed to do so. In Washington State, within 1 year of legal change, three-quarters of commitments were based on "grave disability" rather than dangerousness (Durham 1985).
5. Much of the impact of legal criteria is cosmetic. Within a short time
after changes were made, commitment rates tended to return to baseline and the laws had little impact on the realities of much of the commitment process. For example, in California, Yesavage (1984) studied 47 patients before and 58 patients after a 1981 court ruling that all 14-day certificates for “grave disability” be judicially reviewed. He found no evidence that there was any change in the likelihood of commitment for grave disability, with the addition of the time-consuming judicial review.

6. Finally, and most significantly, as discussed in a review of the Washington State experience (Durham 1985), factors other than legal mandates seemed most powerful in determining the rates of hospitalization—involuntary or otherwise. Many of the same legislatures that passed stricter laws on commitment had additional agendas related to curtailing funding for mental health. These funding agendas have had far more impact than have the laws.

In the face of these consequences of the more restrictive laws, which led to considerable concern on the part of clinicians that patients would be left to “die with rights on” (Treffert 1985, p. 260), the courts themselves began to modify and soften the restrictiveness of the laws. In its Addington v. Texas decision, the U.S. Supreme Court noted both that “it is not true that the release of a genuine mentally ill person is no worse for the individual than the failure to convict the guilty” (Perlin 1983, p. 541) and that “[i]t cannot be said, therefore, that it is much better for a mentally ill person to ‘go free’ than for a mentally normal person to be committed” (Roth 1980, p. 392). In this decision, the Court recognized that the stakes for the civilly committed patient are far greater than a temporary loss of liberty (Roth 1980). In the child case of Parham v. J.R., the Court again rejected the idea that harm per se inevitably results from the fact of institutionalization, stating “What is truly ‘stigmatizing’ is the symptomatology of a mental or emotional illness” (Roth 1980, p. 393).

Example

Ms. C was a single white female in her early 30s who worked as a computer programmer after 8 years of military service. She had a child whose birth had precipitated her military resignation. She was originally seen on a temporary detention order taken out by a community mental health center worker after she had been found trying to asphyxiate herself with car fumes. She claimed she had been possessed by the spirit of a messianic figure who was to be born in the future and who had stimulated the reams of automatic writing she had produced over the past few months. She stated that she had just discovered that the figure meant not to save, but to end, the world, and therefore she felt she had to kill herself to prevent its birth. She maintained that while she had failed in this, the spirit had departed; and she knew it would now never return, at least not to her. Despite all this, in the commitment hearing she was ruled by the judge not to represent a “clear and imminent” danger, and the temporary detention order was dismissed. She was persuaded to accept a period of voluntary hospitalization for workup, but she made it clear that this would be short. Her β-human chorionic gonadotropin test was negative, indicating she was not pregnant. Her electroencephalogram showed a left temporal lobe focus of nonspecific abnormality, and the computed tomography scan of the head was normal. She consistently refused neuroleptic or other medications but eventually consented to a clinical trial of carbamazepine. In the hospital, she consistently dressed and groomed in a style suggestive of a prisoner but continued to maintain that her phenomenon of “possession” was over.

At the end of 2 weeks, she insisted on discharge but agreed to outpatient follow-up, which was begun before her discharge. She went to several outpatient sessions, each time dressed and groomed more stylishly, and consistently maintained that there was no return of either the spirit or the automatic writing. She did, however, discontinue taking the medication. When she missed an appointment, the police were sent to her apartment, where she was found dead of an overdose with aspirin. She had new automatic writings dated over the 2 days before her death.

The current trend is toward a loosening of the commitment laws, reflecting a shift away again from libertarian views of commitment. The courts have, in several rulings, acknowledged that much of what they see as procedurally correct is not only possible but inherent in good psychiatric examination and the medical decision-making process. For example, in the Parham v. J.L. and J.R. case, the U.S. Supreme Court accepted the fact that what the court wanted in terms of investigation of background and interview of all parties before deciding whether institutionalization was needed is exactly the process used by mental health professionals in evaluating the situation. The Court concluded that “due process” has never required that the fact finder be law trained: “neither judges nor administrative hearing officials are better qualified than psychiatrists to render psychiatric judgments” (Lonsdorf 1983, p. 657).

Several states have in fact modified their commitment statutes in an attempt to recognize the legitimacy of parens patriae concerns, as well as those stemming from a “dangerousness” model (Showalter 1986). North Carolina, for example, has expanded its concept of “danger to self” to include the “inability to exercise self control, judgment, and discretion in daily responsibilities and social relations” (p. 38). The state
of Washington has included a concept of deterioration “evidenced by repeated and escalating loss of cognitive or volitional control over his or her [the patient’s] actions” (p. 38). A bill drafted in Wisconsin, the original site of the Lessard decision, has added a “fourth standard” of “need for treatment” based on the “substantial probability of serious mental or emotional deterioration” (p. 38).

The Degree of Coercion Permitted Is a Function of Contemporary Interpretations of the Public Interest

As has been addressed by Shuman (1985), the issue of involuntary treatment brings into conflict two significant and persistent American values: autonomy and paternalism. Roth (1980) very appropriately points out that “the paternalism/individualism controversy is hardly a zero-sum game; it is the balance between these two ethical precepts that counts” (p. 394). That very need for balance, rather than merger, is based on the strength of the conflicting values. Chodoff (1984) attempted to contrast these value systems by demonstrating that medical model adherents take a utilitarian or consequentialist position, whereas the civil libertarians take a deontological or absolutist position. As elaborated by Towes et al. (1980), the medical perspective (based on parents patriae) takes as a basic tenet that individuals who are mentally ill need treatment and that the alleviation of their suffering is a paramount priority.

Initial Coercion Can Lead to Greater Freedom or Prevent Its Loss

Chodoff (1984) contended that defining liberty only in terms of freedom from coercive hospitalization (based on potential abuse of police powers) fails to take into account that such liberty may be meaningless in the presence of the debilitating effects of untreated disease, maintaining, as did Hoaken (1986), that all mental disorders restrict personal freedom through stereotypical maladaptive behaviors or subjective symptoms. Even John Stewart Mill, the patriarch of the libertarian position, excepted from his libertarian principles those whose behaviors were “incompatible with the full use of the reflecting faculty” (Chodoff 1984). Pode and colleagues (1974) similarly maintained a longitudinal concept of liberty and saw freedom from the constraints of mental illness as being a basic prerequisite to longer-term self-direction.

Some authors, such as Hoaken (1986), maintained that the difference in perspective is not merely a question of “values” but, as he contended, a problem that some civil libertarians have in understanding the subjective sense of autonomy and its loss in psychosis. Certainly it can be stated that preventing hospitalization of those impaired by mental illness does not necessarily, or even predictably, protect their freedom, as unhospitalized mentally ill patients routinely have the control of others imposed on them—often with less benevolent intent.

Example

Mr. D was a 43-year-old white married man admitted to hospital on an emergency temporary detention order taken out by his wife. He had a history of a manic episode in his early 20s and a severe depression about 5 years later that led to a suicide attempt. In the interim, he had done well and had a successful business career as a stockbroker. Over the 2–3 months before admission he had little need for sleep and became excessively energetic, increasingly extravagant in his personal spending, and increasingly risk-taking in his handling of client accounts. He had also become quite verbally abusive to his wife when she tried to set limits, but she only petitioned for the temporary detention order when he got a second mortgage on their home to obtain money to pool with that of his clients to invest in a junk bond offering.

Clinical examination revealed the patient to be extremely hypomanic, but not floridly delusional. He was convinced that his venture would make him wealthy and establish him as the preeminent broker in his company. Despite his verbal attacks, his wife was unwilling to testify that she felt herself to be in physical danger. The argument that he was very likely destroying his personal and professional economic standing was judicially rejected as a basis for commitment because of “inability to care for self,” and the patient was released. His venture subsequently failed, he was fired, and his family lost their home.

Coercive Treatment Implies the Availability of Treatment

Judge Frank Johnson in the 1971 Alabama case of Wyatt v. Stickney (Lamb and Mills 1986) addressed the doctrine of a “right to treatment” for patients who are hospitalized involuntarily. He set the minimal standards as requiring a humane physical and psychological environment, qualified staff provided in sufficient numbers, and individualized treatment planning (Perlin 1983). In Goodwin v. Cuielma (Lamb and Mills 1986), the court addressed the requirement that treatment be provided to prevent clinical deterioration whenever a patient is committed. Al-
though the courts in these cases have addressed with some specificity those approaches that are not allowed, they have not delineated the factors involved in deciding what treatment the patient has a “right” to receive. Rappeport (1987) pointed out that the “right to treatment” decisions have sometimes had a paradoxical effect in terms of the patient’s actually receiving treatment. For example, to escape liability for not having adequate resources for full-quality treatment, many state hospitals began extensive “dumping” of patients into the community. Although hospitals have a statutory requirement to provide “adequate treatment,” the community does not.

Coercion Must Be Related to the Need for Treatment

In 1975, the U.S. Supreme Court ruled in the case of O’Connor v. Donaldson that a state cannot incarcerate mentally ill individuals who are not dangerous and who can care for themselves or be cared for by willing others. The Court maintained that “mere public intolerance or animosity cannot constitutionally justify the deprivation of a person’s physical liberty” (Perlin 1983, p. 541) and further stated that undesirable behavior, even if illegal, does not constitute “dangerousness.”

Coercive Treatment Is Recognized as Potentially Powerful

In the 1979 case of Parham v. J.R., a case of mental retardation rather than mental illness, the U.S. Supreme Court found a “substantial liberty interest” in “not being confined unnecessarily for medical treatment” (Perlin 1983, p. 541). Finally, in the 1980 case of Vitak v. Jones (Perlin 1983), the Court ruled that full procedural guarantees were needed in the situation of a prison-to-hospital transfer of a mentally ill individual, emphasizing that hospitalization is, in fact, more a loss of liberty than jail because it has more potential to lead to change in an individual.

Coercive Treatment Is Reportedly Not Abused

One factor that is not much addressed in the debate over the need for judicial safeguards is the empirical data on the prevalence of abuse within the system. It is noteworthy that a congressional hearing by the Senate Judiciary Committee’s Subcommittee on Constitutional Rights, chaired by Senator Sam Ervin, produced no cases of successful railroading (e.g., forcing an individual into a psychiatric hospital not for his or her best interests but for the gain of the petitioner). A field investigation of mental hospitals in six states conducted by the American Bar Association concluded that railroading is a myth (Slovenko 1977). Although clinical and legal safeguards do prevent railroading, as defined above, the involved parties may become so frustrated with the restrictiveness of the system that they “finesse the law” to obtain care that is in the best interest of the patient.

Example

Mr. E was a 29-year-old single white man admitted to the hospital on a temporary detention order taken out by his sister, an emergency room nurse. He had a long history of relapsing cocaine dependence. He lived with his parents and worked sporadically in the restaurant trade. He had a record of past arrests for robbery, drug dealing, and prostitution to support his habit when in relapse. In addition, he had two past psychiatric hospital admissions for paranoid states that had occurred when he was using drugs heavily.

In the temporary detention order petition, Mr. E’s sister alleged that he had attempted to choke her in response to a delusional belief that she was a witch. Before the commitment hearing, Mr. E agreed to stay in the hospital voluntarily. In a subsequent family meeting with the patient and his sister, it was revealed that he had not threatened her in any way; she had made the allegation because, as an emergency room nurse, she was aware that it would ensure his rapid hospitalization before his condition deteriorated to the point of further police involvement. She was also aware that “failure of outpatient treatment” would need to be documented before he could be readmitted just on the basis of his cocaine use relapse, and that he would be fully out of control before this scenario could be played out.

In a study conducted in Massachusetts, Appelbaum and Hamm (1982) found that 1) psychiatrists were knowledgeable about the requirements of the law and 2) the three legal factors of dangerousness to self, dangerousness to others, and inability to care for self carried the greatest weight in their decision to seek commitment. The nonlegal factors of whether the patient had a place to live, whether he or she had a support structure in the community, how severe his or her symptoms were, and whether the symptoms were acute or chronic had significant but much lesser impact. The first three of these latter factors could, of course, be seen as a clinically equivalent way of addressing the patient’s ability to care for self. Appelbaum and Hamm further found that a list of interper-
sonal variables—including whether psychiatrists found the patient frustrating, likable, verbal, discouraging, frightening, gratifying, seductive, intelligent, argumentative, depressing, or presenting a good or bad appearance—did not significantly influence their decision.

In a broader context, Appelbaum and Roth (1984) conducted a study in which they monitored the actions of physicians on the medical and surgical wards of a university hospital for 11 weeks. During this time, they found that the total incidence of involuntary treatment was 1.17 episodes per 100 patient days, with the duration lasting from 1 day to more than 3 weeks. They found that the medical and surgical physicians tended to impose treatment in two instances—when a patient who displayed significantly impaired mental status tried to leave the hospital and when such a patient resisted needed treatment. They further found that refusal of treatment and disruptive behavior in the absence of disorientation and confusion did not provoke forced interventions over the patient’s objections. The de facto standard of incompetency that these physicians employed—severe confusion and disorientation—was felt to be much stricter than that applied by most courts.

Appelbaum and Roth concluded, therefore, that psychiatrists are not unique in using involuntary methods of treatment and restraint. Rather, they act very similarly to their medical and surgical colleagues. Both groups also use similar involuntary treatments—restraints, psychoactive medications, especially neuroleptics, and intravenous fluids. Further, they found that, despite the much greater freedom of action on medical and surgical floors, such interventions are used in an extremely conservative manner and almost always in the best interest of the patient. They concluded that the generalization that physicians cannot be trusted with such discretion does not seem supported by the data—which does support the U.S. Supreme Court’s opinion in Youngberg v. Romeo, which gave deference to professional judgments about the use of restraints in institutions.

**Recommended Criteria for Involuntary Treatment**

In conclusion, this committee would endorse the following guidelines for involuntary-hospitalization legislation, based in part on the American Psychiatric Association (APA) “Guidelines for Legislation on the Psychiatric Hospitalization of Adults” (Council on Governmental Policy and Law of the American Psychiatric Association 1983) and the review of the guidelines by Appelbaum (1985b). We refer interested readers to the full text of the APA guideline proposals for elaboration.

- **Five criteria are required for commitment:**
  1. The patient suffers from severe mental illness.
  2. There is a reasonable prospect of getting the needed treatment at the facility that represents the least restrictive alternative.
  3. The patient refuses or is unable to consent to voluntary admission.
  4. The patient lacks the capacity to make an informed decision concerning treatment.
  5. The patient is likely to cause harm to self or others or to suffer deterioration.

- A “need for treatment” standard should be incorporated into state commitment laws with the clinical issue being the patient’s likelihood of suffering deterioration if treatment is not provided. This guideline represents an attempt to provide criteria for the evaluation and treatment of the “nondangerous” mentally ill.

- The definition of harm or dangerousness should be expanded to include issues of property. For example, acutely manic patients would be seen as harmful to their family and themselves if they are rapidly dissipating all resources on grandiose and poorly advised financial schemes, driven by the cognitive and mood distortions inherent in the disease phenomenology. Justice Warren Burger, while on the circuit court, observed in Overholser v. O’Beirne that dangerousness is a complex and multifaceted issue and is a concept not usefully held too restrictively, warning that the courts should not “confuse danger with violence” (Rachlin et al. 1984, p. 141).

- We differ with the APA guidelines holding that the degree of mental illness triggering the process should be one of psychosis, believing that the “psychosis” provision does not hold in the case of suicidal risk, especially as evidenced by a recent act. We also would recommend that the concept be expanded to include psychotic illness and not just current, florid psychotic symptomatology. For example, if a patient is known to have a recurring and stereotypically presenting psychotic illness, we would hope that intervention could be made at the point when it becomes clear that a relapse is occurring. In the case of Project Release v. Proctor, the U.S. Supreme Court ruled that an “overt act” was not required but that “an impartial fact finder, guided by medical documentation, should be permitted to determine that mental illness is present and danger likely without waiting for an individual’s conduct to make such physical harm all but inevitable” (Lonendorf 1983, p. 689).

- We agree with the extensive enumeration of patients’ rights outlined
in the APA guidelines and also agree that one of these rights should not be the right to refuse appropriate treatment. It is taken as a given that a patient unable to consent to hospitalization is unable to consent to treatment. However, even here, safeguards are provided. For example, the wishes of patients and families are to be given careful consideration on an ongoing basis, and certain types of treatment are not allowed, such as aversive behavioral paradigms or “experimental” treatment. We would hold that experimental treatment does not mean all uses of medication that do not have Food and Drug Administration (FDA) approval. For a medical specialist, prudent somatic treatment is based on the current research literature—a view the FDA itself endorses (Temple 1978).

- In states that do not adopt the APA guideline of making lack of capacity a part of the commitment standard, we would opt for a process of independent peer review of important treatment decisions. As Appelbaum (1988) pointed out, this represents the model of clinical practice already used “in our finest teaching institutions, where attending psychiatrists, consultation services and conferences with outside clinicians serve that function” (p. 418).

Several procedural recommendations are also endorsed:

- There must be an individual treatment plan, and this plan must be approved by the responsible psychiatrist. Definite value is seen in keeping this authority and responsibility circumscribed within a profession.

- Patients committed because they are likely to harm others can be released only by the court, giving liability protection.

- This legislative proposal intentionally does not have a community mental health center prescreening provision. Although prescreening may have some theoretical justification, it has an economic root that is inimical to patients.

The legislative goals of these recommendations, as outlined in the APA document, include the following:

- To make psychiatric evaluation, care, and treatment available to persons who suffer from severe mental disorders and can benefit from treatment and to encourage voluntary rather than involuntary admission whenever hospitalization is necessary.

- To safeguard the legal rights of patients in a manner that will advance and not impede the therapeutic and protective purposes of psychiatric hospitalization.

- To provide workable procedures for obtaining consent to medications and for administering medications and other treatments; and to provide legal immunity for reasonable, good-faith efforts to implement treatment under these guidelines and legal penalties for knowing, willful efforts to subvert the legislative intent.

Summary

Legal and historical trends support the concept that sometimes involuntary psychiatric treatment is necessary, can be effective, and can lead to freedom from the constraints of illness. Conversely, tight restrictions against coercive treatment can have disastrous consequences. The competition between medical and legal models of commitment and the tightening and loosening of restrictions on commitment laws over the decades can be seen as a reflection of society’s efforts to balance its concern for the mentally ill with its concern over the legal rights of its citizens. The resulting variation in criteria for involuntary treatment is evidence that the use of coercion in initiating psychiatric treatment is not a yes/no event, but rather varies on a continuum dictated by society’s needs, even at the formal commitment level.

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Civil Commitment and Involuntary Treatment: Professional, Patient, and Family Perspectives

Loren Roth (1980) contended that ultimately it is people, not laws, that usually govern in the commitment arena. Although we have already addressed to some degree the psychiatric profession’s perspective on the commitment process, it is worthwhile also to examine the interfaces of psychiatry with other groups, especially with regard to the perceptions of these groups about the need for coercion as part of effective and humane psychiatric treatment. Included would be the police, judges, lawyers, community mental health center staff, patients, and their families.

Police

More than 50 years ago Penrose (1939) demonstrated a negative correlation between the proportion of people in a given nation placed in mental hospitals and the proportion held in jail. Bonovitz and Bonovitz (1981) demonstrated an increase in mental illness-related incidents that involved police of 277.6% from 1975 to 1979, coincident with tightening of treatment restrictions; whereas felonious incidents increased only 5.6% and the total number of incidents (excluding these categories)
decreased by 9%. In categorizing the basis of police involvement with
the mentally ill, these two investigators found that neither dangerous-
ness nor penal criteria were met in 29% of calls, whereas in another 29%,
only the dangerousness criteria were met. In their study, only one of
the patients in the “dangerousness-only” group had committed a serious
felony and been arrested; the rest were diverted to the mental health
system. In the remaining 42% of the calls, dangerousness criteria were
not met but penal criteria were—including disorderly conduct, terroris-
tic threats, harassment, defiant trespassing, or indecent exposure.
However, there was only a 13% arrest rate in the calls that involved violation
of the penal code by mentally ill persons. Slovenko (1977) referred to
some of these arrests as “golden rule” or “good Samaritan” arrests,
because of the clear motivation by the police to see to it that the mentally
ill obtained psychiatric care.

Durham et al. (1984) demonstrated that police involvement actually
may increase the possibility of a mentally ill person’s getting into the
mental health system, because their involvement helps establish at least
an assumption of dangerousness. They showed that police involvement
is a more important determinant of whether a hospital referral results in
involuntary commitment than either the behavior of the patient or the
recommendation of the mental health professional. In their study, only
19% of cases without police involvement resulted in commitment as
opposed to 39.2% of cases with police involvement. Thus Durham et al.
contended that the police are increasingly becoming the “gatekeepers”
of the mental health system because they choose whether to take persons
into custody and into which system to enter them. The latter choice is
sometimes influenced by the fact that the disposition of a case via the
mental health system requires less police paperwork than its disposition
to the criminal justice system.

One aspect of the police–mental health system interface is that in all
states, regardless of their civil commitment laws, there is a hospitaliza-
tion route that does not require a finding of dangerousness. A criminal
defendant who is found incompetent to stand trial can be committed for
therapeutic treatment to restore competency purely on the grounds of
mental incapacity, regardless of the behavioral criteria (Peszke 1984). In
Wisconsin, after the introduction of a restrictive civil commitment pro-
cedure in 1972, there was a 263% increase in the number of criminal
commitments to psychiatric hospitals with the legal charges usually
being vagrancy, shoplifting, or disorderly conduct (Roche Report 1978).
Bonovitz and Guy (1979) reaffirmed this observation that subjects hos-
pitalized on prison psychiatric units tend to have committed less serious
crimes and have fewer past convictions than the general prison popu-
lation.

Judges

Reviewing the interface with judges, Bursztajn et al. (1986) found a
converging tendency for judges to defer to psychiatric recommendations
in commitment hearings and a tendency for psychiatrists to attempt to
anticipate the probable judicial disposition when deciding to petition.
They also found that judges generally did not find the decision in these
cases to be difficult, clustering at 1 to 2 on a 7-point scale of difficulty.
They found that judges rated three factors as most important in their
decision:

1. Whether the psychiatrist’s opinion was convincing;
2. Whether the patient would be a reliable outpatient;
3. Whether the patient would be able to take care of himself or herself.

Bursztajn et al. (1986) revealed that factors having to do with compli-
cance were more influential than those having to do with dangerous-
ness—despite the imperative of dangerousness in the legal code. Thus,
they state that “parents patriae may be legislated away, but common
sense and compassion alike keep the question of need for treatment.
occasionally clothed as competence, unmistakably in view” (p. 173–174).
Bursztajn et al. concluded that psychiatrists who petition only when they
feel sure that legal criteria have been met (rather than when there are
clinical grounds to bring the matter up for court resolution) are setting
for themselves too high a threshold for petitioning. This tendency for
psychiatrists to be overly intimidated by the legal system is perhaps
reinforced by Roth’s (1980) observation that judges are more likely than
psychiatrists to view a particular behavior as dangerous.

Rachlin (1987) reviewed the degree of dangerousness that experi-
exenced judges found acceptable for commitment. In North Dakota
dangerousness was found when the “patient lacked sufficient judgment to
protect herself from the hazards of the world” (p. 884). A Montana court
ruled that the legislature did not intend that “the blood of innocent
people must be shed before the statutory definition of ‘overt act’ has been
satisfied” (p. 885). In both Montana and Arizona the courts recognized
the stereotypical nature of illness recurrences by finding persuasive the
coexistence of past violent acts with current threats in the face of clinical
deterioration.

Lebuffe et al. (1979) studied two adjacent areas that had similar
demographics but different commitment statutes (i.e., for initial deten-
tion, one used the signature of two physicians and the other used a
judicial order). They found that in the “physician jurisdiction,” the
commitment rate per year was 6.5 per 10,000 population, whereas in the
“court jurisdiction” the rate was 12.3 per 10,000.

Lawyers

Studies in North Carolina (Hiday 1983) and Iowa (Stier and Stoebe 1979)
compared the attitudes of lawyers toward psychiatry with the opinions
of judges. Hiday (1983) prefaced her study with a reminder that most
attorneys involved in civil commitments are not members of the “mental
health bar” (Chapter 4, p. 33), but rather are junior members of the bar
who work as public defenders or who are appointed by the court from
a list of private attorneys willing to represent indigent clients. These two
studies showed that both judges and lawyers tend to respect psychiatrists
as professionals in the area of mental health and regard them as
having valid tools and remedies to aid the mentally ill. In general, both
groups also accept a medical model of mental illness. The two groups
diverged on their attitudes toward mental hospitals: 14.3% of judges but
51% of attorneys give negative ratings. Both tended to agree that mental
hospitals are helpful and to disagree that they are primarily social
control agencies that do not provide much treatment. But the lawyers
tend to see hospitalization as a step to be taken only after all other
remedies have failed, perceiving the hospitals as hampered by staffing
and funding problems.

Community Mental Health Centers

Faulkner et al. (1985) examined the interface with the community mental
health system, which in many states has been designated, at least by law,
as the gatekeeper to the state mental hospital system and has been given
an economic incentive to prevent hospitalization. For example, in Vir-
ginia the community mental health centers are in direct competition with
the state hospitals for mental health budget dollars, receiving increased
funding for lowering the state hospital census by any means. These
incentives still exist despite a 1978 General Accounting Office study
reported by Lamb and Mills (1986) in which no difference in the utiliza-
tion of state hospitals was found between states with community mental
health centers and states without community mental health centers. This
similarity was attributed to the fact that the community mental health
centers were serving a different and less ill population than were the
state hospitals.

In their study, Faulkner et al. (1985) did identify an impact of
community mental health centers on commitment rates. They proposed
that changes in the agendas of the staff involved in the community
mental health centers were a larger determinant of the rate of commit-
ment than even the changes in the restrictiveness of the law. The manner
in which initial evaluation and triage were done and the effort put into
diversion were the major factors responsible for the observed decreases
in the commitment rate. They present data suggesting that during a
period in Oregon when there were budget cuts and decreased commu-
nity mental health center staff involvement with their agenda of
deinstitutionalization, the rate of commitment increased 171% from a
6-year baseline.

Patients: Who and Why?

Although we have addressed some of the issues surrounding the commi-
mitment process and explored the substantive criteria of commitment,
it is also useful to look at the characteristics of the individuals who
actually are committed.

Symptomatic Behavior

Schwartz et al. (1984) found the committed group to be composed of
patients who were paranoid, had delusions or auditory command hal-
lucinations, were angry or belligerent, had committed assaultive acts,
were manic, or (if being held in hospital pending a hearing) had required
the use of seclusion, maximal observation, or neuroleptic drugs. Thus,
they were a severely psychotic patient group in need of external control.
Zwerling et al. (1975) also demonstrated that the group of committed
patients tended to be belligerent, agitated, and assaultive, whereas
Spengler (1986) found that paranoid and other psychotic productive
symptoms were prominent.

Because of the statutory requirement of dangerousness, assaultive
behavior was significantly correlated with commitment, whereas suici-
dal behavior was less correlated (Beck et al. 1984; Shore et al. 1981).
However, Spengler (1986) pointed out that dangerousness is not predic-
tive of commitment in and of itself; many patients who are dangerous
to themselves want help, and those who are dangerous to others often
wish to safeguard their civil rights.

From a different perspective, Faulkner et al. (1985) thought that
those who are committed can be categorized according to three levels of
preventive criteria. They pointed out that at any time there are many
committable individuals in a community. Whether they are committed
same rate, black men were more likely to be hospitalized involuntarily. This result was entirely explained by their mode of presentation; 39% of the black men presented with police involvement, whereas only 29% of the white men had such involvement. As discussed previously, police involvement, where it occurs, is the major predictor that a hearing will result in a commitment decision. This study also demonstrated the relationship of outcome to the mode of presentation. The involuntary hospitalization rate was 63% when the patient was brought in by police, 42% when the patient was brought in by treatment personnel or family, 16% when the patient was brought in by a friend, and 12% when the patient was self-presenting. When this factor was controlled for, race differences disappeared. Thus, for blacks, the coercive element in admission (police involvement) starts before the point of entry into the mental health system. Although police involvement is a major determinant of a decision for commitment in a given case, overall, 70% of petitioners are family members (Slovenko 1977).

The average age of an Oregon cohort at commitment (Shore et al. 1981) was 32; 64% of the patients were between ages 20 and 39. The men had a mean age of 29, and the women a mean age of 37. Shore et al. (1981) found that 79% of committed patients were single, separated, divorced, or widowed. Towes et al. (1984) also found that only 31% of the committed patients in their study cohort were married. Thirty-five percent of these patients lived alone (Shore et al. 1981), often in room-and-board living situations with no fixed address (Towes et al. 1984). These patients tended to have low incomes (Gray et al. 1985; Towes et al. 1984), with 69% earning less than $150 a week (Shore et al. 1981).

From a slightly different perspective, Gray et al. (1985) examined the characteristics of patients who appealed commitment after it occurred. They found that only 16% (487 of 2,966) of those eligible to appeal did so, and of these, 35% were released. Those who appealed tended to be male; be under age 30; have less than a high school education; be unskilled; be unemployed; be admitted from another institution; be schizophrenic; have problems with work, school, or parents; and abuse alcohol. However, they had normal orientation and no mental retardation or epilepsy.

The Patient's Perspective

Example

Ms. F was a 44-year-old white married woman admitted on a temporary detention order and then committed on the testimony of her husband and her outpatient therapist. She was in a first episode of acute mania: irritable, hypsomoric, loud, frequently obscene, grandiose to the point of delusional, and spending very wildly. This state followed by about 3 months a severe catatonic depression that had required electroconvulsive treatment.

Ms. F was a grade school teacher with a master's degree, whose husband was a high school basketball coach in the same school district. She had missed the previous year of school on medical leave because of her depression. Her commitment occurred at the beginning of the next school year, and the policy of the school district was that 2 consecutive years of medical leave constituted a resignation.

Ms. F maintained strong denial of her manic decompensation even in the face of confrontation from her family and outpatient therapist and bitterly blamed her husband, the clinical staff, and the judge for her job loss.

Example

Ms. G was a 20-year-old third-year university student admitted on a temporary detention order taken out by student health staff. She was floridly manic: loud, argumentative, irritable, hypsomoric, and extremely grandiose. She had had two previous depressions, as well as what, in retrospect, was probably a hypomanic period, although this was her first hospitalization. She was an orphan raised primarily by her grandmother since age 10. She had been involved periodically with street drug use, which seemed at least temporally associated with her prior hypomania and current mania.

Ms. G was hospitalized for almost 2 months. She accepted and responded well to medication, and she developed a productive working alliance with an outpatient psychiatrist. Despite several painful but relatively minor depressive breakthroughs, she did well, finishing college, establishing a career, and getting involved in a stable marriage. She remained compliant with medication and avoided other drug use.

Patient Attitudes

Stone (1975), in his "thank-you theory of paternalistic intervention" (p. 18), held as a basic premise that the only justification for abrogating procedural safeguards is the provision of benefits that ameliorate human suffering. If this goal is being achieved, one would expect that at least a significant number of committed patients would, in retrospect, be grateful for the hospitalization they initially resisted. There are at least a few studies that have examined patients' attitudes toward commitment and how their attitudes change with time.
In their study of 35 involuntary patients interviewed immediately after admission and again before discharge, Kane et al. (1983) found four significant trends:

1. There was a significant change toward recognition of the original need for involuntary treatment.
2. Patients achieving remission of symptoms—69% in this study—were most likely to have positive attitudes.
3. The majority of patients (64%) continued in follow-up after the index episode.
4. Among readmissions, 93% were voluntary.

Even among patients who clearly still had negative attitudes about hospitalization at discharge, 80% were subsequently rehospitalized voluntarily or continued in outpatient follow-up. In an earlier 18-month follow-up study of 96 court-committed patients, Tomelleri et al. (1977) found that of the 20 patients with 30 readmissions, 65% of the readmissions were voluntary.

In the study by Kane et al. (1983), the fact that 64% of the patients followed up their hospitalization with voluntary outpatient treatment and 93% were voluntary on their next hospitalization led the investigators to deduce that the patients' positive attitudes on discharge did not represent an attempt just to be "good" patients and "say the right things."

Gove and Fain (1977), comparing 86 committed and 172 voluntary patients, found that 75% of the committed patients and 80% of the voluntary patients thought the hospitalization had done them good. Surprisingly, only 5.5% of the committed patients but 9.5% of the voluntary patients felt they had been harmed by the hospitalization. In a telephone survey 1 month after discharge, Spensley et al. (1980) found no significant difference between the mean ratings of treatment satisfaction for voluntary and involuntary patients.

Towes et al. (1984) found that 46% of their cohort believed they were helped by commitment, and 33% believed they were harmed; 88% reported that their feelings toward their therapists were unchanged or improved since commitment, and 93% stated that their attitude toward psychiatry was improved or unchanged. These authors concluded that most patients seemed to separate their feelings about psychiatry and their therapists from their feelings about commitment.

Because of the devastating nature of a mental illness severe enough to require involuntary hospitalization, one cannot assume that the usual legal rights and safeguards can be understood by some patients. Towes et al. (1986) interviewed 34 patients shortly after admission and at 1, 3, and 6 months postcommitment. All patients had been given both oral and written information on their status as committed patients and on their rights. At the time of the first interview, only 13.6% admitted knowing they were committed, and 13.6% remembered that they had had their rights explained. At the 3-month interview, 64.7% admitted knowing they had been committed, and 29.4% remembered that they had had their rights explained. Interestingly, none of these patients chose to exercise their right of appeal.

Morbidity and Mortality

In an Oregon study of 189 patients who entered the commitment process, of whom 29% were eventually formally committed, Shore et al. (1981) found that in all diagnostic groups the committed patients who accepted follow-up did significantly better than those who did not. They also found that 19 deaths occurred among the 189 patients over a 19-month period of follow-up. Nine occurred among elderly patients from medical causes, and 10 patients (average age 29) committed suicide. Eight of these 10 suicides occurred among the patients who were released during the commitment process. The mortality rate for patients who came to the commitment process was 65 per 1,000 compared to 15 per 1,000 for the area's adult population, with the deaths being due to medical causes (in elderly patients) and suicide (in young adults).

The authors commented that, although commitment is most likely to occur for assaultive behavior, these mortality figures should be examined. They contend that psychiatric commitment currently is being used by the courts primarily to implement social policy for control of violent behavior in the community rather than to prevent psychiatric morbidity and mortality.

It seems worth emphasizing that the concept of hospitalization as a last resort needs to be reevaluated in the context of the risk-benefit thinking applied to all medical decisions. Sometimes hospitalization is most helpful and reasonable as an early rather than a late intervention based on the diagnostic insight derived from sound diagnosis. Further, if coercion in the process is going to be needed, it makes sense to apply the coercion before the person is essentially beyond coercion—before he or she has nothing left to lose. An example would be the alcoholic patient who is forced into treatment only after all meaningful relationships have been lost, all job prospects have been exhausted, all resources have been spent, and cognitive decline has progressed to the point that the patient can no longer really benefit from the educational aspects of addiction treatment.
Families

Although the illnesses that lead to commitment may in some cases obviate the patient's ability to feel that the intervention was helpful, one would expect that those who care about the patient would feel that way. Unfortunately, there are few studies of family satisfaction with the results of involuntary hospitalization. The previously cited data (Mahler et al. 1986) that about three-fourths of committed patients are committed repeatedly and that 70% of the petitioning is done by families may lend some support to the premise that families are satisfied with the results.

Example

Mr. H was a 64-year-old married man admitted and then committed on the testimony of his neighbor. He was a retired military man who had subsequently worked in a civilian capacity with the armed forces. He had been married four times, the first three marriages being very brief. At the time of commitment, he had been married for 24 years to a nurse more than 20 years his junior. They had two children. Mr. H precipitated his current hospitalization by claiming that his neighbor's son had caused Mr. H's daughter to get bad grades in college and had plotted with the Nicaraguans to kidnap her.

Mr. H had had a manic episode 2 years previously; it followed about 7 years of treatment with low-dose amitriptyline for pain in his lower back, which had caused his retirement 10 years previously. He had then raised the children while his wife obtained her nursing degree and worked.

Throughout the patient's hospitalization, he rejected the diagnosis of bipolar illness and its implications and took medications only reluctantly. Over time he developed a reasonable working alliance with his psychiatrist, and eventually the manic episode did resolve. Meanwhile, major progress occurred in the family's knowledge of and reaction to the patient's illness. Most importantly, his wife, with much support, was able to develop a working strategy for dealing with his illness episodes and became much less intimidated by him.

One good outcome of the controversy surrounding involuntary treatment is that it has fostered a new and important alliance between families and psychiatrists, similar to that between other physicians and families of patients with physical illnesses (Treffert 1985). We believe that the ripple effect of mental illness in families and, by extension, the community is a major and often neglected issue. Clinicians who work with adolescents are repeatedly impressed with the high incidence of familial disruption present in the lives of young patients who come to psychiatric attention. In developing the patient's history, they frequently find that the child's presentation was preceded by a period during which the caregiver lost the capacity to fulfill the demands of the parenting role, often because of mental incapacity ranging from a severe depression to a period of accelerated substance abuse.

In jurisdictions with restrictive commitment laws or practices, a family currently has only three alternatives (Treffert 1985) when it sees one of its members deteriorating from a mental illness and is unable to persuade that person to seek or accept care:

1. Threaten commitment in the hopes of getting voluntary, but coerced, compliance.
2. Disown the family member so that he or she has no rescue or refuge and more quickly meets the criteria of "unable to care for self."
3. Wait until the police pick up the patient for a criminal offense, in which situation it is hoped the judge will recognize mental illness and order hospitalization instead of jail.

As Jonas Rappeport (1987) reported, parents and relations of patients who compose the Alliance of Families of Mental Patients, sometimes called the Alliance for Mental Health, strongly advocate the following: 1) better, stronger, more easily operated commitment laws; 2) limits on the right to refuse treatment; 3) strong outpatient commitment laws; and 4) less patient advocacy.

Summary

As outlined in Chapters 4 and 5, this committee believes that certain characteristics of the functioning of the legal system can be inimical to the needs of the mentally ill and must be taken into balance when the legal system's methods are superimposed on the mental health system. First, the law is an adversarial system. In the legal system lawyers interact with lawyers, their adversarial equals (Chodoff 1984). In medicine and psychiatry the physician's interaction is with the patient, with whom a therapeutic alliance will need to be formed after the legal system has gone home for the night. Although a sensitive and well-trained clinician can learn to do commitment hearings skillfully so as to enhance what potential there is to help patients see the consequences of their current condition, the price is high. The fact that something good can come out of a bad system hardly justifies the more frequent negative outcomes.

A second problem with the legal system in this interface with
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medicine is that the legal process is slow, whereas the crucial decisions about patient care often must be made rapidly and not infrequently at inconvenient hours. As an illustration of this reality, Tanay (1978) outlined the case of Joseph Saithevicz in Massachusetts, a severely retarded man who had leukemia. In this case, the patient’s doctors felt that the painful side effects of a trial of chemotherapy did not make sense and asked the court for permission not to treat. The petition was made on April 26, 1976. The court replied in the affirmative without giving an opinion on July 7, 1976, and did not issue its final written opinion until November 28, 1977. The patient had died on September 4, 1976.

We also are concerned that, as public policy, the dissociation of the concept of “rights” from “obligations” is as bad for psychiatric patients and the systems with which they interact as it is for students and schools, drivers and highways, or citizens and communities. Although we believe that mentally ill patients, like all patients, have very important rights in terms of appropriate self-determination and quality care, we also believe that, as part of the social contract, they have obligations to their families and communities, as well as to themselves. We believe that the conceptual linkage of these two values is vital and is outside the purview of law. Loren Roth (1980) quoted Grant Gilmore, professor of law at Yale, as saying that

Law reflects but in no sense determines the moral worth of society. . . . The better the society, the less law there will be. . . . In heaven there will be no law and the lion will lie down with the lamb. . . . The worse the society the more law there will be. In Hell there will be nothing but law and due process will be meticulously observed. (p. 395)

Finally, an issue we have alluded to several times requires further attention: it is appropriately addressed here because it often represents the final word—money. There is simply not enough money available in the system to do all that should be done for the mentally ill. In Action for Mental Health (Joint Commission on Mental Illness and Health 1961), on which the community mental health center system was based, the authors advocated deinstitutionalization for a number of very sound humanitarian reasons, but also outlined how the system necessary to allow this deinstitutionalization would require increased expenditures. As we indicated earlier, however, deinstitutionalization only really occurred when a system arose—namely, Medicare (Pinsky et al. 1981)—that allowed the states to shift the economic burden for the care of these patients. The funds to care for the patients in the community never followed. When adjusted for inflation, less is spent today on the mentally ill than in 1975. Additionally, insufficient attention was paid to the predictable consequences of “involuntary deinstitutionalization without informed consent”—that is, without a review with the patient of what the world can really be like for certain of the mentally ill without the asylum of the hospital. Given that the end product of the increased legalization of the system is mostly cosmetic (Luckey and Berman 1981), one certainly wonders whether the money spent would not be better used elsewhere, expanding the system and providing viable treatment alternatives. To quote Stone (1975), “where there are no alternatives, the concept of voluntariness is a charade” (p. 13).

The issue of financing mental health care has serious implications in the private as well as the public sector. The majority of insurance carriers, including the government via Medicare and Medicaid policy, severely discriminate against the mentally ill by putting very restrictive caps and limits on the provision of benefits for mental health services. In doing this, they made no distinction between services provided to those with adjustment reactions and those provided to persons with serious and debilitating illnesses. In point of fact, the limit of 30 days of hospital coverage or 20 outpatient visits, either per year or even per lifetime, is simply not adequate for the treatment of the serious psychiatric illnesses that can and do occur in the lives of even generally productive individuals (e.g., an out-of-control eating disorder in a young college woman, a manic episode in a young father, an involutional depression in a middle-aged woman, an acute paranoid state in a recently retired man). For these serious illness states, the amount of coverage available in more and more policies has become less than the predictable treatment response time for both the somatic and the interactive therapies.

As insurance limits have become more restrictive, patients and therapists delay more intensive treatment, either in outpatient or inpatient settings. This delay allows evolving psychiatric illness to progress to the point where the patient’s judgment gets so impaired that commitment becomes a more likely necessity. In this regard, it is noted that the acceptable criteria for hospitalization advanced by many insurance companies are essentially those of committability. Hospital treatment is thus becoming a critical last resort and losing its place in the repertoire of options available in a positive, prospective manner to contain and prevent medically predictable consequences of illness states.

Of particular relevance to the subject of this book, the appropriate and helpful use of coercion, is the fact that the severe limitations on both funding and committability allow resistant patients to “wait out” their treatment experience. When the realities of the situation make the treatment time-contingent rather than goal-contingent, the patient can treat the hospitalization as a “sentence to be served” rather than as a process to be engaged in with clear goals that need to be attained.
We also believe that the imposition of the legal system at the gateway to mental health care has fostered an adversarial trend within the mental health system itself. For example, the patient advocate system that has developed in many institutional settings follows the legal adversarial model—with the advocates acting not to facilitate the patient's cooperation, or even the patient's best interest, but to encourage an adversarial relationship between patients and staff. In so doing, they often paradoxically increase both the costs and the length of the patient's hospitalization.

In summary, then, we feel that the restrictions of the recent past have put the system out of balance—there are too many safeguards to keep patients out of care and too few to get them in (Appelbaum 1985). Unfortunately, with the trend toward an increased prescreening bureaucracy, benefit capitation, health maintenance organizations, and the "industrialization" of medicine, we are concerned that all patients may now need more protection to get into treatment than to prevent unwanted treatment.

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Commitment to Outpatient Treatment

Outpatient commitment is a form of coercive treatment. As with many forms of coercive treatment, the issues surrounding it are a mix of clinical, philosophical, legal, economic, political, and administrative concerns, many of which are addressed in the preceding chapters on commitment. In this chapter the presentation is structured around the indications, contraindications, cautions, and public policy implications in the use of outpatient commitment.

Definition

Outpatient commitment is a court order to the patient that he or she must comply with treatment in an outpatient setting. Usually the site is specified, but the treatment itself is not. The consequences for failing to follow outpatient commitment provisions are variable; but for the purposes of this chapter, we will assume that we are referring to those jurisdictions that have effective mechanisms to hospitalize involuntarily those who are not in compliance with the court order.

Outpatient commitment is specifically allowed in half the states and prohibited in one state, New York (Kellits and Hall 1985). Its legal status in other states has yet to be resolved. The earliest record of outpatient commitment is in the District of Columbia in 1972. In the District, outpatient commitment is sometimes more common than inpatient commitment; outside the District of Columbia, data on its use are incomplete, but apparently it remains infrequent despite the legal availability.
Contraindications for Outpatient Commitment

Below are listed the contraindications for outpatient commitment:

1. The patient’s mental illness is poorly controlled with any treatment that the clinic could provide and the symptomatology includes violence to others or suicidal behavior, or
2. There is no fixed address.

Example

Mr. J, age 24, was admitted to the hospital for the fifth time since age 20. Admission symptoms included auditory hallucinations and persecutory delusions, sometimes marked by unprovoked violence, with apathy between his psychotic episodes. The diagnoses were paranoid schizophrenia and phencyclidine abuse. His mother was invested in his care but felt unable to cope with him; even so, she wanted him to stay with her. Prior referrals to the clinic had been totally unsuccessful. It was decided to pursue outpatient commitment, partly because the mother preferred him to be at home rather than in the hospital and partly because the appropriate inpatient program, a dual-diagnosis track, had a waiting list that suggested he would not be able to get into it for over a year. The court agreed to the outpatient commitment, and he actually kept two appointments (his mother accompanied him).

About 6 weeks after discharge, he apparently bought some phencyclidine, began hallucinating voices that said they were going to kill him and chop him into little pieces, and got into an argument with a bystander. The argument led to an assault in which he caused permanent damage to the bystander’s left eye as well as some brain damage. He then entered the criminal system where he was found not guilty of assault and battery by reason of insanity.

In retrospect, the clinicians thought that his illness had made this man quite lethal and decided that phencyclidine abuse was not a disorder that the clinic was capable of handling. (We are also aware of one case in which a committed outpatient on phencyclidine killed an acquaintance.)

Cautions

One should approach outpatient commitment with caution when the patient does not meet all the criteria outlined above under “Indications for Outpatient Commitment.” As suggested by our discussion of untoward results under “Contraindications for Outpatient Commitment,” a major caution is the patient’s use of substances that lead to violence.

Unfortunately, in some settings, the use of a substance such as phencyclidine is so ubiquitous that practical considerations lead program clinicians to consider substance abuse as a caution, to be considered along with other factors, rather than as a contraindication.

Various factors can encourage one to try outpatient commitment when not all of the indications are met. There is a tendency to use outpatient commitment when the patient’s “dangerousness” is the inability to take care of himself or herself, while some other aspects of the case give hope that such treatment will work. Sometimes making exceptions to the criteria is a successful strategy; other times it is not.

Example

Mr. K, 34 years old, had averaged more than two hospitalizations a year since his 20th birthday, when he had his first delusional and hallucinatory episode. These episodes led him to become withdrawn, unresponsive, and unable to take care of his needs. His response to haloperidol was good, but he detested the feeling that the medication gave him. During the last hospitalization, he was maintained on 2 mg of haloperidol rather than the 5–10 mg of prior years, and he said that he “didn’t mind” taking that dose. A long-time resident of the city and able to stay at his sister’s home, he seemed to meet all the criteria for outpatient commitment except that his sister was unwilling to participate in monitoring him, although she was willing to have him at home. (“I have enough responsibilities already and can’t take him on.”) He kept two appointments, but 18 months ago left the sister’s home after an argument and has not been seen since. Ward staff have reason to believe that he has joined the city’s homeless and have alerted their teams that go into the shelters; but he has not been found, and staff are concerned about his ability to survive.

In this case, the criteria should not have been overruled. The absence of someone to monitor, supervise, or report the patient’s condition led to a failure of outpatient commitment.

Example

Ms. L was originally hospitalized in her mid-teens. She recovered and finished several years of college, but she had almost annual episodes of suicidal behavior or threats. Between these episodes she was impulsive, emotionally labile, and frequently angry to the point that it was difficult for her to function in the classroom or on the job. She also engaged in binge drinking and the use of barbiturates and cannabis.

The 5-year history of borderline personality functioning, substance abuse, impulsivity, and a “soft” local address left the inpatient staff
unenthusiastic about the potential efficacy of outpatient commitment. In part because the ward staff’s lack of enthusiasm for inpatient commitment was even greater and because the clinic was willing to be responsible for her, she nonetheless was committed to outpatient treatment. Despite her changing address, the staff were able to have her rehospitalized twice before she settled into an effective program of individual and group psychotherapy. For over a year she has had a stable job in a bookstore, is using alcohol less and substances not at all, has made no suicidal threats or gestures, and has not been rehospitalized.

Ms. L’s case demonstrates that some patients who fail to meet the criteria can be successfully committed to outpatient treatment. The clinic staff’s eagerness to have her in their program appears to have been the factor that led to success. Her case demonstrates that clinical judgment sometimes should be allowed to overrule the criteria.

Making Outpatient Commitment Work

Outpatient commitment is most successful when the patient is legally committed to treatment and the staff is emotionally committed to making it work (Band et al. 1984; Bursten 1986; Miller and Fiddleman 1984). Because people committed to outpatient treatment may be relatively unattractive patients, staff members may be reluctant to become invested in their care. Although attitudes are hard to measure, and therefore, one must rely on impressions, outpatient commitment often fails when the clinic staff seems reluctant to be part of the process. Staff members may oppose coercive approaches, may dislike participating in forcing “clients” to come into treatment, and may even take the position that “forced treatment doesn’t work.” Staff members may also resent the extra paperwork that is often required with these patients, or they may be reluctant to have anything to do with the courts. The key to successful outpatient commitment is an aggressive clinic staff that wants to work with involuntary patients, is convinced that some of them can be helped, and is willing to make home visits, to call on the courts to take action, and to testify in court.

Although one can find willing staff members that are organizationally remote from the inpatient staff, a positive attitude is more common among staff members that feel a kinship with the inpatient program. When the psychiatrist or mental health professional proposing the outpatient commitment is the same person who will be responsible for carrying out the commitment, the situation is ideal but relatively rare because of the way public psychiatry is organized. In theory, commitment to outpatient treatment should be available in a number of settings, including that of a private practitioner who would follow the patient when hospitalization was necessary. Because this arrangement has been carried out only a few times in the District of Columbia, its general applicability and effectiveness remain unknown.

Another key to making outpatient commitment work is rapid judicial and police action in the event of noncompliance. If there are no teeth in outpatient commitment, it becomes a frustrating, demoralizing experience for the staff and a travesty for the patient. Even though staff willingness to work with involuntary patients is important, court action alone seems to have an impact. Having a judge order them into treatment makes a tremendous impression on some patients. These patients will say in retrospect that they felt compelled to follow orders given by a judge in a courtroom after years of being noncompliant with the wishes of family, friends, teachers, or clinicians.

There are some substantial issues surrounding the use of outpatient commitment that lack guidelines. Even psychiatrists who have had extensive experience with such commitments have difficulty answering the question: When does one discontinue outpatient commitment? Especially troublesome are patients who are doing well but who are noncompliant.

Example

Mr. M, now in his 30s, has a long history of bipolar illness that consisted of long periods of mild depression and at least three manic episodes about 3 years apart, episodes that disrupted his life and were not easily controlled with medications. He also has the Axis II diagnosis of passive-aggressive personality disorder. He was outpatient committed 2 years ago, and after a few weeks of social and occupational instability, he obtained work with a supply company and met a lady there with whom he has been living. He has had no manic episodes, nor has he become so depressed that he was unable to work.

After a month or two, he ceased coming to the clinic, stating that it wasn’t necessary, and was also unwilling to take lithium as prescribed. The U.S. marshals took him from his home to the hospital four times; each time his mental status, except for noncompliance, was not remarkable. He was then transferred back to the clinic, still outpatient committed and still not keeping any appointments. How long should outpatient commitment continue under these circumstances? Mr. M’s case is an example of issues awaiting empirical research.

When an outpatient setting is available and the staff is invested in this approach, the results can be rewarding (Band et al. 1984; Geller 1986, 1991; Van Putten et al. 1988; Zanni and deVeau 1986). For some patients,
outpatient commitment has been the ingredient that broke a pattern of
cycling for which no end was in sight. When an investment in outpatient
commitment exists, not only is there a decrease in the number of inpa-
tient hospitalizations, but also the length of the rehospitalizations is
reduced (Zanni and deVeau 1986). One reason why the length of stay is
shorter is that many of the patients are briefly hospitalized for noncom-
pliance rather than because of an exacerbation of their symptoms.
Geller (1986) summarized the value of outpatient commitment:

To correct the “greatest failing of the modern mental health system . . .
the failure of continuity of care” (Stone 1982), to desist from avoiding
the care of the sickest patients, to shed feelings of impotence, and to do
all this without acts of civil disobedience or moral gyrations that render
him or her too exhausted to attend to patients’ clinical requirements,
the psychiatrist needs a sanctioned system that permits effective ther-
apetic intervention in community settings. One such system may be
civil commitment to outpatient treatment. (p. 1262)

Another summary of the issue came from Mulvey et al. (1987):

The most reasonable position appears to be an open recognition that
there are serious threats to civil liberties posed by a policy of involun-
tary commitment but that little positive treatment can be done for the
casualties of deinstitutionalization without accepting some element of
coercion in the policy strategy. In the end, outpatient commitment is
worth attempting because it is a possible way to get us out of the present
quandary of having to decide between the inhumaneness of institutions
and the neglect involved in dumping mental patients in the community.
The use of an element of coercion should make us wary of the dangers
of this approach, but the unsuitability of our present options should
push us to design a system that is sensitive to both the needs and the
rights of mental patients. (p. 582)

**Persons Acquitted by Reason of Insanity**

Dr. Richard Lamb and his associates completed a 5-year study of persons
acquitted of crimes by reason of insanity who were managed as outpa-
tients—a form of outpatient commitment. On 5-year follow-up, one-
third had been rearrested at least once and nearly half had required at
least one hospitalization. A little more than half of the patients, however,
had achieved satisfactory results. Lamb et al. (1988) also wrote that

Working with this difficult population requires a close liaison with the
criminal justice system and a clearly articulated treatment philosophy.

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Essential elements include an emphasis on structure and supervision,
a recognition of the importance of neuroleptic medication, a reality-
based approach to therapy and a focus on the problems of everyday
living, and incorporation of the principles of case management. Treat-
ment staff must be comfortable with giving support, enforcing limits,
and recommending revocation of the patient’s community status when
necessary. (p. 1080)

**Implications for Public Policy**

Probably the most significant single trend in psychiatry in the second
half of the twentieth century has been the deinstitutionalization of
psychiatrically ill patients. Deinstitutionalization resulted from scientifi-
cally untested policies made possible by scientifically tested medi-
cations. It is important for policies to be approached with the same care
that we use in approaching medication; we must determine for whom a
policy is useful and for whom it is harmful.

In this chapter, we have shown that outpatient commitment is a
potentially positive treatment option for some patients. Like any other
treatment option, however, it can be dangerous to the patient or to others
unless the patient meets appropriate criteria, the treatment is imple-
mented properly by staff, and the courts are able to respond quickly.

The criteria for outpatient commitment do, however, bring into
question several issues relating to values. If a state’s criteria for outpa-
tient commitment are the same as for inpatient commitment, questions
about the ethics of outpatient commitment are not separable from more
general questions about the ethics of involuntary treatment. If the criteria
for outpatient commitment are less stringent than those for inpatient
commitment, the threat of involuntary commitment for noncompliance
may be lost. How practical it is to have equivalent criteria is a function
of the state’s inpatient commitment criteria. There are two aspects to
consider:

1. An inpatient commitment standard that requires a recent dangerous
event is difficult to apply to outpatient commitment (Appelbaum
1986). Most patients under treatment will soon no longer have any
“recent” events.
2. A commitment standard that is time limited (e.g., 30 days) will not
apply to outpatient commitment.

The ideal legal climate for outpatient commitment exists when the
dangerousness standard does not require recent events and when the
commitment can be for a substantial period of time. Outpatient commit-
ment is frequently used in the District of Columbia because the legal
standards are ideal: commitment is based on the finding that the patient
is mentally ill and is likely to injure self or others (injury to self includes
the inability to take care of oneself), and the commitment remains in
effect as long as those findings pertain. Thus, in the District, repeated
past history of behavior that is dangerous to oneself or others, including
an inability to care for oneself, can lead to indefinite commitments.

Another legal question pertinent to outpatient commitment is the
status of “right to refuse treatment” standards in a given jurisdiction. In
inpatient settings, such refusals can be addressed by simply waiting out
the situation and using other means (e.g., restraints), but those methods
are not feasible in outpatient settings. In jurisdictions where one has to
go to court to obtain permission to give medications involuntarily, such
a decision is best obtained simultaneously with the outpatient commit-
ment if there is any prospect that one will want to give the patient
medications.

Beyond these legal values, there are other public policy issues. To
achieve satisfactory outpatient commitment, the public psychiatric sys-
tem needs to ensure a connection between the inpatient and outpatient
programs that will be serving an individual patient. This connection can
more easily be accomplished when the state’s organization of mental
health services does not compartmentalize patient care. The authority
responsible for the patient should remain the same as the patient’s
condition changes; in other words, the patient should not cross major
administrative barriers as he or she improves or deteriorates. This is
consistent with the general principle that continuity of care is a major
ingredient in successful care, a principle already acknowledged in the
public-sector management of chronically mentally ill patients.

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Coercion in Psychiatric Treatment of Prisoners

There are close to one million people in state and federal prisons in America (768,845 as of June 1991; American Correctional Association 1991). This group of people is both larger and more varied than is popularly supposed. It is likewise a population with a high prevalence of mental disorders (Steadman et al. 1987; see below). Psychiatric treatment of prisoners is a special case because of the closed, authoritarian milieu in which it occurs.

Historically, the practice of psychiatry in prison has given rise to questions and controversy about forced treatment. Some do not want to mitigate punishment by showing too much concern for prisoners; others have come to fear that psychiatric techniques will violate human rights and legal protections (Kittrie 1971; Milford 1973). By its nature, the prison system exerts very strong pressures on the individual prisoner; for example, review boards typically evaluate a prisoner's cooperation with rules and activities in their decisions regarding early release. Coerced treatment, therefore, is uniquely feasible in a system that has so much power over the individual. Potential secondary benefits (such as early release) or negative consequences can be powerful incentives for prisoners to participate in activities or programs with which they would not otherwise cooperate.

Halleck, in his book on psychiatry and crime, asserted that in prison, "obviously the psychiatrist or any other professional will be constantly tempted to control people in ways and for durations which are neither helpful nor necessary" (Halleck 1967, p. 239). Some psychiatrists take the
position that there is so much potential for abuse in prison psychiatry that no treatment should be attempted (Group for the Advancement of Psychiatry 1977).

The psychiatrist in a prison setting must maintain awareness of the forces influencing patients and scrutinize their consent for treatment accordingly. These forces can be friend or foe to treatment, promoting motivation at one time and discouraging it at another. Some psychiatrists and therapists who practice in prison and parole settings will not attempt treatment unless there are external pressures to reinforce their patients' motivation (Rappeport 1974; Reid 1985). Reid, in his review of the literature on the treatment of antisocial personality disorder, found consensus that establishing control of the patient is foremost. He stated that a principle of successful inpatient treatment is that "forced or coerced treatment—for example treatment mandated by a court—is preferable to voluntary hospitalization" (Reid 1985, p. 835).

Harris and Watkins (1987) took the position that a low-pressure sales pitch to gain the cooperation of the client is ethically sound and that clinical situations need to be judged individually. The national associations of psychiatrists and psychologists have supported professionals practicing in prison and adopted guidelines for ethical practice in that setting (Dubler 1986). Court decisions in the United States have declared that prisoners have a right to mental health services of a quality similar to that of mental health services available in the community.

Clinical Practice in Prison

A wide variety of diagnoses and circumstances can be encountered by the psychiatrist in the criminal justice system. The study by Steadman et al. (1987) in New York State found that 8% of the prison population had "severe" disabilities from mental illness that warranted treatment, and another 16% had "significant" mental disabilities. In each case there is the problem of developing useful motivation and a treatment contract. A review of the general psychiatric literature revealed little on the general topic of motivation, and information on research techniques used to investigate mandated treatment and on the outcome of mandated treatment is nearly absent. Many reports of individual efforts, however, provide some principles regarding treatment of prisoners.

Treatment Contract

There is universal agreement that treatment beyond that of the acute psychotic state, whether psychotherapy or pharmacotherapy, requires that the patient eventually consent to a treatment contract. Larke (1985) proposed that a written contract be developed and that the therapist make a positive contribution such as offering to review with the patient the case notes and any record of prior treatment.

Developing a viable treatment contract in the prison setting is a complex and difficult task. It is affected not only by the presence and nature of coercion but also by the degree to which the psychiatrist is involved in the coercion. The most extreme instance of psychiatrist involvement occurs when the patient is acutely ill or psychotic; the psychiatrist may find the patient unable to exercise choice and mandate treatment without the patient's consent. More commonly, however, the psychiatrist is not the initiator of the coercion. A prisoner may be coerced to enter treatment by the strong negative consequences of failing to do so; such consequences may be applied by the court, by the authorities of the prison system, or by a parole board, as well as by other less obvious sources. A prisoner may be told at his sentencing by the court that the sentence will be modified according to whether or not the prisoner gets psychiatric treatment. A parole board with the power to release a prisoner beyond the end of a sentence may likewise make psychiatric examination and treatment a requirement for such consideration.

The latter situations are the ones that most often are viewed as impossible for the therapist because they invite feigned consent and dishonest participation. They are indeed difficult—but not impossible—to work with. Meltzoff and Kornreich (1970), in their review of psychotherapy outcome research, concluded that the research supported the impression that "the need for therapy and the desire for change via therapy do not necessarily have to be understood or accepted by patients at the onset of treatment but can develop as therapy proceeds" (p. 251). The therapist who wants to be successful in this difficult situation must accomplish several things early on toward negotiating a true treatment contract with the patient (Smart 1970).

Understand the Nature of Coercion

First, the nature of the coercion that is being applied needs to be examined by the patient and psychiatrist together. What does the patient think will be the result of not getting into treatment? What is the patient's understanding of the requirement that has been made of him? The patient's attitude toward this coercion must be assessed. The task of the psychiatrist seeking trust extends to making explicit the less obvious forces with which the prisoner may be complying. This requires knowledge of the prison culture and circumstances, in addition to knowing the
laws and regulations. It is not only judges, officials, and therapists who may be influencing prisoners but other prisoners as well (Larke 1985).

**Example**

A prisoner came knocking on the psychiatrist’s office door asking for treatment. He had been sentenced to 5 years for involuntary manslaughter (passenger) as a result of an automobile accident while he was driving under the influence of alcohol. He acknowledged that he had a history of drinking on the weekends with the guys. He said he could stop whenever he wanted to and that this was the only time his drinking had caused him any problems. He said he had been reluctant to come for treatment before because he wasn’t really an alcoholic and his friends in prison usually played dominoes when AA meetings were scheduled in the evening. He acknowledged that his participation in AA meetings would look good when he came before the review board; he wanted to do everything he could to get out of prison early. The psychiatrist explained what the entire program consisted of and that he expected full compliance with the treatment program if he were to accept the prisoner into treatment. The prisoner agreed.

**Understand the Prison Value System and Address Secondary Gains**

In prison there is a stigma associated with seeking help; thus, the exaggerated “macho” value system in male prisons often raises resistance to treatment. In addition, all of the secondary gains that can be encountered in psychotherapy situations in other settings exist in the prison environment as well. It is necessary to address these secondary gains early in the treatment and to make them explicit.

One group of therapists who reported an early attempt to treat parolees in a mandated program described the phenomenon of negative correlation between expressed motivation and actual motivation without recognizing what they were seeing. They reported their conclusion that the results were negative because most of the parolee patients continued to deny any need for treatment: “The prevailing attitude expressed in the (follow-up) questionnaire was one of contempt for the program, denial of its usefulness, and negation of any need for it. Interspersed were contradictory statements of agreement that psychotherapy should have been a condition of the parole, and recommendations that it be provided for other parolees. Paradoxically, the questionnaires returned by the reincarcerated parolees were generally more favorable in their retrospective evaluations than those who ‘made’ parole and are currently in the community” (Patterson et al. 1962, p. 190). A therapist more experienced with this population would not find this outcome paradoxical, but recognize it as a result of the need to deny personal need for help.

**Offer Alternative Interventions**

The ability to give free consent, and thereby enter into the treatment contract, depends on the alternatives. If the alternatives are extremely punishing, as can be the case in the prison setting, the freedom to make a choice and give consent is greatly diminished. This diminished freedom is perhaps the strongest argument of those who maintain that no treatment contract can be arrived at in the prison setting. When a prisoner is coerced into treatment, he may find it difficult to know whether he is responding to pressure or making his own decision. This question needs to be addressed many times at different stages of treatment. Miller (1984) found that the literature supports the view that providing clients with a selection of intervention alternatives decreases dropouts and resistance, increases compliance, and improves overall effectiveness of the treatment program.

**Examine the Fairness of the Coercion**

Many therapists who report successful therapy in the prison setting note the importance of the issue of fairness. The coercion must be forgivable. If the patient perceives the requirement of therapy as someone’s unfair decision motivated by prejudice, this attitude must be addressed immediately because it will poison therapy if the therapy does proceed. If there is to be a future treatment alliance, there must also be a perception on the part of the future patient that the coercion is fair. The patient may resist and be resentful of the requirement for treatment but nevertheless see it as just and not unexpected. Some patients say the parole board should not be able to require treatment; however, they feel that because of their repeated criminal behavior, they should make some effort to change and that the treatment really is fair and appropriate. Such an attitude is quite promising and can predict a successful psychotherapeutic engagement (Claron 1966).

**Example (continued)**

During the course of the treatment program, the prisoner minimally participated in group, but nevertheless attended regularly. With time,
he skipped some meetings and then stopped coming altogether. The psychiatrist inquired into his absenteeism. The prisoner said he felt that the program was a waste of time. Last week, however, he sought out the psychiatrist after he received news that his younger brother died when his car ran into a tree; he had been drinking. The prisoner spoke of his shame in not admitting he could have had a drinking problem. He wondered if his brother would have entered a treatment program and still be alive had the prisoner not told him the treatment program was a “waste.”

The psychiatrist suggested individual sessions to work through the prisoner’s grief before he got involved in the treatment program for alcoholic patients again; the prisoner agreed. At the prisoner’s request, the psychiatrist explained that he would submit an accurate report of the prisoner’s attendance in the treatment program; he would also state the reason for the prisoner’s recent discontinuation of treatment, as well as the new treatment plan on which they agreed.

Establish the Psychiatrist as the Agent of Therapy, Not Punishment

Therapy in prison cannot work if the psychiatrist does not continually affirm his separation from penological methods and goals. If the psychiatrist participates in or cooperates with punitive measures disguised as rehabilitative coercion, that will inevitably negate and prevent the development of any motivation for change. Such actions affect not only the individual prisoner but also others who take note of what is being done. This dishonest coercion often provokes a response of total opposition. The worst case occurs when this type of coercion provokes a covert resistance to the specific changes one might want the patient to make. In this worst case, the patient counteracts by continuing the proscribed behavior; the punishment becomes paradoxically rewarding and reinforces the very behavior one is attempting to extinguish. The psychiatrist in the prison setting who allows himself or herself to be used for purposes other than patient care will find that his or her practice does not grow. Constant vigilance and self-examination are required. Information about a new therapist spreads rapidly in a prison community, and if it is negative, this information will interfere with development of trust by most prisoners.

Promote Engagement of the Patient

One hopes to see compliance lead a prisoner first to become a patient, then to involvement, and after that to a treatment alliance. The psychotherapy concept of resistance is very pertinent to understanding the factors that lead to success or failure in effecting these transitions. Coercive treatment is especially likely to be perceived by the patient as a threat to ego integrity and danger to the self-image. In a manner familiar to therapists, prisoners therefore conceal from themselves as well as the therapist why they avoid and evade dealing with their problems.

Harris and Watkins (1987), in their book Counseling the Involuntary and Resistant Client, developed 10 principles for working with involuntary patients to promote engagement. They can be summarized, with modifications, as follows:

1. Provide structure and set expectations.
2. Provide as much choice to the patient as possible and minimize demand on the patient.
3. Let the patient save face.
4. Ignore resistant behavior at times rather than taking the “bait.”
5. When optimum anxiety exists, use the opportunity to stimulate self-examination and reflection.
6. Time interventions for critical moments when optimum anxiety exists.
7. Pique curiosity about psychology and therapy.
8. Identify and acknowledge the positive as well as the negative motives of patients with antisocial behavior.
9. Use nonverbal techniques.
10. Recognize and allow for the various styles of learning and changing.

Some Caveats

Treatment of patients whose motivation is weak should also include positive rewards promised and delivered when there is movement in the desired direction. Positive reinforcement is particularly important in prison settings because of a high incidence of antisocial personality disorder. It is not successful to rely, as do more traditional, analytical approaches, on confrontation, interpretation, and clarification alone without support and reward for the positive movement that is observed. Many believe that it is necessary to be more forthcoming and more open as a therapist in prison settings (Reid 1985). Imprisonment is a very lonely experience, and there is a tendency for patients to develop a very strong positive transference in a short time (Cox 1986). If this transference is overlooked by therapists, it can be destructive to the therapy and sometimes to the patient. Thus, some
therapists argued that individual therapy is difficult to conduct in prison and that group therapy has advantages that are specific to that setting (Carmi 1984; Clonon 1966).

Larke (1985) recommended the use of a multymodal approach, including behavioral and cognitive methods and support groups such as Alcoholics Anonymous. Because personality disorder occurs frequently in the prison population, he applied some techniques used for treatment of borderline personality disorders. He also stressed the need to remain aware during therapy of the fragile self-image of the patient and to strengthen ego boundaries.

Miller (1984), in his excellent review (one of the few on this topic), found that research on motivation reveals that therapists tend to attribute lack of motivation to the patient when their own lack of desire to treat the patient is more prominent.

Implications for Public Policy

Public policy recommendations can be made from clinical observations and experiences. Even in the coercive prison setting or in a parole setting, it is possible to provide effective treatment. Public policy should recognize this possibility by providing opportunities for prisoners to obtain treatment. A reasonable standard, supported by both clinical and legal authorities, is that mental health services should be available to the same extent that they are available from public sources in the community. We suggest a philosophy that would regard prisoners and parolees as citizens of their home community, with the same needs for treatment opportunities as other members of the community.

Administrative policy and organizations within prisons should recognize that therapists are needed in prison and parole settings. There is also a need to clarify the purposes of imprisonment and the priorities of these purposes. Criminologists speak of punishment, incapacitation, and rehabilitation as the goals that guide the criminal justice system. These goals cannot always be served simultaneously. Current sentencing procedures need to be reformed to resolve this confusion. The laws and policies that permit authorities such as courts and parole boards to mandate treatment should recognize that it is possible to mandate an attempt at treatment but that actual treatment comes about when and if the mandate can be converted to motivation. “Until a clear social policy is provided, rehabilitation will remain as it often is now: inefficient, ambiguous, and controversial” (Linton 1978, p. 55).

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Mandated Therapy in Military Settings

The military is an authoritarian, highly structured, and intensely regulated societal organization. The military mission, to prepare for and engage in combat, comes first in all aspects of the participant’s professional and personal life. Within this authoritarian culture, however, there is less overtly coerced treatment than one might think. Mandated evaluation and therapy exist in three areas: drug and alcohol rehabilitation, family abuse counseling, and psychiatric care. As with all military health care, these programs focus on preserving personnel who are fit for duty, deployment, and combat. Mandated treatment or therapy can accomplish this military goal while also benefiting individual patients. The military experience has been that coercion does not have to interfere with the therapeutic process if it is acknowledged and dealt with in treatment.

Most military-mandated care involves the treatment of substance abuse or family violence, in which psychiatrists participate as consultants to the social worker or psychologist clinicians who historically initiated and now manage the programs. Psychiatrists have authority for mental health services and psychiatric services, which constitute the most limited mandated therapy in the military, in both scope and volume.

This chapter examines substance abuse programs, family advocacy programs, and psychiatric services in the United States Army, Air Force, and Navy, specifically in terms of coercive care aspects that are unique to the military setting.
Alcohol and Drug Abuse Treatment Programs

Drinking is included in many customs and social rituals important to military life. With alcohol so ubiquitous, the problem drinker can be difficult to spot; the military historically has ignored alcohol problems or treated them administratively (Finnan et al. 1973; Porsch 1976). In the 1970s, the Department of Defense began to devise educational programs and officially “deglamorize” and deemphasize alcohol; however, cultural change has been slow. These same programs initiated mandatory identification and treatment of alcohol- and drug-dependent persons in the armed forces (Ruben 1974).

The stated rationale is that elimination of alcohol and drug problems is important to maintaining a fit military force. Despite unit members’ resistance, commanders frequently refer them for evaluation or treatment. The treatment program strives to change the patient’s compliance with the commander’s mandate to an internal motivation for treatment. Initial compliance is driven by two factors. The subtle factor is that service members are accustomed to doing as they are told; the more overt factor is their commander’s option of separation if they balk. A “rehabilitation failure” administrative separation is an honorable discharge. Eligibility for Veterans Administration treatment remains; however, military pay and benefits (including family health insurance and housing) stop. Processing a rehabilitation failure separation requires approval of both the treatment program director and the commander, whose assessments are made from independent and different perspectives.

Example

A 32-year-old warrant officer presented to the emergency room reporting anxiety about his marital separation the day before. He was visibly shaking and acknowledged daily drinking. Laboratory tests showed macrocytosis and significantly elevated liver enzymes. He was admitted for alcohol detoxification, evaluation, and intervention, which confirmed alcohol dependency.

Following medical recommendation, his commander enrolled him for further outpatient treatment despite the patient’s insistence that his alcohol use was “not bad.” His denial remained high, and subsequently he was directed to a 6-week residential treatment facility. He agreed to go because his commander told him it was important. On his return, he showed more acceptance of his alcoholism and more motivation for participation in the program and support groups.

In the world’s largest employee assistance program, each armed force runs local programs staffed with full-time military and civilian clinical staff. Participants receive outpatient treatment during duty hours at no cost, and they continue to receive pay and benefits if they receive treatment in a residential program. Intervention and confrontation of denial are widely used in initiating treatment, which focuses on group counseling, Alcoholics or Narcotics Anonymous, and other support groups. Group cohesion is a focus, and participants receive treatment within their military community so their treatment or counseling groups frequently include their co-workers or neighbors. This group focus could be interpreted either as an optimal use of peer pressure or an invasion of privacy. Some settings do provide their patients with treatment groups based on age, rank, sex, stage of disease, or relapse characteristics. Twelve-step groups are not official components of the program and maintain their traditional independence and anonymity.

Disulfiram (Antabuse) is a component of treatment in many programs. Physicians who prescribe disulfiram for patients in the military find that it is useful in maintaining abstinence when it is dispensed by commanders. In civilian settings with mandated compliance, disulfiram also has been found to increase abstinence rates (Fuller et al. 1986; Gerrein et al. 1972).

Disulfiram interacts with alcohol to produce byproducts that can cause flushing, sweating, headache, nausea, vomiting, chest pain, and, potentially, death, with the severity dependent on the quantity of alcohol consumed and one’s personal biology. Although this “Antabuse reaction” is the best known aspect, it may be the least effective part of disulfiram therapy. The threat of an Antabuse reaction is rarely effective for long; most problem drinkers are not responsive to threats, and using disulfiram only for its adverse action contributes little to the therapeutic process.

Using disulfiram in support of positive thinking and teamwork seems to be more important and successful than using it for its more explicit threat. Patients can be encouraged to use their daily dose as a daily reminder that “I shouldn’t drink today because I want my life to be better.” The daily ritual of taking disulfiram dispensed by the commander or designated section sergeant symbolizes and reinforces the leadership’s interest in abstinence and recovery. Disulfiram can also be used to combat peer pressure to drink. When taking disulfiram, soldiers are initially encouraged to blame it (and the commander) when refusing a beer. This is especially useful early in treatment for younger soldiers in the barracks and older ones in their own social situations. Also, daily supervision helps to remind the unit leaders that they have soldiers who
should not be drinking, which can be helpful during the planning of social events to include alcohol-free components.

**Example**

A 21-year-old infantryman was referred for evaluation after a driving under the influence charge. He clearly qualified for a diagnosis of alcohol dependence. During the evaluation, he acknowledged that although alcohol had several adverse effects on his life, he was ambivalent about acknowledging that it was a problem or that he needed to abstain "forever." He wanted to stay on active duty and knew that his commander would not tolerate another alcohol-related incident. He lived in the barracks; his roommates and "all" his friends drank. He was counseled on the risks, benefits, and side effects of disulfiram, and he consented to it as part of his treatment plan. His squad leader dispensed his disulfiram for the next 120 days.

Unsupervised disulfiram is not effective, perhaps because the positive teamwork effects are lost. Even the most motivated patient does not want to believe that he "needs Antabuse" as a deterrent, so he is tempted to go without it. The marginally motivated soldier is unlikely to take it.

By regulation, disulfiram treatment cannot be mandated, so physicians must obtain consent to prescribe it, and a service member may refuse it. More education about disulfiram and its benefits, followed by encouragement and support, is often successful with aanking service member (Armitage 1984). In practice, for those who still refuse disulfiram, treatment continues without it, although in theory, a complicated procedure such as that detailed in Army Regulations (AR 600-20, 1980) might result in an order for the patient to take the drug. Thus, a service member’s fear that he or she could be ordered to take it anyway may have an indirect coercive effect on his or her consent.

Members of the military force are primarily in treatment to improve their performance. To achieve this end, treatment is ordered with or without the cooperation of the patient. Changing the focus from coercion into cooperation and motivation for abstinence and recovery can be affected by the service member’s relationship with commanders, his or her perceptions about the confidentiality of treatment, and his or her career concerns. Staff awareness of and sensitivity to these issues determine in large part how well all facets of the treatment program are administered, including the mandate.

Successful treatment depends on cooperation among commanders, treatment personnel, and active-duty patients. Several factors can make cooperation so difficult that command and treatment personnel function at cross purposes (Long et al. 1977). Some commanders tend to see treatment staff as unsatisfactory, and some treatment staff tend to see commanders as inflexible. Civilian staff may view the coercion as punitive or ambiguous and see themselves as patient advocates at odds with both command and military clinical staff.

If command and treatment staff members work together, issues of mandate, reporting, and punitive consequences will be as clear and uniform as possible. The mandate must be well defined, fair, and non-discriminatory. Optimally, commanders refer all those with problems for evaluation, and then enroll all those diagnosed for treatment. If a therapeutic alliance is to be established, treatment staff should release no personal information to commanders beyond enrollment, disulfiram prescription, progress reports, and documented relapses such as intoxication at treatment sessions. Quarterly reports to the commander should indicate only satisfactory or unsatisfactory progress. “Rehabilitative team meetings” that include the commander also should include the patient. Successful treatment staff members avoid giving advice or having discussions with commanders about “what to do” with relapsed or recalcitrant patients beyond comments on their potential to engage in further treatment.

Any punitive sanctions are, and must be acknowledged by all to be, the commander’s purview. A commander has options in dealing with a subordinate who continues to abuse substances or who has an alcohol- or drug-related incident while in treatment. Those who relapse may be given an opportunity for further treatment and continued military service, although the decision process by which some are retained and some are separated after relapse is highly variable (Kolbre et al. 1977). Individual commanders tend to be personally either tough or lenient in all their dealings with troops. Keeping the separation between treatment motivation and sanctions clear helps with several categories of difficult patients. Some plan to fail, hoping to get out of the service. Some hope to avoid responsibility or punishment for an alcohol-related incident. Some marginal patients “cut back” on intake and do much better at work. Some patients appear motivated or improving but have recurrent relapses.

For members who want to stay on active duty, their fears about career security can motivate or impede treatment progress.

**Example**

A 36-year-old noncommissioned officer resisted all attempts to engage in treatment even though he was enrolled by his commander after a driving under the influence charge. He felt that any cooperation would
be an acknowledgment of an alcohol problem, would prolong his time in the program, and would decrease his chances for a choice assignment. His denial prohibited progress toward recovery while he maintained abstinence. He relapsed in a public incident, which both increased his length of enrollment in treatment and removed the likelihood of a choice assignment.

Many patients come to treatment after a considerable period of mediocre performance, several “minor” alcohol-related incidents, and a rather dramatic “precipitating event.” This history usually impedes careers more than the enrollment for treatment per se, although the treatment usually gets the blame. Variability among commanders leads to variable treatment of service members in similar circumstances, which fuels fears about career insecurity (Long et al. 1977). Each service has career safeguards such as those in the Army Regulations (AR 600-85, 1986), which state that enrollment will not be the sole basis for restricting continued service, permanent security clearances, or career advancement [emphasis added].

Military treatment appears capable of meeting the goal of returning service members to a more productive status, supporting sobriety, and starting recovery. The regulations are well meaning, organized, and clear, although local interpretation and execution of the programs vary widely. The military experience shows that successful rehabilitation can begin with coercion.

Family Abuse Treatment Programs

Abuse in military families is multifactorial, involving marital, family, legal, financial, and occupational aspects. Lanier (1983) found that military parents who abused their children were like abusive civilian parents, with risk factors of immaturity, unrealistic expectations, unmet emotional needs, frequent crises, lack of parenting knowledge, social isolation, emotional problems, and substance abuse. As may be expected for a predominantly young population such as military personnel, parental immaturity is a predominant problem. These families also tend to be socially isolated, live off post, and have only one car.

In the 1970s, social workers began to institute therapeutic and preventive programs for family abuse in the military setting because the military was thought to have numerous “at risk” factors arising from inadequate reporting and problems of legal jurisdiction (Center for Child Abuse Education 1983). In 1981, a Department of Defense Directive established a policy covering both child and spouse abuse (Department of Defense 1981). Each service then formulated its own regulations, such as those for the Army Family Advocacy Program (Army Regulation 608-1, 1983), which contained provisions for prevention as well as treatment programs for both the “maltreater” and the “maltreated” in cases of sexual and physical abuse.

Example

Neighbors called the military police to a home on post because of a loud fight. The wife reported that her soldier husband had hit her. He was brought to the military police station, where his unit was called. His commander then restricted him to the barracks and referred him to the Family Advocacy Team for evaluation.

Schwab and Kaslow (1984, p. 39) pointed out that ordering the husband (if he is on active duty) out of the home is usually ineffective without concomitantly referring him for treatment.

After family abuse, a commander can pursue a number of actions, including administrative separation or criminal charges. These possibilities are often used directly or indirectly to motivate the active-duty abuser (Raiha 1982). Schwab and Kaslow reported that coercion of initially resistant military husbands into treatment has positive features. They thought that a man’s reluctance to submit to control by others may indicate a willingness to accept responsibility for his situation, in contrast to a more submissive man who may expect his therapist to resolve the situation. They also observed that a man in military service also appears to respect a show of power by the therapist. Overall, the authors suggested that coercion can lead to a successful therapeutic alliance and a good prognosis (Schwab and Kaslow 1984).

The skills previously described as necessary for making a successful transition from mandate to alliance in substance abuse treatment programs are also necessary in family abuse treatment programs. Successful programs include clear boundaries, effective communication, and involved families. Jurisdictional problems and the fear of prosecution may hamper efforts to work with families. One significant aspect of these programs is that only an active-duty individual, regardless of who abuses or is abused, can be militarily ordered to participate in counseling or to leave an abusive living situation. The treatment team can only encourage a reluctant civilian spouse to seek treatment, or the team may report the situation to a civilian social service agency. Access to only one-half of a marital dyad complicates treatment of a family problem.

The fear of prosecution may also encourage a conspiracy of denial and provide a barrier to family participation because there is no guaran-
tee that a commander will allow treatment rather than pursue prosecution. Prosecution of an active-duty service member can result in loss of benefits, including housing and medical care, to the victim and the family. This situation creates a dilemma for families; confirming the abuse may separate them from basic necessities of life. The Department of Defense is attempting to relieve the situation by allowing continuation of treatment benefits for the abused person if the active-duty abuser is separated from service; however, local application of this provision is quite variable. With more active-duty women married to civilian men, a new, therapeutically difficult scenario has evolved. Mandated therapy for the female victim can be followed by disciplinary actions if she is perceived as allowing abuse to continue by an abuser who cannot be ordered into treatment at all.

**Psychiatric Evaluation and Treatment**

Unlike service members in substance abuse and family abuse treatment programs, many service members seek and receive psychiatric care in the military system without involvement of their commanders. They have psychiatric problems that are unrelated to their military service as well as multifactorial situational adjustment, and personality problems that are related to military service. Psychiatric care is provided at freestanding community mental health center clinics, hospital clinics, emergency departments, and inpatient settings. Psychiatrists have tightly compartmentalized roles as clinicians and military members. Their central mission is evaluating and treating service members to keep them fit for duty and deployment. Patients can be self-referred, referred from other medical clinics, or command-referred from their units. Virtually no directly mandated treatment (except involuntary emergency treatment) occurs in the military setting because of widespread beliefs, not officially stated, that scarce psychiatric resources are not spent effectively on the unwilling patient.

**Example**

A 22-year-old divorced, enlisted man was referred by his commander because of complaints of stress, poor attitude, appearing depressed, and poor performance at work. When interviewed, he attributed all of his problems to his duty supervisor. Neurovegetative symptoms were normal, and no major psychiatric illness was found. He refused follow-up. He was “clear” for command to pursue administrative solutions. No coercion to accept treatment was attempted.

No programs of mandated psychiatric treatment exist analogous to the alcohol/drug and family abuse treatment programs. Mandated psychiatric evaluation is much more prevalent than mandated therapy. Mirin (1974) described those ineffective service members who are unlikely to be command-referred; unable to function in the military, they become frustrated, lose self-esteem, perform poorly, and resort to antisocial behaviors that bring them to the attention of commanders. Both the commander and the service member may hope that the psychiatrist will diagnose a personality disorder to facilitate an administrative separation. Nicholson et al. (1974) discussed the pressures on the psychiatrist to avoid attempts at treatment. Alleged abuse of psychiatric evaluation for punitive reasons has been the focus of recent attention (Schichitanu 1990). The integrity and appropriate conduct of individual psychiatrists, psychologists, or social workers are the main safeguards against such abuse, because no clear regulatory mechanisms exist.

Command-directed psychiatric evaluation does identify service members with treatable disorders. Emerging manic, paranoid, depressive, or schizophrenic episodes all have behavioral manifestations that interfere with work performance and may prompt referral for mandatory evaluation. If they then are given an appropriate diagnosis, most service members voluntarily accept offered treatment.

Most psychiatric care consists of brief individual and marital interventions, group therapy, and short-term medication. A service member can refuse offered treatment; however, failure to cooperate often leads to a decision to recommend separation from active duty. The extent of the effect of this direct coercion on treatment is hard to estimate.

Service members and civilians present to military facilities with various psychiatric emergencies. Civilians who appear to have a mental disorder and dangerous behavior cannot be involuntarily admitted to a military hospital, whereas active-duty service members presenting to a military facility who appear to need psychiatric hospitalization can be involuntarily hospitalized as long as necessary (for evaluation and a decision on fitness for duty). Again, the individual psychiatrist is responsible for preventing abuse by only admitting bona fide psychiatric patients. Hospitalized service members have the right to refuse non-emergency medication; however, they may perceive a coercive threat in the therapeutic milieu that may prevent free choice.

**Example**

A 37-year-old single staff sergeant was hospitalized for evaluation of odd behavior despite his insistence that nothing was wrong. While on the psychiatric ward, he was seclusive and minimally interactive with
others in the milieu, but consented to examinations and medical testing. A diagnosis of paranoid schizophrenia was made. He refused medication while awaiting medical retirement. He was then transferred to a Veterans Administration hospital near his home.

Summary

In the military, it is believed that mandated treatment works best with clear reporting requirements, clear separation of the therapist from the coerced, and clear consequences of noncompliance. For major mental disorders, the lack of such formalized procedures means that there is very little military-mandated psychiatric care. This lack is partly because clinicians are reluctant to treat the unwilling or resistant patient. In contrast, such formalized procedures exist for substance abuse and family abuse disorders, for which clinicians believe they can offer appropriate treatment. As a result, a great deal of military mandated care occurs in these two areas. The effectiveness of this treatment depends on how well the mandate is transformed into motivation via a therapeutic alliance.

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Summary

In this report we set out to examine the conventional psychiatric wisdom that treatment must be voluntary to be effective. We found examples of successful treatment in a variety of coercive situations.

The Continuum of Voluntary and Forced Treatment

As we examined these forced-treatment situations, we found repeatedly that initial coercion can lead to greater freedom. For example, we have heard from families of chronic schizophrenic patients how the illness tyrannized over the whole family, including the patient; when involuntary commitment finally brought appropriate treatment, the patient and family experienced a new freedom. Indeed, we have seen that patients who initially fought against treatment often came to accept continued treatment voluntarily. Similarly, outpatient commitment can serve to keep patients functioning in the community rather than experiencing repeated hospitalizations when they stop their medications. The child molester forced into treatment by the terms of his probation may finally be relieved of his tormenting need to prey on children. The alcoholic patient threatened with losing his job, the soldier in danger of discharge from the service, the prisoner in jail for the third time—all have the potential to achieve greater autonomy through a treatment that they would not have accepted without external pressure.

As we researched and studied the exceptions to the original premise that coercion is antithetical to treatment, we began to view coercion not in terms of presence or absence, but in terms of degree and source. For example, the threat of imminent job loss as a consequence of alcoholism is a coercive factor in a patient’s coming to treatment whether the
employer "forces" treatment as a condition of keeping the job or the alcoholic person seeks treatment "voluntarily" because of the fear of being broke and unemployable. Similarly, the cumulative internal and external consequences of untreated mental illness are at least as powerful a coercion as the threat of hospitalization or incarceration.

With the broader view of coercion and the examples of successful treatment in which coercion plays an overt part, we can reexamine the usual treatment of adults (which we heretofore considered voluntary) and see that degrees of coercion, including use of therapeutic power, have perhaps been present all along—but not openly acknowledged. We must conclude that coercion does indeed have a role in clinical practice.

Of course, coercion alone, whether covert or overt, does not guarantee that the patient will use an offered treatment to good advantage, nor do we want to minimize the potential for abuse of power that can exist when treatment is forced. The evidence shows, however, that such abuse is infrequent and that adequate safeguards exist to counter it. We believe that this report demonstrates that being forced into treatment does not preclude a successful and humane outcome.

When Does Forced Treatment Work?

Treatment factors that favor a positive outcome include the following:

1. The treatment itself is appropriate and effective for the patient's clinical state.
2. An alliance between the coercer (courts, employer, parents, military commander) and the therapist exists to the extent that both parties share a definition of the patient's best interests. At the same time, the therapist must be identified as the agent of the patient and create a climate of trust with the patient so that a therapeutic alliance can develop.
3. A reporting requirement about the patient's cooperation with treatment is clearly defined and agreed to by all the parties.
4. The consequence of noncompliance is clearly defined. The threat—going to jail, losing a job, being admitted to a hospital—must be enforceable. However, the penalty must be seen as fair.
5. A structure exists that ensures that treatment can be delivered (e.g., adequate funding, cooperative staff, enough time to engage the patient in treatment, family support, legal sanction, transportation).

Patient factors that favor a positive outcome include the following:

Summary

1. Patients have the ability to understand the immediate consequence of refusing to comply with treatment, although they may not appreciate the effects of the illness itself. Even severely disorganized patients may develop this ability and benefit from treatment.
2. Patients value what will be lost if the treatment is refused (e.g., their job, freedom to live in the community).
3. Patients can trust that compliance with treatment will avert the negative consequence.
4. Patients must be able to cooperate at least minimally. "Ann," the adolescent described in Chapter 1, did not run away from home rather than go to therapy, physically attack the therapist, or disrupt therapy unacceptably.
5. Patients' problems are psychiatrically treatable. Some conditions have a poor prognosis no matter what the setting is or what treatment is attempted.

Conclusion

Psychiatric treatment that is not completely voluntary can indeed be effective. The nature of treatment, as examined here, goes beyond conventional modalities. It may encompass dynamically informed psychotherapy, behavior therapy, group methods, psychopharmacologic agents, administration of hormones, and more; all these modalities may be valid and effective. We conclude that coercion (as it is broadly defined in this report) can have a positive role in the referral process as well as in clinical treatment. Further study of more subtle forms of coercion in traditional adult psychiatry is warranted.

Similarly, we must expand the usual definition of effective treatment to include outcomes that are defined behaviorally as well as subjectively. Child molesters who stop molesting children have been treated successfully, no matter what their inner residual fantasy may be.

Finally, we return to the theme that voluntary and forced treatment lie on a continuum, with different elements working to strengthen motivation. We believe that optimism in these forced-treatment situations can be justified. We encourage psychiatrists to provide such treatment when appropriate to help the patient progress from a posture of defiance to compliance to alliance.
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