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Practitioner-Suggested Voluntary Psychiatric Hospitalization from a Feminist Therapy Perspective

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Abstract

This study explores "practitioner-suggested voluntary psychiatric hospitalization" or the gray area between voluntary and involuntary admission into psychiatric inpatient treatment where voluntary patients feel they have been persuaded into admission by practitioners with the authority to admit them involuntarily. Some scholars discuss this phenomenon in terms of power, indicating that what a practitioner views as a suggestion may be interpreted by a patient as coercion due to power imbalance within the psychiatric setting. However, research on how individuals with marginalized identities are affected by practitioner-suggested hospitalization is largely inconclusive. This study sought to address this gap by interviewing four feminist therapists, who focus on the intersections of social identities such as race, gender, and sexual orientation while promoting an egalitarian therapeutic relationship. The study discussed the experiences and opinions of feminist therapists and analyzed emerging themes.

Introduction

In 1860, Elizabeth Packard was committed to an asylum by her husband, a Calvinist pastor, for her exploration of faith and "unclean spirit" (Testa & West, 2010). Following hospitalization, she devoted her life to changing hospitalization laws (Langsworthy). While activists have made progress in reforming mental institutionalization, evidence shows coercive psychiatric practices still exist. In fact, a gray area between voluntary and involuntary hospitalization exists where voluntary patients feel they have been persuaded into admission by practitioners with the authority to involuntarily admit them. The goal of this study is to explore this phenomenon of practitioner-suggested voluntary psychiatric hospitalization through the lens of feminist therapy to further understand the role of power dynamics and the effects that hospitalization has on individuals with marginalized identities.

History

Prior to when asylums developed, individuals with mental illnesses were often relegated to prisons and homeless shelters with the intention of ensuring community safety (Testa & West, 2010). However, in the early 19th century, four asylums were established. Despite the benefits of space for individuals experiencing mental illness, the Victorian Era blurred the distinction between "morality" and "sanity"; criteria that constituted "mental illness" overlapped with what was considered immoral (Curtis, 2001). Ambiguous hospitalization standards led to unjust hospitalization of people who did not meet societal expectations. In fact, women who did not fulfill their duty of wife and mother were often diagnosed as insane and hospitalized (Testa & West, 2010).

In the 1950s, over 50,000 people resided in asylums (Testa &West, 2010). However, reform emerged during the 1960s as marginalized individuals fought for fundamental rights, and many began to question the psychiatric system (Curtis, 2001). For example, Dr. Thomas Szasz argued psychiatry was social control, converting social constructions of deviance into diagnoses (Curtis, 2001). However, these ideas did not gain enough credence to change hospitalization laws; arguments of freedom remained more salient to America's values. Therefore, arguments against hospitalization emerged based on the idea that "despite the existence of mental illness, and despite the fact that the mentally ill might benefit from treatment, personal freedom is a higher order good than treatment" (Curtis, 2001). Psychiatric care began to transition from the hospital to the community, leading the inpatient population to decline from 550,000 to 30,000 by the 1990s (Testa & West, 2010).

Following deinstitutionalization, hospitalization standards shifted from a need-for-treatment model to a dangerousness model where, to be hospitalized, one must demonstrate risk of harm to self or others. The dangerousness model rests on *parens patriae,* meaning "parent of the country," or the belief that the government must care for individuals unable to care for themselves (Testa & West, 2010). While this model intended to provide protections to individuals experiencing mental illness, the idea that those in distress lacked autonomy had unintended adverse effects. First, this model stigmatizes people with mental health concerns by fueling fear regarding their supposed dangerousness. This is dangerous because perpetrators of mass violence are often labeled as mentally ill to mask underlying systems of oppression that fuel hate crimes, such as misogyny and racism. Further, this stigma oftentimes results in the

relegation of those experiencing mental illness to societal margins, such as prisons or homeless shelters (Testa & West, 2010).

Coercion in "voluntary" hospitalization

In theory, this model created clear distinctions between voluntary and involuntary hospitalization. However, one study challenged the assumption that voluntary hospitalization is conducive to an autonomous decision to seek treatment, determining that individuals are often induced to voluntarily admit themselves by professionals with authority to involuntarily commit them (Gilboy & Schmidt, 1971). Several studies replicated this finding, including a study of 412 voluntarily patients where 44% did not regard their status as truly voluntary (Rogers, 1993).

Other scholars argue that what patients interpret as "coercion" is simply verbal persuasion. In an observational study, researchers saw that while persuasion by physicians was prevalent, it generally lacked substantial pressures, such as inducements or threats. However, researchers indicated this persuasion did not involve thorough information; rather, physicians presented information as "non-negotiable" statements (Lidz et al., 1993). The authors argue that patients' perceptions are guided by power imbalances, stating:

> When the attending says 'I think you need to come in' it appears to be a simple expression of opinion. A simple attempt at persuasion. Yet we need to ask some questions about such judgments. Does it matter that a large safety officer is sitting outside the door? Does it matter that at any point the clinician can decide to commit the patient? Does it matter that the patient has been committed against his/her will before? How do these things affect the nature of the pressure? Indeed, clinicians sometimes use that same phrase ('I think you need to come in') to mean 'we are going to commit you.' Can any statement made by a clinician be simply advice? (p. 277).

Discussions of power regarding hospitalization call into question who is most affected in terms of race, gender, and other identities. Given the historical unjust hospitalization of women, one might argue women are susceptible. Research demonstrates that women may be diagnosed as mentally ill according to restrictive standards, as women have been historically defined by their anatomy and diagnosed as "hysterical" for not conforming to norms (Roth, 1974). Therefore, men are guided by gendered bias in their admission and treatment. Because women have been socialized to be submissive to male authority figures, scholars argue that "the distinction between voluntary and involuntary admissions… may be effectively eliminated" (Roth, 1974, p. 798).

However, Holstein criticizes such findings for defining gender as fixed rather than dynamic and situational. He states that "gender's relevance is not found in the candidate patient's gender per se, but rather in its rhetorical usage" (Holstein, 1987, p. 143). In other words, because men and women are judged differently in psychiatric settings based on social constructions of gender, those who display behavior deemed inappropriate may be pathologized. For example:

> "Mr. Simms suffers from drastic mood swings. His affect is extremely labile. One minute he'll be in tears, the next he's just fine. He fluctuates. His affect may be flattened, then elevated. One moment he'll be telling you about his cleaning business, then he'll flip out and cry like a broken-hearted schoolgirl over the most insignificant thing. Something that should never upset a grown man like Mr. Simms… His passivity- he's almost docile in a very sweet sort of way. He just smiles and lets everything pass. It's completely inappropriate for an adult male." (Holstein, 1987, p. 145).

In this example, the patient is not committed because he is a man. Rather, he is pathologized for crying "like a broken-hearted schoolgirl" in a way that deviates from societal expectations of masculinity. Roth argues "the inherent vagueness of many of psychiatry's diagnostic terms makes it easy for the clinician to conceal, even from himself, political and cultural preferences in the guise of neutral and detached judgments about objectively verifiable disease" (Roth & Lerner, 1974, p. 809).

Physician perspectives regarding practitioner-suggested voluntary hospitalization are complex, as some view coercion as necessary. In a Swedish study, fourteen psychiatric nurses stated that while they viewed coercion negatively, they were unable to identify alternatives (Olofsson, Gilje, Jacobsson, & Norberg, 1998). Appelbaum affirms this view, stating that "many mental health professionals believe… that in the absence of judicious (but not necessarily judicial) coercion patients will not receive needed care" (Appelbaum, 1985). Whether this coercion has benign intentions, or whether, according to Dr. Szasz, social control is involved, its impacts on patients must be considered. In a study of involuntarily admitted patients, participants negatively viewed their experiences, citing feeling "inferior as human beings" (Oloffson, 2001).

Feminist Therapy

Given the inconclusivity of research into how practitioner-suggested hospitalization affects people with marginalized identities, this study uses a feminist therapy lens. During the second-wave feminist movement in the United States, "consciousness-raising groups" formed where

women shared collective experiences of womanhood, allowing them to discover a political root behind their "personal" problems (Brown & Brodsky, 1992; Randolph & Ross-Valliere, 1979). Inspired by consciousness-raising groups and the criticism that psychotherapy excluded women, many therapists began to apply feminist awareness into practice, resulting in feminist therapy (Brown & Brodsky, 1992). Feminist therapy operates under two guiding principles: the personal is political and the egalitarian therapeutic relationship (Gilbert, 1980). In the context of feminist therapy, the personal is political refers to how client and practitioner attend to the sociocultural context in which they live, reframing clients' distress as adaptive responses to oppression (Enns, 2012). Additionally, an egalitarian relationship views the client as the expert and promotes autonomy (Gilbert, 1980). While feminist therapy literature has expanded, the exercise of power by clients and therapists remains essential. In a study by Rader and Gilbert, feminist therapists were more likely to demonstrate power-sharing behaviors, such as self-disclosure; in turn, their clients were more likely to perceive such behaviors (Rader & Gilbert, 2005).

Research Questions

Because feminist therapy focuses on intersections of race, gender, sexuality, etc., feminist therapists may address how individuals with marginalized identities are affected by practitioner-suggested voluntary hospitalization. Further, because feminist therapists foster an egalitarian therapeutic relationship, their professional opinions regarding power dynamics in psychiatric hospitalization may provide valuable insight. By interviewing feminist therapists, the study sought to address the following questions:

1. How do feminist therapists view psychiatric hospitalization, focusing on practitioner-suggested hospitalization?
2. How do feminist therapists interpret the role of power dynamics in psychiatric hospitalization?
3. According to the experiences and opinions of feminist therapists, how are individuals with marginalized identities affected?

Addressing these questions is essential because individuals who have been hospitalized are at high suicide-risk immediately following hospitalization; one-third of suicides occur within 3 months of discharge (Olfson et al., 2016). Further, coercion in hospitalization may be viewed as a human rights violation that "perpetuates power imbalances in care relationships, causes mistrust, exacerbates stigma and discrimination and has made many turn away, fearful of seeking

help within mainstream mental health services", further demonstrating the importance of understanding its effects (UN Human Rights Council, 2017, p. 15).

Methods

Participants

Study staff recruited therapists through Psychology Today's database, professional references from study staff, and the American Psychological Association's Division 35 listserv, resulting in a sample of four practitioners. Three participants identified explicitly as feminist therapists through online profiles or verbal statements during the interview. While one practitioner did not identify as such, they used feminist therapy practices. All participants identified as cisgender and heterosexual, three being cisgender women and one being a cisgender man. Two participants identified as Jewish and one as Catholic. One participant identified as a peer, or an individual with lived experience of extreme mental distress or hospitalization.

Procedure

Following IRB approval, participants engaged in one-hour semi-structured in-person interviews. First, they were asked questions about feminist therapy, followed by questions about their experiences with psychiatric hospitalization. Finally, participants were asked to discuss their professional opinions, power dynamics, and how individuals with marginalized identities are affected. Following the interview, participants were asked to fill out a demographic survey. Interviews were transcribed and analyzed to find common themes using inductive techniques.

Results

Main Themes

The data analyst perceived the following themes in relation to the research questions:

psychiatric hospitalization as a last resort. Participants viewed hospitalization as a final option only to be employed when the client is at suicide-risk and unable to adhere to treatment alternatives. All participants had little experience with involuntary hospitalization; while some had experience with practitioner-suggested hospitalization, this was only used when participants questioned "Are [clients] going to die if I don't do anything?" (Participant 4). While participants did not cite their feminist therapy lens as their reason for avoiding hospitalization, this finding is consistent with the feminist therapy ideal of promoting client autonomy and minimizing power

imbalances. For some participants, avoiding hospitalization meant prioritizing clients in suicide-danger above other obligations. In discussing working with at-risk clients, Participant 4 stated "My goal is at that moment to drop everything. We're going to sit, and it may take hours… and I trust that almost every time, if we sit with it and stick with it, we'll find some other way for them to get through it."

power imbalance in psychiatric hospitalization. Participants prioritized alternative treatments because they viewed hospitalization as power abuse, depriving patients of autonomy and authorship. This stems from the fact that practitioners have the power to make treatment decisions on clients' behalf, leaving them without agency. While patients may encounter overtly coercive practices, including forced medication and restricted mobility, coercion may be covert as patients lack authorship. In other words, a patient is diagnosed in a manner that defines their experiences as symptoms of an inherent illness, ignoring context and adversity. Once the person is diagnosed, all actions are interpreted through that lens; for example, a patient crying due to hospitalization may have their behavior redefined as a depressive symptom (Participant 4). Because the patient must adhere to this self-definition, they lack the human right of understanding their experiences (Participant 4). These findings connect with the feminist therapy practice of the egalitarian therapeutic relationship, viewing the client as their own expert and promoting autonomy.

susceptibility of individuals with marginalized identities. According to participants, individuals with marginalized identities face unique obstacles with hospitalization. Participant 4 argued that individuals of minority status may be susceptible because they are likely to face adversity, leading to distress; when taken out of context, this distress may be diagnosed as mental illness, leading to hospitalization. This aligns with the minority stress model, which argued that individuals with minority identities are exposed to unique stressors, such as discrimination, that may harm their mental health (Meyer, 2003). Participant 1 stated that individuals of minority status may be vulnerable to hospitalization as they lack affirmative resources and knowledge of other options. These viewpoints indicate it is not necessarily minority status that makes them vulnerable; rather, it is the systematic oppression they experience that increases vulnerability, aligning with the feminist therapy ideal of "the personal is political".

Another obstacle unique to individuals with marginalized identities is distrust in the medical system (Participant 1). For example, this distrust is characteristic among African-Americans, dating back to when slaves were used for medical experimentation (Gamble, 1997). As described by participants, this is not only frequent among people of color, but also among gender and sexual minorities; Participant 3 described a transgender client with intense fear of hospitalization. Participants indicated this distrust is justified, as hospital environments may be hostile to minority individuals. According to Participant 3, "hospitals reflect community standards. And if community standards are heteronormative, so is the hospital", creating a dangerous environment for individuals who do not adhere to societal standards.

Additional Themes

semi-voluntary hospitalization as a dynamic spectrum. Participants demonstrated that psychiatric hospitalization is dynamic rather than dichotomous, as voluntary status could become involuntary if the clinician deemed the patient as dangerous. Further, practitioner-suggested voluntary psychiatric hospitalization took many forms. While some participants suggested hospitalization, others took additional steps, including offering to call the hospital. Sometimes practitioner-suggested hospitalization took the form of "above and beyond" care, or extreme safety measures. Participant 3 described a colleague who demonstrated "feminist therapy at its best and most costly for the practitioner" when working with a transgender client whose suicidal ideation was worsened by a fear of the medical system. The therapist offered to accompany them, then "canceled her day, went to the psychiatric ER, sat with [the client] for 5 hours, talked them through the process, [and] navigated gender biases of the system with them", leading the client to be admitted on a semi-voluntary basis (Participant 3). Such situations demonstrate that semi-voluntary hospitalization is nuanced and therefore cannot simply be labeled as ill-intentioned without further examination.

However, even when practitioners have benign intentions, clients may interpret practitioner-suggested hospitalization as coercive. For example, Participant 4 described a client who ended therapy because the mere suggestion of hospitalization was interpreted as coercive, even though the therapist intended to avoid hospitalization.

hospitalization as trauma. In describing why feminist therapists often avoid hospitalization, Participant 1 stated "I do not feel comfortable, at all, that as a psychologist, I have the power of institutionalizing people. That feels that I could be perpetrating a trauma on someone else [by]

taking away their power to make decisions about their lives." In other words, the lack of autonomy patients experience due to coercion, and lack of authorship caused by being told they must interpret their experiences through the lens of illness, can be distressing. Patients also face other traumatic factors, including exposure to law enforcement, as patients may be handcuffed and escorted by police. This is not only traumatic, particularly in a political climate where tension exists between law enforcement and marginalized individuals, but it also perpetuates stigma surrounding patients' supposed dangerousness. Patients may find hospitals to be a dehumanizing environment, worsening trauma (Participant 2).

hospital avoidance. Because hospitalization may be traumatic, individuals often lie about their feelings to escape or avoid hospitalization and regain autonomy. Participant 3 described a patient who indicated they were okay in the therapist's office, yet attempted suicide immediately after. When the participant met their client in the hospital, the client said "I lied to you," indicating their dishonesty stemmed from fear of hospitalization. Participant 4 linked hospital avoidance to lack of authorship, or how patients are told they must interpret their experiences through the lens of an illness, even when adversity played a significant role in their suffering. To be released, they must comply with this worldview, leading them to stifle feelings to regain autonomy; this is dangerous when patients feel they must lie about suicide-risk. Creating a situation where patients shut themselves down to avoid hospitalization may hinder healing, calling into question the effectiveness of hospitalization (Participant 4).

Discussion

Participants' discussions of power align with literature indicating the existence of psychiatric coercion. Further, participants addressed ambiguities in the literature by demonstrating that while minority identity may not inherently make one susceptible to hospitalization, the systematic oppression that marginalized individuals experience may do so. Participants cited other factors unique to individuals with marginalized identities, including distrust, lack of affirmative resources, and hostile hospital environments; this shows that further research must operate from an intersectional feminist perspective. One limitation is that the small sample was not representative, as three participants were white, and all were cisgender and heterosexual. For research to operate from a feminist standpoint, voices of minority individuals must be central; therefore, future research must be more inclusive in race, gender, sexual orientation, etc.

Additional research might also compare the opinions and experiences of feminist therapists with practitioners who do not identify with this discipline.

By discussing hospitalization as trauma, participants demonstrated this research's importance. Practitioners indicated that many clients viewed hospitalization as dehumanizing. These discussions align with literature among patients who perceived coercion, leading them to feel isolated and inferior. Because patients are at high suicide-risk immediately following release, the effects of non-consensual psychiatric interventions must be explored. Much of this research occurs within the peer movement, where individuals with lived experiences of extreme distress or psychiatric hospitalization "attempt to give voice to individuals who have been assumed to be irrational – to be out of their minds" (Chamberlin, 1990). While one participant identified as a peer, future research should include individuals who have experienced coercive psychiatric practices to amplify voices that are often ignored.

This research demonstrates the importance of alternative therapeutic practices to avoid traumatization through hospitalization. The United Nations Human Rights Council argues that mental health "should be managed not as a crisis of individual conditions, but as a crisis of social obstacles which hinders individual rights" (UN Human Rights Council, 2017). A rights-based approach to mental health may incorporate feminist therapy, minimizing power differentials and addressing how individuals with marginalized identities uniquely experience adversity, stigma, and distress. Further, a rights-based approach may shift from a dangerousness model to a trauma-informed model, given that mental health problems are linked to abuse, inequalities, violence, poverty, and isolation (UN Human Rights Council, 2017); trauma-informed practice integrates knowledge about trauma and seeks to avoid retraumatization (SAMHSA, 2014). Finally, practitioners may recommend peer support, or services provided by and for individuals who have experienced mental distress or hospitalization; peer support "provides hope and empowers people to learn from each other, including through peer support networks, recovery colleges, club houses and peer-led crisis houses" (UN Human Rights Council, 2017, p. 19). By viewing mental health as a product of one's identities and experiences, rather than as an innate deficit, practitioners may avoid (re)traumatization through hospitalization.

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