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 patients with voluntary status 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 may be 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.

Keywords: feminist therapy, psychiatric hospitalization, peer movement

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

History

Prior to the conception of mental asylums in the United States, individuals with mental illnesses were often relegated to prisons and homeless shelters with the intention of ensuring safety for the community rather than providing treatment to people in distress (Testa & West, 2010). However, in the early 19th century, four privately funded asylums were established. Despite the benefits of having a designated space for individuals experiencing mental illness, the Victorian Era in which asylums emerged, marked by a "lower tolerance for disorder and deviance, and a sense of urgency about maintaining public safety and social order," blurred the distinction between "morality" and "sanity;" in fact, much of the criteria that constituted "mental

illness" overlapped with what was considered immoral and socially abhorrent (Curtis, 2001). Ambiguous hospitalization standards oftentimes led to their abuse through the unjust hospitalization of people who did not meet the rigid societal expectations of the era. Women, who held nominal civil rights that were rarely enforced, were particularly vulnerable to this phenomenon. In fact, women who did not adequately fulfill their duty of wife and mother were often diagnosed as insane and subsequently relegated to a mental institution, such as Elizabeth Packard (Testa & West, 2010).

Involuntary and coerced psychiatric hospitalization persisted into the 20th century, with over 50,000 people residing in mental asylums in the 1950s (Testa &West, 2010). However, substantial reform to the system of mental institutionalization emerged during the 1960s as individuals with marginalized identities fought for their fundamental rights. This spirit of activism and social justice infiltrated through all aspects of life, as scholars, activists, and practitioners alike began to question the system of psychiatry and the fundamental definition of mental illness (Curtis, 2001). For example, radical psychiatrist Dr. Thomas Szasz argued that psychiatry was a form of social control that converted social constructions of deviance into diagnoses, despite a lack of evidence regarding the cellular-level disease processes of "mental illness." In fact, he viewed the psychiatric system as a "tacit contract existing between society as a whole and the class of psychiatrists, in which psychiatrists arrange to confine and control persons disturbing to society, in return for a social regard as members of the medical profession," (Curtis, 2001). However, these progressive ideas did not gain enough credence to significantly change the laws and practices of psychiatric hospitalization; though they aligned with the radical nature of the civil rights era, arguments of freedom and liberty remained more salient to America's values. Therefore, arguments against involuntary or coerced psychiatric

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). As a result, psychiatric care began to transition from the hospital to the community, leading the number of people in inpatient treatment to decline from 550,000 to 30,000 by the 1990s (Testa & West, 2010).

From the deinstitutionalization era arose a new way of conceptualizing mental illness and psychiatric hospitalization, shifting from a need-for-treatment model to a dangerousness model. In other words, to be hospitalized, an individual must demonstrate that they are at imminent risk of harm to self or others. The dangerousness model rests on two principles regarding the state's responsibility to people experiencing mental health problems. The first, *parens patriae,* meaning "parent of the country," is the belief that the government must care for individuals who are unable to care for themselves. On the other hand, the state is guided by police power, or the duty to protect the interest of all citizens. These guiding forces interact to form the dangerousness model, creating a situation in which "the state has the right to write statutes for the benefit of society at large, even when providing this benefit may come at the cost of restricting the liberties of certain individuals," (Testa & West, 2010). While the deinstitutionalization era and the dangerousness model intended to provide protections to people experiencing mental illness, the idea that those in distress lacked the autonomy to make their own treatment decisions had unintended adverse effects. First, this model stigmatizes individuals with mental health problems by fueling a public fear regarding the supposed dangerousness of persons with mental illness. This is particularly detrimental as perpetrators of mass violence are often labeled as mentally ill in order 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 the criminal justice system or homeless shelters, in order to protect society from their perceived burden (Testa & West, 2010).

Coercion in "Voluntary" Hospitalization

In theory, this model created clear distinctions between voluntary and involuntary hospitalization. However, a pioneering study by Gilboy and Schmidt (1971) challenged the assumption that voluntary admission into a mental hospital is conducive to an autonomous decision to seek treatment. Rather, in an observational study in a Chicago hospital, the scholars determined that individuals are often induced to voluntarily admit themselves by professionals who have the authority to involuntarily commit them, subsequently limiting their ability to leave the hospital upon request, regardless of their "voluntary" status (Gilboy & Schmidt, 1971). Several studies replicated this finding, indicating that coercion should be viewed as a continuum. For example, in a study of 412 voluntarily admitted patients, 44% did not regard their status as truly voluntary (Rogers, 1993). Though voluntary patients enter inpatient treatment under the assumption that their voluntary status affords them certain rights, they, oftentimes unknowingly without sufficient information regarding their decisions, sacrifice the right to a court hearing that would have been available to them upon involuntary admission. Therefore, according to Gilboy and Schmidt, coerced "voluntary" commitment is not only a breach of civil liberties, but is also a direct violation of constitutional rights. In order words, "the involuntary commitment process, with its various safeguards, is a constitutionally required means of protecting citizens from the dangers of arbitrary civil commitment," (Gilboy & Schmidt, 1971, p. 453).

However, other scholars argue that what patients interpret as "coercion" by psychiatrists is no more than verbal persuasion, or a description of how hospitalization could benefit the patient. In an observational study in a large hospital, Lidz, Mulvey, Arnold, Bennett, and Kirsch

(1993) saw that while verbal persuasion by physicians and nurse clinicians was frequent, this persuasion generally lacked substantial pressures. However, in line with Gilboy and Schmidt, researchers indicated that this persuasion did not involve thorough information about the hospitalization process or alternative options; rather, physicians presented information in the form of "non-negotiable" statements or already decided facts (Lidz et al., 1993). Therefore, the authors argue that patients' perceptions of coercion are guided by power imbalances in a psychiatric setting, 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 some 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? (Lidz et al., 1993, p. 277).

Discussions of power regarding psychiatric hospitalization call into question who is most affected, taking into account intersections of race, gender, class, and other social identities. Given the historical unjust hospitalization of women, one might argue that women are particularly susceptible. In fact, research demonstrates that women may be diagnosed as mentally ill according to more restrictive standards that are used as a method of reinforcing their subordinate social status. Discrimination against women has been largely ingrained within psychiatric theory as women have been historically defined by their anatomy and diagnosed as "hysterical" for not conforming to rigid gender norms (Roth, 1974). This gendered bias within

theory permeates into practice, as men within the psychiatric profession are guided by gendered bias in their admission, treatment, and release of women in inpatient settings. Because women have historically been socialized to be submissive to male authority figures, it is argued that "the distinction between voluntary and involuntary admissions, already blurred by the existence of alternative coercive procedures, may be effectively eliminated," (Roth, 1974, p. 798). However, Holstein criticizes such findings for defining gender as a fixed characteristic of a patient, rather than dynamic and situational. Therefore, he examines how patients perform their gender in civil commitment hearings, arguing that "gender becomes relevant and influential only through these participants' specifically situated and motivated gender depictions. Thus, 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 the social construction of gender, those who display behavior not deemed as appropriate given their assigned sex may be pathologized. Holstein cites the following example from a hospitalization court hearing:

> "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. During his periods of flattened affect, he seems to lose all interest… 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," (1987, p. 145).

In this example, the patient is not involuntarily committed because he is a man. Rather, he is pathologized for how he produces his gender by crying "like a broken-hearted schoolgirl" in a manner 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, 1974, p. 798).

Despite these findings, research on the demographics of coercion in mental health treatment has been unclear and oftentimes contradictory. While one study found correlations between increasing age and minority identity, implying that Black and ethnic minority identities make one at particular risk of being coerced, two Nordic studies found no major correlations involving age and gender, and other studies found black and minority ethnicity to be a protective factor (Newton-Holmes, 2010). In fact, scholars within the MacArthur Coercion Study state that demographic factors do not affect the amount of coercion that a patient experiences in hospital admission. Rather, the researchers argue that coercion is related to the "procedural justice" of the admission process; patients who believe that they were treated respectfully and with genuine concern, and were afforded the opportunity to share their experiences, perceived less coercion (Hoge et al., 2001). Such contradictory findings in regards to the demographics of psychiatric hospitalization indicate the importance of further investigating nonconsensual psychiatric interventions and their ethical and multicultural implications.

Physician perspectives regarding practitioner-suggested voluntary psychiatric hospitalization are complex, as some view coercion as a "necessary evil" that is essential in aiding patients in distress. For example, in a Swedish study, fourteen psychiatric nurses stated that while they viewed coercion negatively and found it emotionally distressing, they were

unable to identify alternatives that would allow them to adequately provide care for their patients (Olofsson et al., 1998). Appelbaum affirmed 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, their condition will deteriorate, and they will suffer psychological and perhaps physical distress," (Appelbaum, 1985). Whether this coercion has the benign intention of ensuring treatment to patients in distress, or whether, as indicated by Dr. Szasz's theory, there is some level of social control involved, it is essential to consider the profound impacts that semi-voluntary psychiatric hospitalization may have on patients. In a study of 18 involuntarily admitted psychiatric patients, participants viewed their experiences of coercion in a negative manner. Further, they cited feeling "inferior as human beings," as one patient described "you become a nobody, they can do whatever they want with you, although maybe you are a very valuable person being in a crisis," (Oloffson, 2001). Given the detrimental effects that such coercion may have on patients, it is essential that practitioner-suggested voluntary hospitalization is further explored.

Peer Movement

While research into coercion within psychiatric hospitalization conducted by scholars and practitioners provides valuable information, the effects of nonconsensual psychiatric interventions are best understood through the voices of individuals who have experienced them. In the 1970s, the peer or ex-patients' movement formed from this notion, drawing upon ideals of the black, women's, and gay liberation movements which indicated that individuals with privileged identities are unable to fully understand the lived experiences of individuals with marginalized identities. Similarly, ex-patients found that "their own perceptions about 'mental illness' were diametrically opposed to those of the general public, and even more so to those of

mental health professionals," leading them to form organizations consisting solely of people with lived experience of mental distress or psychiatric hospitalization, otherwise known as "ex-patients," "ex-inmates," or "peers" (Chamberlin, 1990). Drawing upon consciousness-raising groups, which initially emerged during the women's movement, mental patients began to recognize commonalities and patterns of oppression among their experiences, indicating that their struggles were not solely internal and personal, but rather existed on a societal level (Chamberlin, 1990). From these consciousness-raising groups emerged two primary goals of the peer movement: self-help and empowerment, and advocacy.

In the 1970s, self-help groups began to emerge from the ex-patients' movement, generally consisting of individuals who were skeptical about the value and effectiveness of the psychiatric system. Members of such groups oftentimes expressed outrage towards the mental health system after experiencing injustices; rather than pathologizing this outrage, members of the ex-patients' movement viewed anger as a healthy reaction to the abuses they experienced within the psychiatric institution (Chamberlin, 1990). Activist and ex-patient Judi Chamberlin, writing of her personal experiences with psychiatric hospitalization in her article *Confessions of a Non-Compliant Patient,* described such outrage:

> Being a patient was the most devastating experience of my life. At a time when I was already fragile, already vulnerable, being labeled and treated only confirmed to me that I was worthless. It was clear that my thoughts, feelings, and opinions counted for little. I was presumed not to be able to take care of myself, not to be able to make decisions in my own best interest, and to need mental health professionals to run my life for me. For this total disregard of my wishes and feelings, I was expected to be appreciative and

> grateful. In fact, anything less was tacked as a further symptom of my illness, as one more indication that I truly needed more of the same (1998).

Self-help groups allowed individuals such as Judi Chamberlin who felt abused and dehumanized by the psychiatric system to process their experiences outside of a medicalized environment.

Despite recognizing the faults of the psychiatric system, many peers partake in professionally run services in combination with self-help groups. For this reason, the movement also promotes empowerment among ex-patients, allowing members to "take a stronger role in advocating for their own needs within the larger mental health system" and "reject the role of passive service recipient," (Chamberlin, 1990). Whether they consist solely of ex-patients, or whether they involve mental health professionals to some degree (including professionals who also identify themselves as peers), peer support groups take on a number of different forms. For example, experiential peer support allows participants to explore what would be considered by many as "extreme" states, such as voices, visions, or hallucinations. While such groups acknowledge that difficulty coping with trauma and adversity often play a role in these "extreme" experiences, experiential peer support encourages people "to explore their own beliefs, be they spiritual, religious, paranormal, technological, cultural, counter-cultural, philosophical, medical, and so on," (Dillon & Hornstein, 2013, p. 289). This philosophy operates in direct contrast with the psychiatric system, which defines such experiences as symptoms of an inherent disease that is often deemed "untreatable." In addition to experiential peer support, intentional peer support allows individuals to "work together to develop awareness of personal and relational patterns, to view life experiences from many angles, and to create new ways of seeing, thinking, and doing," (Probert & Nash, 2015). For example, one of the core foundations of intentional peer support is that relationships are viewed as partnerships in which both

participants learn and grow, rather than one person helping the other (Intentional Peer Support); this mutuality exists in contrast to the relationships one might experience in a hospital setting, in which the psychiatrist is viewed as the expert and sole authority, while the patient is viewed as a passive recipient. Ultimately, while group members may still experience the emotional distress that led to their psychiatric diagnoses, self-help groups serve as "a powerful confirmation that people, despite problems and disabilities, can achieve more than others (or they themselves) may have ever thought possible," (Chamberlin, 1990).

As important as self-help is to the ex-patients' movement, advocacy, or working for political change, is just as essential. In the words of activist Judi Chamberlin:

> The basic principle of the movement is that all laws and practices which induce discrimination toward individuals who have been labeled "mentally ill" need to be changed, so that a psychiatric diagnosis has no more impact on a person's citizenship rights and responsibilities than is a diagnosis of diabetes or heart disease. To that end, all commitment laws, forced treatment laws, insanity defenses, and other similar practices should be abolished (1990).

The long-term goal of eradicating nonconsensual psychiatric interventions is backed by a number of other agencies. In fact, in 2017, the United Nations Special Rapporteur on the right to health called for a "sea of change" in mental health care: one that embraces a human-rights approach rather than a biomedical approach, and one that acknowledges that crisis within the mental healthcare system is "not a crisis of chemical imbalances, but of power imbalances," (United Nations Human Rights, 2017). Further, in 2011, the National Coalition for Mental Health Recovery, which aims to ensure that ex-patients have a voice in the development and implementation of mental health care and policies, affirmed that nonconsensual psychiatric

interventions should never be seen as treatment; rather, hospitalization should only be considered as a last resort option when all other methods have been exhausted (National Coalition for Mental Health Recovery, 2011). While a number of patient liberation groups have formed to undertake the overarching goal of eradicating nonconsensual psychiatric interventions, such as the National Association of Psychiatric Survivors, such activism may also take place on a more individual level, as mental health practitioners advocate for their clients and employ human-rights-based and trauma-oriented therapeutic practices; these approaches acknowledge the profound role that trauma plays in human suffering by avoiding an exclusively biomedical approach, and employ empathy and human connection in order to avoid taking away someone's rights through hospitalization (Probert, 2014).

Feminist Therapy

Given the inconclusive nature of research into how practitioner-suggested voluntary hospitalization affects people with marginalized identities, this study seeks to explore the phenomenon through the lens of feminist therapy. During the second-wave feminist movement, feminist therapy emerged from consciousness-raising groups, as therapists began to apply feminist awareness into their therapeutic practice (Brown & Brodsky, 1992). Feminist therapy operates under three guiding principles: the personal is political, diversity, and an egalitarian therapeutic relationship (Enns, 2012). In the context of feminist therapy, the personal is political refers to how both client and practitioner attend to the sociocultural context in which they live, reframing clients' distress as adaptive responses to oppression and helping clients to cultivate an active role in addressing inequalities (Enns, 2012). Feminist therapy also draws upon the idea of intersectionality, or how marginalized identities are intertwined and inseparable, leading to overlapping forms of oppression (Crenshaw, 1991). Finally, the third feminist therapy facet, an

egalitarian relationship, is defined as one that views the client as their own expert, one that uses strategies to promote client's autonomy and power, one that encourages the expression of anger, and one that models appropriate behavior for the client (Gilbert, 1980). While the literature on feminist therapy has significantly expanded since this initial research was conducted, the exercise of power by both clients and therapists is still arguably the most important factor that arises in discussions of feminist therapy (Rader and Gilbert, 2005). In fact, in a study conducted by Rader and Gilbert, practitioners who identified as 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 and Gilbert, 2005).

Research Questions

Because feminist therapy attends to sociocultural context while promoting an egalitarian therapeutic relationship, the professional opinions of feminist therapists regarding practitioner-suggested voluntary psychiatric hospitalization provide valuable insight. By interviewing feminist therapists, the study sought to answer the following research questions:

1. How do feminist therapists view the system of psychiatric hospitalization, specifically focusing on practitioner-suggested or semi-voluntary hospitalization?
2. How do feminist therapists interpret the role of power dynamics in psychiatric hospitalization?
3. According to the experiences and professional opinions of feminist therapists, how are individuals with marginalized identities (ex. minority status in terms of race, gender identity, sexual orientation, etc.) uniquely affected by psychiatric hospitalization?

This research is important because, as previously stated, the experience of coercion in mental health treatment can have detrimental effects on the patients involved, as many cite feeling dehumanized and inferior (Oloffson, 2001). Further, people who have been hospitalized are at high suicide-risk immediately following hospitalization, with one-third of all suicides among patients occurring within 3 months of discharge. (Olfson et al., 2016). This alarming statistic demonstrates the importance of further investigating non-consensual psychiatric interventions and their effects on patients of all races, gender identities, socioeconomic statuses, etc.

Methods

Participants

I recruited therapists through online databases of mental health practitioners, professional references, and the Division 35 listserv of the American Psychological Association. These recruitment methods resulted in a sample of four mental health professionals. Three participants identified explicitly as feminist therapists. While one practitioner did not formally identify as such, they incorporated feminist therapy practices into their work by focusing on power dynamics and the role of marginalized identities on mental health and adversity. All practitioners were licensed psychologists at the doctoral level, and the number of years they had been practicing ranged from 11.5 to 45. Two participants worked in college mental health settings, while the other two participants worked in private practice. In terms of their social identities, three participants were white, while one was of Latin American descent. All participants in the study identified as cisgender and heterosexual, three being cisgender women and one being a cisgender man (in order to further respect the confidentiality of participants, the gender-neutral pronouns they/them/theirs will be used for all participants). Three participants cited religious background as important facets of their identity, as two identified as Jewish while one cited a

Catholic upbringing. Finally, one participant shared their identity as a peer, defined as an individual who self-identifies as having lived experience of extreme mental distress or within the system of psychiatric hospitalization (Gainesville Peer Respite).

Procedure

After the study received IRB approval, I conducted one-hour, semi-structured interviews with participants. During the first segment of the interview, I asked participants questions about feminist therapy, such as the feminist practices that they incorporate into their work. In addition, I asked participants how their own social identities affect their practices as feminist therapists. In the second section of the interview, participants were asked questions about their experiences with voluntary, involuntary, and practitioner-suggested voluntary psychiatric hospitalization. Finally, participants were asked to discuss their general professional opinions on psychiatric hospitalization, the role that power dynamics play in hospitalization, and how individuals with marginalized identities may be uniquely affected by psychiatric hospitalization (see Appendix for full list of questions).

Following the interview process, participants were asked to fill out a brief demographic survey. The survey asked a number of professional questions, such as the participant's title and theoretical orientation, along with questions about their personal social identities. More specifically, participants were asked about their race/ethnicity, gender identity, sexual orientation, and any other aspects of their identity they felt important to the purpose of the study.

Finally, I transcribed interviews and analyzed emerging themes. Along with themes related to initial research questions, a number of other themes emerged and are further discussed in this study.

Results

Main Themes

Upon reviewing the interviews, the data analyst perceived the following themes in relation to the research questions:

Psychiatric hospitalization as a last resort. Participants generally viewed psychiatric hospitalization as a final option only to be employed when the client is at high risk of suicide and is unable to adhere to alternative treatments. All four participants indicated that they had little to no experience with involuntary hospitalization; while some had experiences with practitioner-suggested voluntary hospitalization, this was also rare, and only used when participants reached the point of questioning "Are [the clients] going to die if I don't do anything?" (Participant 4). In addition to an inability to adhere to alternative treatment plans, participants cited several other factors that served as warning signs that the client may be at risk of suicide. Participant 2 began to consider hospitalization when they witnessed the deterioration of the client, or when the physical and mental state of the client became progressively worse. Conversely, Participant 3 discussed the dangerousness of stagnation, or the sense that therapy sessions remained the same from week to week. According to Participant 3, stagnation can be alarming even if the sessions seem positive, as the therapy room can provide a sense of solace for clients; in other words, "people do the most drastic things when they feel utterly alone on the planet, and they do not feel utterly alone in [the therapist's] office," (Participant 3).

For some participants, avoiding psychiatric hospitalization meant employing an "above and beyond" standard of care when working with clients in suicide-danger, prioritizing them above other obligations in order to ensure their safety. In discussing their process of working with clients at suicide risk, 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." One potential alternative treatment option used by participants is a safety plan, consisting of activities that the person at risk of suicide can do to stay safe, along with personal and professional references within their support network (Participant 1). Participants also relied on peer respites as alternative treatment options, which are facilities run by staff members with lived experiences of extreme emotional distress, psychiatric hospitalization, or other mental health challenges. Such respites aim to provide sanctuary and support to individuals experiencing distress outside of the medicalized environment of psychiatric hospitals by creating a community of "open dialogue, empowerment, self-determination, recovery, and wellness," (Gainesville Peer Respite). Ultimately, while participants tended to view hospitalization in a negative manner, and took all possible measures to avoid it, some acknowledged it may be necessary in certain instances, even if this means severing therapeutic bonds. In the words of Participant 3, "they'll hate me for the rest of their life, but they'll have a rest of their life to hate me with."

Power imbalance in psychiatric hospitalization. Participants prioritized alternative treatment methods over psychiatric hospitalization because they tended to view it as an abuse of power depriving patients of autonomy and authorship. This lack of autonomy stems from the fact that mental health professionals are given the power to make treatment decisions on behalf of clients, leaving them without a sense of agency. While patients may encounter overtly coercive practices, such as forced medication or restricted mobility, coercion may be more covert as patients lack authorship over their experiences. In other words, an individual that is hospitalized is often diagnosed in a manner that defines their experiences as symptoms of an inherent "illness," ignoring context and the role that adversity and marginalization play in human

suffering. Once the person is diagnosed, all actions are interpreted through that lens; for example, a patient crying because of their hospitalization may have their behavior redefined as a symptom of depression (Participant 4). Because the patient must adhere to a particular worldview and self-definition, they lack a sense of authorship and the human right to understanding their own experiences in a manner that feels right to them (Participant 4).

Two participants also discussed hierarchical power structures among mental health professionals themselves. Participants 2 and 3 indicated that "power imbalance is present when you put your foot in the door" of a psychiatric hospital, as psychiatrists generally take precedence over nurses (Participant 3). Participant 2 discussed the gendered implications of these hierarchical power structures through their experiences with both male and female psychiatrists. While female psychiatrists tended to be more collaborative and included the participant in their treatment decisions, male psychiatrists were generally more exclusionary. In fact, Participant 3 discussed two instances of when male psychiatrists interfered with their clients without any notice or collaboration, with one psychiatrist going as far as using Electroconvulsive Therapy without consulting the therapist. These discussions align with existing literature suggesting that psychiatric theory is inherently guided by gendered biases.

In order to offset power imbalances within the therapeutic relationship, participants in this study employed a number of power-sharing techniques central to feminist therapy in order to foster a more egalitarian relationship. For example, Participant 3 only used their first name with patients in order to avoid power differentials caused by using formal titles. Further, Participant 1 often engaged in an appropriate level of self-disclosure when they felt it could benefit the client. By viewing the client as the expert of their own experiences, therapists in this study gave their clients a sense of agency and autonomy.

Susceptibility of individuals with marginalized identities. According to participants, discussions of power are complicated by the fact that individuals with marginalized identities are oftentimes powerless in society as a result of systematic oppression, leading them to face unique obstacles in terms of psychiatric hospitalization. For example, Participant 4 argued that people with marginalized identities may be susceptible to psychiatric hospitalization because they are more likely to face adversity, leading to emotional distress; when taken out of context, this distress may be diagnosed as mental illness, thereby leading to hospitalization. This perspective aligns significantly with the minority stress model, which argued that individuals with minority identities are exposed to unique minority stressors, such as discrimination, which may lead them to develop mental health problems (Meyer, 2003). Further, Participant 1 stated that individuals of minority status may be vulnerable to hospitalization as they lack affirmative mental health resources and knowledge of other options. Finally, Participant 3 discussed a situation reminiscent of the historical unjust hospitalization of women such as Elizabeth Packard, stating that "people can be involuntarily hospitalized just for being different," aligning with Dr. Szasz's theory of psychiatry as social control. While they acknowledge this is not as prevalent in present day, they claim that it may still happen, as parents may push for a transgender adult to be hospitalized for not conforming to the gender binary. These viewpoints indicate that it is not necessarily the fact that these individuals have marginalized identities that makes them vulnerable to hospitalization; rather, it is the systematic oppression they experience outside of the hospital environment that increases their vulnerability.

Another obstacle unique to individuals with marginalized identities is a distrust in the medical system (Participant 1). For example, distrust in the medical institution is characteristic among African-Americans, stemming from their historical exploitation dating back to the

antebellum period when slaves were often used as subjects for dissection and medical experimentation (Gamble, 1997). As described by participants in the study, this distrust is not only frequent among people of color, but also among individuals of gender and sexual minorities. For example, Participant 3 described a transgender client who had an intense fear of psychiatric hospitalization due to a medical system that is often hostile towards people with non-normative gender identities. Participants indicated this distrust is justified, as hospital environments may be hostile to individuals with minority identities. 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.

However, discussions of how psychiatric hospitalization affects individuals of marginalized identities were not unanimous among the practitioners who participated in this study. For example, Participant 2 stated they did not notice gender differences among their clients who had been hospitalized. Further, Participant 3 discussed a transgender client whose experience in a psychiatric hospital was gender-affirming. Such discrepancies among the participants are reflective of the inconclusive nature of the literature, indicating that further research that centers the importance of social location in psychiatric hospitalization is essential.

Additional Themes

In addition to these themes addressing the initial research questions, the following additional themes emerged:

Semi-voluntary hospitalization as a dynamic spectrum. Participants demonstrated that psychiatric hospitalization cannot be viewed as dichotomous, with clear distinctions between voluntary and involuntary legal status. Rather, participants viewed hospitalization as dynamic, as

voluntary admission had the potential to become involuntary (Participant 4). In other words, if a voluntary patient requests to leave the hospital, clinicians have the authority to change their status to involuntary if they deem that patient to be dangerous, thereby preventing them from leaving the hospital. Further, practitioner-suggested voluntary psychiatric hospitalization took a number of forms. While some participants simply suggested hospitalization as a final treatment option when the client was unable to adhere to alternatives, other participants took additional steps to aid the process, such as offering to call the hospital on the patient's behalf (Participant 2). Sometimes practitioner-suggested hospitalization took the form of "above and beyond" care, or extreme measures taken by therapists in order to ensure safety and security for their clients. Participant 3 described the case of a colleague who demonstrated "feminist therapy at its best and its most costly for the practitioner" when working with a transgender client at high risk of suicide. Because of their gender identity, the client's suicidal ideation was worsened by an intense fear of the medical system. However, the client was able to receive treatment when their therapist offered to accompany them to the ER, then "cancelled 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 to a psychiatric hospital on a semi-voluntary basis (Participant 3). Such situations, when practitioner-suggested voluntary hospitalization takes the form of dedication to the client and determination to ensure safety, demonstrate that semi-voluntary hospitalization is nuanced and complex, and therefore cannot simply be labeled as coercive and ill-intentioned without further examination.

However, it is important to note that even when the practitioner has benign intentions, practitioner-suggested voluntary hospitalization may still be interpreted by a client as coercive, potentially due to an unequal balance of power within the therapeutic relationship. For example,

Participant 4 details a situation in which a client decided to stop therapy because the mere suggestion of hospitalization was interpreted as coercive, even though the therapist had all intentions of avoiding hospitalization and using other treatment methods.

Hospitalization as trauma. In describing one of the primary reasons that feminist therapists tend to avoid psychiatric 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] really taking away their power to make decisions about their lives." In other words, the lack of autonomy patients experience due to coercive measures such as restricted mobility and forced medication, as well as a lack of authorship caused by being told they must interpret their experiences through the lens of a mental "illness," can be distressing to people who are hospitalized. Participant 4 discussed this lack of autonomy and authorship, not only as a mental health practitioner who has worked with many ex-patients, but also as a "peer" having lived experience within the psychiatric hospitalization system. After a period of extreme distress due to trauma, they were diagnosed with severe mental illness and hospitalized in a manner that violated their civil rights. Participant 4 internalized the idea that their experiences were caused by an inherent, incurable disease, leading them to question "who am I, a mental patient, to question all of these authorities and doctors and science?"; lacking the ability to define their own experiences led them to experience worsened distress. Participant 4 indicated that these lived experiences now inform their therapy, as they practice in a manner that focuses on the role that trauma, adversity, and marginalization plays in human suffering.

In addition to a deprivation of agency, patients may face a number of other traumatic factors, including exposure to law enforcement, as patients who are hospitalized involuntarily

may be handcuffed and escorted by police. This is not only traumatic, particularly in a political climate in which significant tension exists between law enforcement and individuals with marginalized identities, but it also perpetuates stigma surrounding the supposed dangerousness of individuals with mental health problems. Further, many patients experience hospitalization as an overall dehumanizing environment. For example, Participant 2 discussed a client who was involuntarily hospitalized following a suicide attempt. The client described the hospital environment to be a "snake pit;" she was met by apathetic staff who only managed her symptoms through medication, rather than providing therapy and support. The patient stated that even the physical environment was distressing; the rooms were "dreary and gray" and the furniture was falling apart, serving as a physical manifestation of the lack of care that clinical staff held for patients (Participant 2). These viewpoints align with existing research of patients who felt coerced into mental health treatment, indicating that their treatment made them feel inferior or unworthy. Understanding the traumatic aspects of hospitalization indicate the importance of further investigating nonconsensual psychiatric interventions and their effects on patients.

Hospital avoidance. Because inpatient treatment may be experienced as traumatic, psychiatric hospitalization oftentimes creates a situation in which individuals lie about their feelings and experiences in order to escape or avoid hospitalization and regain a sense of autonomy. In fact, Participant 3 described a patient who indicated they were okay in the therapist's office, yet attempted suicide immediately after, leading to involuntary hospitalization. When the participant met their client in the hospital, the client said "I lied to you," indicating that her dishonesty stemmed from a fear of being involuntarily admitted (Participant 3). Participant 4 discussed hospital avoidance by linking it to the lack of authorship that stems from psychiatric hospitalization, or the fact that patients are told they must interpret their experiences through the

lens of a mental "illness," even when underlying adversity or trauma has played a significant role in their suffering. In order to be released from the hospital, they must comply with this worldview, leading them to stifle the feelings they are truly experiencing in order to regain autonomy. This is particularly detrimental when patients feel they must lie about the suicide risk they are facing, given that patients who have been hospitalized are at high risk of suicide immediately following their release from the hospital. Creating a situation in which patients must shut themselves down in order to avoid hospitalization may be detrimental to healing, calling into question the effectiveness and humanity of psychiatric hospitalization as a form of treatment (Participant 4).

Discussion

Participants' discussions of power align with existing literature indicating that coercive practices occur within psychiatric hospitalization. Furthermore, participants addressed ambiguities in the literature by demonstrating that while a minority identity does not inherently make one more susceptible to psychiatric hospitalization, the systematic oppression that individuals with marginalized identities experience may do so. Participants cited other factors unique to individuals with marginalized identities, such as distrust, a lack of affirmative resources, and a hostile hospital environment. These experiences indicate that further research on hospitalization should operate from an intersectional feminist perspective. While participants provided a wealth of knowledge, one limitation is that the small sample was not representative, as three of four participants were white, and all were cisgender and heterosexual. The lack of diversity within the sample was made particularly clear to me when interviewing Participant 1, who is of Latin-American descent. When asked how their social identities impact their therapeutic practice, they described how the intersections of their privileged and marginalized

identities influenced their interactions with clients; while their marginalized identities allowed them to empathize with others of minority status in race, gender, sexual orientation, etc., their privileged identities allowed them to "use the social power [they] have as a heterosexual person to speak out for injustices," (Participant 1). For example, Participant 1's office, which is decorated with various flags and representations of individuals of all races, classes, genders, and sexual orientations, served as a physical manifestation of the intersectionality that they infused in their therapy. While all four participants relied on feminist and social justice practices within their therapeutic practice, Participant 1 demonstrated a unique perspective as a person of color. In order for research to operate from a feminist standpoint, the voices of people with marginalized identities must be central; therefore, future research must be more inclusive in terms of race, gender identity, sexual orientation, and other social identities.

By discussing hospitalization as trauma, participants demonstrated the central importance of this research. Practitioners indicated that many clients viewed hospitalization as a dehumanizing experience that hindered healing rather than fostering it. These discussions align with existing literature among psychiatric patients who perceived coercion, leading them to feel isolated and inferior. Because patients are at high suicide-risk immediately following release, it is essential to explore the effects of non-consensual psychiatric interventions. Further, because trauma and adversity play an immense role in human suffering and emotional distress, which may be diagnosed as mental illness, hospitalization as a traumatic event has the potential to worsen already existing traumas. For this reason, mental health practitioners must implement trauma and recovery-oriented therapy which "understands the depth of terror, rage, hopelessness, and powerlessness – and the potential for escalation of suicide danger – that can be evoked

within many distressed individuals by the threat of involuntary hospitalization and all that can go with it," (Probert, 2014).

In addition, one of the most enlightening themes that emerged from this research project is that of "hospital avoidance," or the idea that patients must repress their pain, suffering, and suicidal ideation in order to escape or avoid hospitalization. Hospital avoidance is epitomized in Judi Chamberlin's *Confessions of a Non-Compliant Patient,* as she juxtaposes what it means to be a "good patient" and a "bad patient." A "bad patient" is one that seeks autonomy and empowerment, yet is met with coercive forces such as seclusion rooms or locked wards. A "good patient" is one that complies, that stifles negative emotions, that learns "to cry only at night, in [their] bed, under the covers without making a sound," (Chamberlin, 1998). In describing her experiences, Chamberlin states, "I've been a good patient, and I've been a bad patient, and believe me, being a good patient helps to get you out of the hospital, but being a bad patient helps to get you back to real life," (1998). The "secret rebellion" she fueled within herself while in the hospital inspired her activism within the ex-patient movement, promoting a message of recovery, empowerment, hope, and healing while encouraging patients to regain one's belief in themselves. Ultimately, the peer movement attempts "to give voice to individuals who have been assumed to be irrational – to be out of their minds," (Chamberlin, 1990). While one participant in this study identified as a peer, future iterations of this research should strive to further include individuals who have experienced coercive practices within psychiatric hospitalization in order to amplify voices that are often ignored.

References

Appelbaum, P. S. (1985). Empirical assessment of innovation in the law of civil commitment: A critique. *Law, Medicine and Health Care, 13*(6), 304-309.

Brown, L. S., & Brodsky, A. M. (1992). The future of feminist therapy. *Psychotherapy: Theory, Research, Practice, Training, 29*(1), 51-57. doi:10.1037/0033-3204.29.1.51

Chamberlin, J. (1990). The ex-patients' movement: where we've been and where we're going. *The Journal of Mind and Behavior,11*(3/4), 323-336.

Chamberlin, J. (1998). Confessions of a non-compliant patient. Journal of Psychosocial Nursing, 36 (4), 49-52. Available at http://cpr.bu.edu/wp-content/uploads/2011/11/chamberlin1998b.pdf (accessed 6 January, 2015).

Curtis, A. (2001). Involuntary Commitment. Retrieved from http://psychrights.org/states/Maine/InvoluntaryCommitmentbyAliciaCurtis.htm

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against Women of Color. *Stanford Law Review, 43*(6), 1241-1299. doi:10.2307/1229039

Dillon, J., & Hornstein, G. A. (2013). Hearing voices peer support groups: A powerful alternative for people in distress. *Psychosis,5*(3), 286-295. doi:10.1080/17522439.2013.843020

Enns, C. Z. (2012). Feminist approaches to counseling. In E. Altmaier & J. Hansen (Eds.), *Oxford handbook of counseling psychology* (pp. 434-459). New York: Oxford University Press.

Gainesville Peer Respite. (n.d.). Retrieved from http://www.gainesvillerespite.org/

Gamble, V. N. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health*, *87*(11), 1773–1778.

Gilbert, L. A. (1980). Feminist therapy. In Brodsky, A. M., Hare-Mustin, R. T., (Eds.), Women and psychotherapy (pp. 245–266). New York: Guilford

Gilboy, J. A., & Schmidt, J. R. (1971). Voluntary Hospitalization of the Mentally Ill [article]. *Northwestern University Law Review*, (4), 429.

Hoge, S. K., Lidz, C. W., Gardner, W., Mulvey, E. P., & Eisenberg, M. (2001). The MacArthur Coercion Study. Retrieved from http://www.macarthur.virginia.edu/coercion.html

Holstein, J. A. (1987). Producing Gender Effects on Involuntary Mental Hospitalization. Social Problems, 34(2), 141-155.

Intentional Peer Support. (N.d.) Website homepage. Retrieved from http://www.intentionalpeersupport.org/

Langsworthy, D. (n.d.). Elizabeth Packard. Retrieved from http://www.mccarter.org/education/mrs-packard/html/4.html

Lidz, C. W., Mulvey, E. P., Arnold, R. P., Bennett, N. S., & Kirsch, B. L. (1993). Coercive interactions in a psychiatric emergency room. Behavioral Sciences & the Law, (3). 269.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin,129*(5), 674-697. doi:10.1037/0033-2909.129.5.674

Monahan, J., Hoge, S., Lidz, C., Roth, L., Bennett, N., Gardner, W., and Mulvey, E. (1995). Coercion and commitment: Understanding involuntary mental hospital admission. International Journal of Law and Psychiatry, 18,249-263.

National Coalition for Mental Health Recovery Releases Guidelines for Promoting Recovery Through Choice and Alternatives. (n.d.). Retrieved from https://www.ncmhr.org/press-releases/4.28.11.htm

Newton-Howes, G. (2010). Coercion in psychiatric care: Where are we now, what do we know, where do we go? *The Psychiatrist, 34*(6), 217-220.

Olfson, M., Wall, M., Wang, S., Crystal, S., Liu, S., Gerhard, T., & Blanco, C. (2016). Short-term suicide risk after psychiatric hospital discharge. *JAMA Psychiatry,73*(11), 1119. doi:10.1001/jamapsychiatry.2016.2035

Olofsson, B., Gilje, F., Jacobsson, L. and Norberg, A. (1998), Nurses' narratives about using coercion in psychiatric care. Journal of Advanced Nursing, 28: 45–53. doi:10.1046/j.1365-2648.1998.00687.x

Olofsson, B., & Jacobsson, L. (2001). A plea for respect: Involuntarily hospitalized psychiatric patients' narratives about being subjected to coercion. *J Psychiatr Ment Health Nurs Journal of Psychiatric and Mental Health Nursing, 8*(4), 357-366.

Probert, J. (2014). Part 1. Toward a more trauma- and recovery-informed practice of lethality assessment and suicide prevention. SAMHSA Recovery to Practice Highlights, 5 (4). Retrieved from http://www.dsgonline.com/rtp/wh/2014/2014_02_27/ WH_2014_02_27.html. SAMHSA Recovery to Practice Highlights. 5.

Probert, J. & Nash, S. (2015). Mental health recovery and peer support at UF: A social justice perspective. (Poster.).

Rader, J., & Gilbert, L. A. (2005). The egalitarian relationship in feminist therapy. *Psychology of Women Quarterly, 29*(4), 427-435.

Rogers, A. (1993). Coercion and 'voluntary' admission: An examination of psychiatric patient views. *Behavioral Sciences & the Law Behav. Sci. Law, 11*(3), 259-267.

Roth, R. T., & Lerner, J. (1974). Sex-Based Discrimination in the Mental Institutionalization of Women. California Law Review, 62(3), 789

Testa, M., & West, S.G. (2010). Civil commitment in the United States. Psychiatry (Edgmont), 7: 30–40.

World needs "revolution" in mental health care – UN rights expert. (n.d.). Retrieved from http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21689&LangID=E

Appendix

Interview Questions

Feminist Therapy

1. How long have you been a practicing therapist/counselor/psychologist?
2. How would you describe the theoretical orientation of your therapy?
3. How would you define feminist therapy? Do you identify with this definition?
4. How do you incorporate feminist practices into your therapy?
5. How would you describe the therapeutic relationship that you maintain with clients (ex. egalitarian, authoritarian, etc.)?
6. How do you feel your social identities influence your practice as a feminist therapist? (ex. race, gender, etc.)

Voluntary, Involuntary, and Practitioner-Suggested Voluntary Hospitalization

1. Have you ever had a client who was involuntarily admitted into an inpatient psychiatric treatment?
2. If so, was this your treatment decision, or someone else's? For example, was it the decision of a psychiatrist or another practitioner?
3. What criteria do you use to determine whether or not someone should be involuntarily admitted into a psychiatric hospital?
4. Have you ever had a client who was voluntarily admitted to a psychiatric hospital?
5. If so, what role did you play in this treatment decision?
6. Have you ever suggested that a patient voluntarily admit themselves into inpatient treatment?

7. What criteria do you use to determine whether or not a client should voluntarily admit themselves into a psychiatric hospital?
8. What are your professional opinions regarding involuntary or practitioner-suggested voluntary psychiatric hospitalization?
9. Do you believe that power dynamics in the therapeutic relationship affect the experience of psychiatric hospitalization? Why or why not?
10. In your experience, are particular individuals more likely to be involuntarily admitted into a psychiatric hospital? For example, do you believe that individuals of a particular race or gender identity are more likely to be involuntarily admitted?
11. In your experience, are there some individuals that are more likely to be encouraged to enter psychiatric hospitals voluntary? For example, do you believe that individuals of a particular race or gender identity are more likely to experience this?
12. Do you believe that particular communities are more susceptible to involuntary or practitioner-suggested voluntary psychiatric hospitalization? Why or why not?