BRIDGING THE GAP: AN EVALUATION OF INVOLUNTARY COMMITMENT PERSONAL NARRATIVES AND ACADEMIC LITERATURE

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# TABLE OF CONTENTS

**ABSTRACT** iv  
**INTRODUCTION** v  

**CHAPTER**  
1. **THE HISTORY OF INVOLUNTARY COMMITMENT** 1  
   Definitions 1  
   The History of Involuntary Commitment in the United States 3  
   Involuntary Commitment in North Carolina 7  
   Narrative Use in Medicine 8  
   Narrative Use in the Context of Involuntary Commitment 9  
2. **INVOLUNTARY COMMITMENT ACADEMIC LITERATURE** 12  
   Principlism Overview 12  
   Academic Literature 15  
   History of Involuntary Commitment and Bioethics 15  
   Ethical Issues Addressed in Current Involuntary Commitment Literature 21  
3. **INVOLUNTARY COMMITMENT PERSONAL NARRATIVES** 26  
   Loss of Freedom and Autonomous Choice 27  
   Patient-Provider Relationship: Patient Respect and Communication 31  
   Mental Health Stigma 36  
4. **EVALUATING THE INTERSECTION** 40  
   Ethical Concerns Addressed in Both Academic Literature and Narratives 41  
   Addressing Skepticism 44  
   Involuntary Outpatient Commitment 45  
   Psychiatric Advance Directives 46  
   Implications for Mental Health Treatment 48  
   Value for Mental Health Professionals 49  
   Areas for Future Research 50  
   Conclusion 51  

**REFERENCES** 53  
**CURRICULUM VITAE** 58
ABSTRACT

Involuntary commitment has an extensive history in the United States. The practice requires forcibly admitting an individual with a mental health disorder into an inpatient treatment facility on the grounds that the individual poses a significant threat of danger to him/herself or others. Involuntary commitment raises issues of ethical concern largely due to the restriction of individual freedom that occurs during commitment. This thesis examines both involuntary commitment academic literature and personal narratives in order to establish the argument that personal narratives can be used to enhance the protection of individuals’ rights and welfare in cases of involuntary commitment.

Through a historical analysis, academic literature revealed three main themes: autonomy, treatment by caregivers, and violation of individual rights. The themes that emerged from narrative study were autonomy and personal freedom, the patient-provider relationship, and mental health stigma. This research suggests that increasing individual freedom to the extent possible in the involuntary commitment setting, establishing quality respectful relationships with patients, using effective communication, and avoiding mental health stigma may improve patients’ experience with involuntary commitment. Doing so may also allow caregivers to increase the protection of patients’ rights and welfare during involuntary commitment.
INTRODUCTION

Mental illness has an extensive history in the United States. While mental health treatment has improved significantly in recent decades, several treatment methods continue to bring about ethical concerns. One such method is involuntary commitment. While I understand that involuntary commitment and treatment are distinct, a majority of narratives regard the two as intertwined. For that reason, I treat the two as such. From bioethics’ infancy, involuntary commitment has been an issue of large, consistent debate. Perhaps the most significant issue cited in the debate is the loss of personal freedom that occurs during commitment. Personal freedom serves as a fundamental human right and depriving an individual of that basic right is concerning from both a legal and ethical perspective (Brooks, 2006). Aside from the issue of personal freedom, a patient’s refusal of treatment, inconsistent levels of capacity, and potential harm further complicate the ethical concerns associated with involuntary commitment.

Involuntary commitment is the act of forcing an individual into an inpatient treatment facility on the grounds that the individual poses a significant threat of danger to him/herself or others. While criteria for commitment vary among states, policy typically includes the presence of a mental disorder, a risk of harm to the individual patient or others, and, in some states, an expectation of therapeutic benefit (Deemer, 2004). Although this practice is relatively common within United States’ psychiatric hospitals, the act of forcing an individual into treatment is littered with ethical concern.

Involuntary commitment calls into question the four principles of bioethics cited in Beauchamp and Childress’, Principles of Biomedical Ethics (Beauchamp & Childress, 2012). Adhering to all four of the bioethics principles, respect for autonomy, beneficence,
nonmaleficence, and justice, in these psychiatric cases becomes very difficult. The tension that exists as a result of attempting to respect all four principles serves as the basis for the debate. In addition, involuntary commitment creates conversation about strong and weak paternalism, the bounds of beneficence, and interpretation of state policy.

In the medical field today, increasing importance has been given to individual patient narratives. These narratives allow readers to obtain greater perspective regarding a particular issue. Given the debate that surrounds involuntary commitment and the significant loss of freedom that occurs, it is extremely important to understand the ethical concerns addressed by those who have experienced involuntary commitment firsthand. This broadened perspective is important for both individual clinicians making commitment decisions and those involved in policy development. Identifying and evaluating ethical concerns expressed through narrative and in academic literature may be extremely useful in enhancing protection of individuals’ rights and welfare during involuntary commitment.

This thesis examines both individual narratives and academic literature that focus on ethical concerns associated with involuntary commitment. Identifying the intersection between narrative and academic literature in this particular area functions as a vital aim of my research. Through achievement of that aim, I identify the major ethical concerns addressed by those involved in the process. In addition, I offer a better understanding of how narrative can be used in this context. Research for this thesis is primarily document-based. This thesis addresses the problem that presents itself when comparing involuntary commitment academic literature and involuntary commitment personal narratives;
personal narratives expose areas of ethical concern that academic literature does not address and provides understanding in areas where academic literature lacks specification.

The first chapter of this thesis establishes the argument that is addressed throughout: **Personal narratives can be used to enhance the protection of individuals’ rights and welfare in cases of involuntary hospitalization. Narratives should be used during policy development in order to address the interests of all stakeholders.** It is important to mention that the use of the term protection in this thesis refers to the security of patients’ rights and the need to ensure that individual rights are exercised to the greatest extent possible. Aside from establishing the thesis argument, chapter one defines and discusses the differences between the terms involuntary commitment, civil commitment, and involuntary hospitalization. After operationally defining the terms used in this thesis, I conduct a brief overview of the history of civil commitment in the United States. The chapter reviews the Supreme Court case *O’Connor v. Donaldson*, 422 U.S. 563 (1975) and the case *Wyatt v. Stickney*, 325 F. Supp. 781 (1971). I discuss the impact that these cases have had on mental health treatment and civil commitment itself. Following the brief history of civil commitment in the United States, the chapter discusses its use in the state of North Carolina. The chapter also discusses the incorporation of narrative into medicine and examines how narratives may help to enhance patient welfare. Analyzing that information may allow for an increased understanding of the ethical concerns expressed by those involved in the involuntary commitment process.
Chapter two examines ethical issues addressed in involuntary commitment academic literature. The chapter begins by describing the four ethical principles cited in Beauchamp and Childress’ Principlism (2012). The chapter considers how involuntary commitment relates to the bioethics principles respect for autonomy, beneficence, nonmaleficence, and justice. I focus on the loss of freedom experienced during involuntary commitment as a major ethical concern, and identify how academic literature addresses that issue. Additionally, this chapter discusses paternalism and the bounds of beneficence in this particular context.

Like chapter two, chapter three identifies ethical concerns cited in involuntary commitment personal narratives. Chapter two and three have a very similar format. In addition to identifying ethical concerns in narratives, the chapter mentions how the medical field has increased the use of personal narratives in patient treatment. I include a variety of mental health narratives in order to increase the breadth of narrative research. The focus of this chapter is to identify the major concerns cited by authors of narratives during their experiences with involuntary commitment and mental health treatment in general. Narratives are drawn from the National Alliance of Mental Illness and the bioethics journal, Narrative Inquiry in Bioethics.

Chapter four uses the data cited in both chapters two and three to evaluate ethical concerns addressed in involuntary commitment academic literature and personal narratives. Using these two sources of literature, I offer an increased understanding of involuntary commitment from both an administrative and a patient perspective. I also examine how narrative can be used to help protect individuals’ rights in the process. This chapter addresses the use of Psychiatric Advance Directives, and how these directives
may improve mental health treatment. It also discusses the use of involuntary outpatient commitment and its relation to the ethical concerns with involuntary inpatient commitment.

In addition, chapter four focuses on the conclusions drawn from the data described in chapters two and three and considers how narrative can be used to enhance the welfare, rights, and interests of mental health patients. This process reveals areas of ethical concern experienced by patients that are not addressed in academic literature and provides recommendations regarding how to address those concerns. I expect that this thesis will prove successful in addressing multiple perspectives of involuntary commitment, and stress the importance of considering all perspectives when formulating policy. In addition, I suggest the use of narrative as an effective way to gain access to the interests of all stakeholders during policy development. This chapter closes with a summary of the thesis argument and identifies areas for future research.
CHAPTER ONE

THE HISTORY OF INVOLUNTARY COMMITMENT

Involuntary psychiatric hospitalization has an extensive history in the United States. While the practice has evolved significantly from its use in insane asylums during the first part of the 19th century, involuntary hospitalization continues to bring about ethical concern. The practice demonstrates conflict between individual rights and freedom, individual needs, and societal needs. There are several terms used to describe the act of holding an individual in a hospital setting against his/her will. For the purpose of this thesis, it is important to understand the terms involuntary hospitalization and involuntary civil commitment. The two terms are used interchangeably in both academic literature and personal narratives to describe this practice. The first section of this chapter is dedicated to defining these terms. The second portion of this chapter discusses the historical use of involuntary hospitalization in the United States and the current use of involuntary civil commitment in the state of North Carolina. The chapter concludes with a discussion of narrative use in medicine and how narratives can be used in the context of involuntary hospitalization.

Definitions

The Cornell University Law School’s Legal Encyclopedia provides the following comprehensive definition of the term involuntary civil commitment:

Involuntary civil commitment is the admission of individuals against their will into a mental health unit. Generally speaking, there are three reasons why an individual would be subject to involuntary civil commitment under modern
statutes: mental illness, developmental disability, and substance addiction. In the case of mental illness, dangerousness to self or others defines the typical commitment standard, with almost all states construing the inability to provide for one's basic needs as dangerousness to self. In terms of process, every state provides for a hearing, the right to counsel, and periodic judicial review, while most states have statutory quality standards for treatment and hospitalization environment. (Cornell University Law School Legal Information Institute, *Involuntary Civil Commitment*, https://www.law.cornell.edu/wex/involuntary_civil_commitment)

Involuntary civil commitment and involuntary commitment are legal terms used to describe the process illustrated in the above definition. The term involuntary hospitalization is often used to describe the same process, but it is not technically a legal term. This point is worth mentioning because many personal narratives refer to the process of involuntary civil commitment and involuntary commitment as involuntary hospitalization.

For the purpose of this thesis, I use the term involuntary commitment to describe the act of forcibly admitting an individual with a psychological disorder into a mental health facility on the grounds that the individual poses a significant threat of danger to him/herself or others. In some states, commitment criteria also include an expectation of therapeutic benefit (Deemer, 2004). When referring to the term involuntary commitment in this thesis, I do not include expectation of therapeutic benefit as a criterion because of the high variation among states.
It is also important to note in this section the distinction between treatment and involuntary commitment. The fact of commitment itself does not include any form of mental health treatment. That said, when individuals write about their experience with involuntary commitment, a majority do not make a distinction between commitment itself and the subsequent mental health treatment. The majority of narratives I examined regard the two as intertwined. For example, many individual narratives refer to involuntary commitment as a part of treatment or the beginning of their mental health treatment in a hospital setting. Due to the fact that narratives do not make a clear distinction between the two, this thesis does not attempt to separate commitment and treatment.

The History of Involuntary Commitment in the United States

The idea of forcing an individual into a treatment facility is not novel in the United States. From the birth of psychiatry as a field, involuntary commitment has served a significant role in psychiatric care (Testa & West, 2010). Disorders of thought and mood often interfere with individuals’ perceptions of themselves and their environment (Testa & West, 2010). Distortion of thought can be so severe that it alters an individual’s ability to function to the extent that treatment is required for the safety of the patient. Psychiatric illness and an altered perception of reality often serve as both the reason for treatment need and patient refusal of care. Disorders of thought influence judgment, and involuntary commitment is used to provide necessary treatment for individuals who inappropriately refuse care (Testa & West, 2010). Psychiatrists and health care professionals often encounter patients who refuse care despite their immediate, often life-threatening, need for treatment (Testa & West, 2010). In these cases, physicians must balance their professional duties and respecting the autonomy of the patient (Testa &
West, 2010). Today, physicians can rely on state and hospital policy and hospital ethics committees to assist in making decisions about commitment. Physicians have not always had access to the above resources and reviewing the history of involuntary commitment is important in understanding the evolution of the practice.

Before the development of the earliest asylums in America, individuals with mental health disorders were forced into prisons or homeless shelters (Testa & West, 2010). These individuals received little to no treatment and were often forced to live in inhumane conditions (Anfang & Appelbaum, 2006). With the help of activists such as Dorothea Dix, the United States funded state psychiatric hospitals to provide care for those with mental illness (PBS, 2012). When compared to modern commitment standards, those in effect during the mid-19th century were inadequate. Involuntary commitment only required the presence of a mental disorder and a physician’s recommendation for treatment (Testa & West, 2010). Commitment was based solely on a need for treatment determined by an individual’s physician (Testa & West, 2010). During the second half of the 19th century, mental health disorders and diagnoses had little scientific evidence supporting their existence (Augstein, 1996). For example, “moral insanity” was a widely accepted diagnosis during that time (Augstein, 1996). Those suffering from moral insanity experienced what physicians considered abnormal emotions and behaviors. Little scientific evidence supported the existence of moral insanity as well as many other mental health disorders of the time (Augstein, 1996). That fact coupled with the need for only a physician’s recommendation for treatment allowed for an extremely subjective involuntary commitment environment in which individuals were easily forced into institutions. In this context, little attention was paid to individual
rights and welfare. In fact, during the late 1800s the belief that all people who suffered from mental illness lacked the capacity to make decisions for themselves was widely held within American society and the medical community (Testa & West, 2010). In addition, the majority also believed that involuntary treatment would benefit all patients (Testa & West, 2010).

Due to a lack of effective treatment methods for mental illness, institutions quickly became long term care facilities for patients who were unable to adequately care for themselves (Testa & West, 2010). By the 1950s, ineffective treatment and patients’ inability to reenter society resulted in extreme overcrowding of American asylums (Testa & West, 2010). In the second half of the 20th century, involuntary commitment standards in the United States became much more stringent. States provided legal protection for individual rights through a “right to trial, with attorney representation, prior to psychiatric admission” (Testa & West, 2010, p. 32). In addition, commitment power shifted from individual physicians to judges in the legal system (Testa & West, 2010). While the new standards focused on protection of individual rights, they ultimately resulted in significant waiting periods for patients while legal proceedings occurred (Anfang & Appelbaum, 2006). The American public began to criticize the ineffective treatment that took place in institutions in the 1960s and, with the rise of the Civil Rights Movement, urged the closing of mental institutions (Anfang & Appelbaum, 2006). The Civil Rights Movement, alongside several benchmark Supreme Court Cases in mental health law, allowed for a shift in commitment standards. Instead of focusing on a need for treatment, new standards called for the existence of significant danger to self or others (Anfang &

The Supreme Court case O’Connor v. Donaldson (422 U.S 563, 1975) was one of the landmark cases cited above that changed the landscape of involuntary commitment and mental health law in the United States. Kenneth Donaldson was an individual held for nearly 15 years as a mental health patient in a psychiatric hospital in Florida. Donaldson made numerous requests for his release during his 15-year stay. Each time, Donaldson stated that he was not a danger to himself or others. All of his requests were denied. The Supreme Court found that the State cannot confine an individual who does not pose a threat of danger and who is capable of living independently or with the help of family/friends. In confining Donaldson, O’Connor denied his right to individual liberty. This ruling established standards regarding civil commitment that are still evident in current commitment criteria. The patient must present a risk of harm to self or others, be unable to live independently or with the help of others, and must be in need of mental health treatment.

At this time, procedural changes also occurred. States began allowing medical professionals to hold patients for a predetermined amount of time (Testa & West, 2010). After the predetermined period of time has passed, patients are entitled to a legal hearing with adequate representation (Testa & West, 2010). Additional landmark cases in mental health law that pertain to the issue of involuntary commitment are Addington v. Texas and Lake v. Cameron. The Supreme Court case Addington v. Texas established that a clear and convincing standard of proof is required to commit an individual for an indefinite period of time (441 U.S 418, 1979). Lake v. Cameron, a district court case in
the District of Columbia, established that non-dangerous patients have the right to the least restrictive treatment alternative (267 F. Supp.155 D.D.C., 1967). These court cases had a dramatic impact on mental health care in the United States and continue to influence involuntary commitment today.

Involuntary Commitment in North Carolina

Severe mental illness has a significant presence in North Carolina. According to the US Bureau of the Census, of the total adult population in North Carolina, 7.7 million people, roughly 85,000 individuals have schizophrenia and approximately 169,000 have severe bipolar disorder (2015). In 2010, the state had 761 psychiatric hospital beds, roughly 8 beds per 100,000 people (Treatment Advocacy Center, 2016). The Treatment Advocacy Center recommends 50 beds per 100,000 people, a benchmark that all states, including North Carolina, fail to meet (2016). This fact illustrates current issues associated with access to mental health treatment in the United States today.

North Carolina offers two forms of civil commitment. Mental health patients who meet the criteria for civil commitment can be placed in either an inpatient or outpatient setting. In order to meet the criteria for involuntary inpatient commitment, patients must be a danger to self/others, need nourishment, medical care, shelter, or self-protection and safety (Treatment Advocacy Center, 2016). In order to meet the criteria for outpatient commitment, an individual must be “capable of surviving safely in the community with available supervision, be in need of treatment to prevent further deterioration predictably resulting in dangerousness, and be unable to make an informed decision to seek/comply with voluntary treatment” (Treatment Advocacy Center, North Carolina, 2016, http://www.treatmentadvocacycenter.org/north-carolina).
Narrative Use in Medicine

Narrative use in medicine has become increasingly popular in recent years. Narratives are attractive to those in the fields of medicine and bioethics. Medical narratives are both constructed and analyzed in order to increase understanding. Narratives are used to uncover areas that academic literature does not address and provide understanding in areas that academic literature lacks description. Although physician narratives have been a mainstay in medical teaching for quite some time, emphasis on patient narratives has become increasingly popular. For many, writing narratives about a medical experience serves a therapeutic purpose. According to Greenhalgh and Hurwitz in “Narrative Based Medicine: Why Study Narrative,” “the narrative provides meaning, context, and perspective for the patient’s predicament. It defines how, why, and in what way he or she is ill. The study of narrative offers a possibility of developing an understanding that cannot be arrived at by any other means” (1999, p 48). According to Rita Charon in Narrative Medicine: Form, Function, and Ethics, “narrative knowledge, the capacity to understand the meaning and significance of stories, is being recognized as critical for effective medical practice” (2001, p 83).

Humans are narrative beings, and narratives are used in virtually every aspect of life. As medicine has made a shift to patient centered care, the need for knowledge and insight obtained from narrative study has grown significantly. Illness serves as an interruption in human life and is often anxiety producing. Illness narratives provide information that allows physicians to address “existential qualities such as inner hurt, despair, hope, grief, and moral pain which frequently accompany, and may even constitute, people’s
illnesses” (Greenhalgh & Hurwitz, 1999, p 48). In addition, they encourage physicians to approach treatment in a holistic manner (1999).

According to Charon, physicians are now attempting to practice what she coins narrative medicine (2001, p 83). She describes narrative medicine as “medicine practiced with the narrative competence to recognize, interpret, and be moved to action by the predicaments of others” (Charon, 2001, p 83). Practicing narrative medicine requires a certain sensitivity and openness toward patients and their medical experiences. In addition, it requires self-reflection by those involved in the medical realm, whether it physicians or others involved in mental health treatment. Medical narratives can be extremely useful in cases of ethical conflict. This is especially true in cases of involuntary commitment. Narratives have the ability to present the concerns of all stakeholders and display issues that only an individual who has first-hand experience may understand.

Narrative Use in the Context of Involuntary Commitment

While involuntary commitment is relatively common in the United States, the practice itself is littered with ethical concern. Although protection of individual and public safety are used to support involuntary commitment, the loss of personal freedom that occurs during commitment is the most significant ethical concern cited in the debate. Medical ethics often turns to the four principles cited in Beauchamp and Childress’ *Principles of Biomedical Ethics* to help make difficult ethical decisions. In involuntary commitment cases the tension that exists between the four principles is obvious (2012). That tension serves as the basis for the majority of the debate surrounding this psychological practice. It is here where personal narratives may aid in the process. Individuals who have experienced involuntary commitment first-hand have valuable
knowledge about how to ensure patient welfare and protect individual rights in an environment where individual personal freedom is limited.

The narratives analyzed in this thesis demonstrate concerns of autonomy and patient respect. In addition, they point to the necessity of involuntary commitment while highlighting areas in which medical health professionals can encourage and protect patient choice. As chapters two and three demonstrate, narratives offer essential information that academic literature and quantitative study simply cannot provide. Rather than argue ethical theory or quantitatively study patient experience, narratives display emotion and provide the type of thick case description that Dena Davis argues for in her article “Rich Cases: The Ethics of Thick Description” (1991). She states, “We need thick description to allow cases to remain open to different interpretations over time, and also to enable cases to ground an ethics of care” (Davis, 1991, p 15). The majority of narratives are descriptive in nature and prove valuable because they can offer more than a simple case study. “Thick description, like myth, allows for a fuller moral response” (Davis, 1991, p 12). Personal narratives invite readers to think critically about ethical issues and consider more than just the physical facts of a case. They force medical professionals to pay attention to the writer’s perception of the medical experience and the specific role that they play in the narrative. In addition, the narratives studied here display the power imbalance present in mental health treatment. They also demonstrate how physician’s awareness of that imbalance can drastically impact patients’ perception of care.

Studying narratives about involuntary commitment forces the reader to consider the values and wishes of the patient despite the presence of a mental health disorder.
Narratives written by individuals who had a positive experience with involuntary commitment often talk about how they felt respected because their care givers understood what was important to them throughout the treatment process. Engaging in narrative study may influence how medical professionals use involuntary commitment in the future. These narratives may also help medical professionals think about the questions that they should ask their patients outside of current symptoms and medical history. The narratives examined in chapter three illustrate that learning about patient values often translates into a more positive hospital experience. Discovering and analyzing the intersection between involuntary commitment academic literature (chapter 2) and involuntary commitment personal narratives (chapter 3) serves as a vital aim of this thesis. Mental health professionals and those involved in policy development can use that information to enhance the protection of individuals’ rights and welfare in cases of involuntary commitment.
CHAPTER TWO

IN Voluntary COMMITMENT ACADEMIC LITERATURE

As mentioned at the end of chapter one, discovering and analyzing the intersection between involuntary commitment academic literature and involuntary commitment personal narratives (chapter 3) serves as a vital aim of this thesis. Understanding the connection between the two mediums may allow health care professionals to enhance the protection of individuals’ rights and welfare in cases of involuntary commitment. Academic literature takes many forms. This thesis examines academic literature that is data driven, academic literature about ethical concerns with involuntary commitment, and academic literature about narratives. This chapter reviews academic literature that focuses on the ethical concerns associated with involuntary commitment. The chapter begins with an overview of Tom Beauchamp and James Childress’ ethical approach Principlism. Principlism and is often used in the health care context and by those in the field of bioethics. Much of the literature involving involuntary commitment references the four principles emphasized in Principlism when discussing ethical concerns. The brief overview of Principlism is followed by an analysis of involuntary commitment academic literature. The analysis addresses the history of involuntary commitment, recent use, and evolution of the ethical concerns associated with the practice.

Principlism Overview

Tom Beauchamp and James Childress’s *Principles of Biomedical Ethics* provides an approach to moral decision making that is often used in the health care context. The
approach is based on the presence of a common morality or set of views held by those intending to live a moral life (Beauchamp & Childress, 2009). Beauchamp and Childress note that while common morality includes many principles, Principlism emphasizes four that are of particular importance in the health care context: respect for autonomy, nonmaleficence, beneficence, and justice (Beauchamp & Childress, 2009). The four principles are first specified, or applied to the specific context of the case. After specification, the principles must be balanced. The principles are prima facie. This means that the principles can override each another depending on the specific context of the case. Balancing is the process of determining which of the principles should have primacy. In this process, one determines which principles are relevant to the particular context and the influence or weight each relevant principle should hold. These balancing judgments should be made based on moral norms (Beauchamp & Childress, 2009).

Respect for autonomy refers to an individual’s right to exercise free will and make decisions for him/herself. In order for a decision or action to be considered autonomous, Beauchamp and Childress assert that the following three conditions must be met: an action must be committed with intention, made without outside influence, and the individual must understand all of the information relevant to the particular context (Beauchamp & Childress, 2009). Autonomy is both situation-specific and time-specific. It is influenced by an individual’s ability to understand the relevant information. Individuals suffering from a mental health disorder, particularly a disorder of thought, will probably experience periods in which their ability to make autonomous decisions fluctuates. This fact is one of the many reasons autonomy is cited in academic literature as an ethical concern in involuntary commitment cases. It is important to make note of
the difference between autonomy and individual freedom. If an individual meets the
criteria for involuntary commitment, they may or not be considered autonomous.
Restricting the freedom of a nonautonomous person is not a violation of autonomy. But,
as this thesis demonstrates, restriction of freedom can drastically affect a patient’s
experience with involuntary commitment.

Nonmaleficence or “do no harm” is an obligation to avoid causing harm
(Beauchamp & Childress, 2009). This principle represents a negative duty, in that one
should refrain from performing acts that may inflict harm. The third principle,
beneficence, is the promotion of good (Beauchamp & Childress, 2009). Beneficence
represents a positive duty. It requires one to perform acts that either promote good or
prevent harm (Beauchamp & Childress, 2009). Nonmaleficence and beneficence are
often cited in involuntary commitment academic literature as areas of ethical concern.
Involuntarily committing an individual with a mental health disorder displays the tension
that exists among autonomy, nonmaleficence, and beneficence in this particular context.
If a physician determines that an individual should be committed, the physician must
restrict the freedom of that patient. While some would consider this rejection of
individual freedom beneficent because it provides protection from harm, others consider
restriction of freedom a harm in itself that violates nonmaleficence.

The fourth principle, justice, is concerned with distribution. While Beauchamp
and Childress offer many principles of justice, the majority involve establishing a fair
distribution of both benefits and burdens associated with a particular moral decision
(Beauchamp & Childress, 2009). In addition to distribution, the principle of justice
involves the ideas of access to resources and wellbeing (Beauchamp & Childress, 2009).
As one can imagine, the four principles are of great interest in cases of involuntary commitment. After specifying and balancing the principles, physician and health care professionals must determine which of the four principles should have primacy. The dilemma that health care professionals face as they attempt to balance reducing harm and respecting individual freedom is often cited in academic literature. Given the large presence of the four principles in academic literature, the remainder of this chapter analyzes the evolution of involuntary commitment while paying special attention to the four ethical principles cited above.

Academic Literature

Involuntary commitment has an extensive history in the United States. The evolution of law regarding the practice reflects larger changes in medicine, psychiatry, and societal attitudes toward restriction of individual liberty. In order to understand that connection, a more in depth history than provided in chapter one is necessary. According to Stuart Anfang and Paul Appelbaum in “Civil Commitment- The American Experience,” civil commitment laws reflect social attitudes and “need to be understood within the context of changes in psychiatry and medicine, as well as larger social policy and economic changes” (2006, p. 209). Over the past 200 years, commitment law has reflected society’s fluctuating views about the extent of freedom restriction deemed acceptable (Anfang & Appelbaum, 2006).

History of Involuntary Commitment and Bioethics

Mental health treatment in Colonial America was virtually nonexistent. In addition, little legal regulation was available to protect the interest of mentally ill patients (Anfang & Appelbaum, 2006). Those who suffered from mental illness and were unable
to care for themselves were forced into prisons or homes for the poor (Anfang & Appelbaum, 2006). Jails and poorhouses quickly became overcrowded and society, driven by interests of public safety, searched for a solution (Anfang & Appelbaum, 2006). Robert Whitaker, in his book Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill, notes that the first hospital in the colonies was opened in Pennsylvania in 1756 (Whitaker, 2002). Benjamin Franklin and his fellow Quakers advocated for the hospital because they felt that there were too many lunatics “going at large [who] are a Terror to their neighbors, who are daily apprehensive of the Violences they may commit” (as quoted in Whitaker, 2002, p.4). This quote demonstrates a general belief during the time that society needed protection from the mentally ill. This new hospital would serve two functions: treatment and confinement (Whitaker, 2002). During this hospital’s initial years, the most severely afflicted mental health patients were kept in the basement of the hospital, which resembled a prison. The following quote describes the living conditions:

> The lunatics were kept in gloomy, foul smelling cells and were ruled over by “keepers” who used their whips freely. Unruly patients, when not being beaten, were regularly “chained to rings of iron, into the floor of wall of the cell…restrained in handcuffs or ankle-irons,” and bundled into Madd-shirts that left the patients an impotent bundle of wrath. (Whitaker, 2002, p. 4)

Although there was a general sense that society needed protection from the mentally ill during this time, there was also public curiosity. “After the hospital opened, visiting the mad had quickly become a popular Sunday outing, similar to visiting a zoo” (Whitaker, 2002, p. 4). People visited the hospital so frequently that the hospital
administrators were forced to build a fence in order to keep visitors out (Whitaker, 2002). The fence proved ineffective and the hospital instead began charging four pence as a visitor’s fee (Whitaker, 2002). Containment had little therapeutic benefit for patients and was driven by the police power of the state to protect public safety (Anfang & Appelbaum, 2006). Little consideration was given to the individual rights of the patient. Autonomy was virtually nonexistent for these individuals, and public safety took precedence over individuals’ rights.

By the early part of the 19th century a small number of private and public mental health facilities had opened in the states (Anfang & Appelbaum, 2006). At this time, all admissions into these facilities were involuntary and were often initiated by family members (Anfang & Appelbaum, 2006). “Insane persons were considered by definition to be unable to recognize their own interests and make decisions about hospitalization” (Anfang & Appelbaum, 2006, p. 210). Patients were kept in these facilities for as long as family members or friends could afford to pay for their stay (Anfang & Appelbaum, 2006). By the middle of the 19th century, reformers brought “moral treatment” to mental health in America (Whitaker, 2002). This European form of treatment called for humanitarian treatment of the mad. Instead of being viewed as animals, the mad should be viewed as:

Beings within the human family -- distressed people to be sure, but “brethren.” The mad had an inner capacity for regaining self-control, for recovering their reason. The ultimate source of their recovery lay inside themselves, and not in the powers of medicine. (Whitaker, 2002, p. 25)
For the first time, the interests of the patients and concern for individual care began to guide state involuntary commitment policy (Anfang & Appelbaum, 2006). Thanks to the work of advocates such as Dorothea Dix, who brought light to the horrible conditions people with mental illness were subject to, and to the new focus on patients’ need for treatment, states began developing asylums (Anfang & Appelbaum, 2006). It was clear that previous treatment of mental health patients generally produced little benefit for patients. In the transition from protecting public safety to addressing patient needs, states’ interests in adhering to the principles of beneficence, nonmaleficence, and justice began to emerge. The establishment of state run facilities demonstrated a need for legislation and regulation (Anfang & Appelbaum, 2006). Commitment laws focused on the need for treatment, and judicial involvement included supporting medical opinions, cost control, and distribution of resources (Appelbaum & Kemp, 1982). In the mid-1800s, during the United States Civil War, commitment decisions were made by family members and physicians for people who were mentally ill and required care (Anfang & Appelbaum, 2006). It was assumed by the public and those in the medical field that state run asylums were the best place to receive mental health treatment. At this point, admissions were still involuntary because there was a general belief that mentally ill patients lacked the reasoning capabilities required to refuse treatment (Anfang & Appelbaum, 2006).

The humanitarian approach that moral treatment required would soon be impossible to provide in state run asylums. First, the treatment required a small facility, which state hospitals could not provide (Whitaker, 2002). The rush of mentally ill patients into state run facilities meant large patient populations with a large variety in
disorder type. States cut costs by eliminating “day rooms, the reading parlors, the bathing facilities, and the other amenities that were essential to moral treatment” (Whitaker, 2002, p. 35). States paid employees extremely low wages and because of this were unable to staff qualified caregivers (Whitaker, 2002). Treatment success rates steadily declined, and state asylums became crowded with chronic patients (Whitaker, 2002).

From the start of the Civil War to the 1960s, involuntary commitment law focused on procedural concerns (Anfang & Appelbaum, 2006). Reform advocated for jury trials for individuals who were considered for involuntary commitment (Anfang & Appelbaum, 2006). In addition, reform focused on patient protection and respect for individual liberties. States began to develop emergency commitment standards that would bypass lengthy judicial hearings (Anfang & Appelbaum, 2006). In 1951, the National Institute of Mental Health published the “Draft Act Governing Hospitalization of the Mentally Ill” (Anfang & Appelbaum, 2006, p. 211). This act limited the application of the involuntary commitment criterion on the need for treatment only to those who lacked capacity (Anfang & Appelbaum, 2006).

The 1960s brought significant changes to the field of psychiatry. The development of antipsychotic medication, a new focus on community-based psychiatry, and recognition that treatment in state facilities was generally not successful led to deinstitutionalization in the United States (Anfang & Appelbaum, 2006). Without state-run facilities, involuntary commitment cases drastically decreased. States were forced to shift from a ‘need for treatment’ standard for commitment to ‘dangerousness.’ This new commitment standard was adopted by nearly every state by the 1970s and continues to influence commitment law today. While dangerousness still stands as a commitment
criterion for the majority of states in the US, many recognize the value that commitment has for patients who are in grave need of treatment but do not pose an imminent threat of danger (Anfang & Appelbaum, 2006). Anfang and Appelbaum state:

Several states have broadened the definition of “grave disability” for inpatient commitment to include the prospect of severe deterioration, disabling illness, or general inability to care for self. This may reflect the perception that civil commitment was too difficult to achieve with the strict dangerousness model, or that too many patients needing treatment were being excluded. (Anfang & Appelbaum, 2006, p. 212)

Some states have attempted to combat this problem with the use of involuntary outpatient commitment, which is discussed further in chapter four of this thesis. Courts can order outpatient treatment for patients who are not currently dangerous but have significant need for treatment. The history of involuntary commitment law demonstrates shifts in both medical and societal views of mental illness. In addition, it displays the historical struggle between respecting individual rights and protecting patient/other’s safety that continues to influence involuntary commitment legislation today. If anything, this historical analysis address the fact that the United States has yet to establish commitment standards that appropriately address the needs of all mental health patients. Understanding the history of involuntary commitment in the United States in the context of larger societal change is imperative because societal attitudes have affected and will continue to affect case law, statutes, and regulations.
Ethical Issues Addressed in Current Involuntary Commitment Literature

While the ethical interests associated with involuntary commitment have evolved as standards have evolved, respecting autonomy, nonmaleficence, beneficence, and justice have remained steadfast concerns. Before analyzing involuntary commitment narratives, it is important to understand the current issues addressed in academic literature. It is also important to note that there is a vast amount of literature on the subject of involuntary commitment. It is not my intention to review all of the literature, but instead to draw attention to areas of ethical concern that repeatedly appeared throughout my research.

Respect for autonomy, or lack thereof, serves as a prominent issue of concern in involuntary commitment literature. Involuntary commitment overrides the patient’s right to make autonomous decisions about his/her health care. Although this issue takes many forms, the loss of personal freedom that is a consequence of involuntary commitment is an issue that consistently appears in the literature. According to D. P. Olsen in his article “Influence and Coercion: Relational and Rights Based Approaches to Forced Psychiatric Treatment,” there are two major justifications for denying patient choice (2003). The first is patient capacity or the ability to make an informed decision, and the second is threat of harm (Olsen, 2003). Threat of harm and the existence of a mental health disorder are criteria that exist in many states’ involuntary commitment policies (Deemer, 2004). Olson notes that the requirement of a mental health disorder often unfairly represents decisional incapacity (Olsen, 2003). Incapacity is an inability to make appropriate decisions about one’s health care. It is important to note that the presence of a mental health disorder does not automatically disqualify the individual from having capacity. In
light of the historical analysis above, this article illustrates the fact that the idea that those with mental health disorders are unable to make decisions, while unfair, still persists in medicine today.

Research has shown that patients do not always agree with the need for involuntary commitment (Olsen, 2003). In fact, one study found that of 15 involuntary commitment cases, “40% said that they would never commit another person” (Olsen, 2003, p.706). Another study found that of 24 patients who experienced involuntary commitment, only half agreed that commitment was necessary (Binder & McCoy, 1983). In an additional study involving perception of involuntary commitment, patients reported that improvements were related to their perception of autonomy during the experience (Kjellin, Andersson, Candeljord, Palmstiema, & Wallsten, 1997). These studies represent a disconnect between the actions that are taken by health care professionals in the best interest of their patients and the patients’ views about involuntary commitment and its necessity. Patient satisfaction with involuntary commitment and its success rate demonstrated in the above studies clash with the idea of beneficence. Low success rates and dissatisfaction with involuntary commitment do not align well with the ideas of promoting good and preventing harm.

With that said, other studies have found that patients support the need for involuntary commitment. After conducting semi-structured interviews with 59 patients, Valenti, Giacco, Katasakou, and Priebe, in their article “Which Values Are Important for Patients During Involuntary Treatment? A Qualitative Study with Psychiatric Inpatients”, found that 86% recognized that they were not well at the time of commitment and “83% experienced benefit from the involuntary treatment” (2014, p. 834). Although a large
percentage of the participants noted that they did benefit from the treatment, 92% of the individuals interviewed stated “that they were not involved in decision making during treatment and felt that their rights had been violated” (Valenti et al., 2014, p. 833). Patients cited paternalistic attitudes of professionals as reason for their loss of control, and “41% of patients perceived being overpowered by staff” (Valenti et al., 2014, p. 833). In their qualitative study, Valenti et al. conclude that although involuntary commitment is extremely restrictive, there are ways in which health care professionals can increase patient freedom and autonomy. The variation among patients’ opinions about the success of their involuntary commitment reveals an area in which narratives may prove useful. Narrative can help us determine why those differences exist and how to increase treatment success rates.

This academic literature focuses on the fact that loss of freedom is a legitimate concern in cases of involuntary commitment. Through patient interviews and questionnaires, academics have investigated ways in which health care professionals can increase perceived personal freedom for patients during involuntary commitment. In addition, this academic literature focuses on strategies clinicians can use to help make these moral decisions.

The general guidelines for involuntary commitment are rooted in the bioethics principles nonmaleficence and beneficence. As cited above, the criteria for involuntary commitment include the presence of a mental health disorder, threat of harm to self or others, and, in some cases, the prospect of therapeutic benefit. Committing patients who may present a potential danger to themselves or others aligns very well with the idea of beneficence. Through involuntary commitment of a patient who poses a threat of danger,
clinicians are keeping the patient and/or others safe from potential harm. As Valenti et al. mention, their study revealed that the majority of patients recognized that they were not well and benefited from the treatment that they received regardless of its involuntary nature (2014). This statement also aligns well with the nature of beneficence. With that said, many in the same study cited that the paternalistic actions of health care professionals severely limited their autonomy and perceived freedom (Valenti et al., 2014). While attempting to balance autonomy and beneficence, physicians are often forced into paternalism. In the context of involuntary commitment, there is no doubt that a certain level of paternalism occurs. When a patient meets the criteria for involuntary commitment, mental health professionals are required to act paternalistically.

I think it is important to first discuss both strong and weak and hard and soft paternalism before applying the concept to this mental health context. According to the Stanford Encyclopedia of Philosophy, “a weak patronalist believes that it is legitimate to interfere with the means that agents choose to achieve their ends, if those means are likely to defeat those ends” (Dworkin, 2016, “Weak vs. Strong Paternalism”). In other words, “it is legitimate to use coercive means to achieve a person’s desired consequences” (Paternalism, Encyclopedia Britannica, 2016). An individual practicing strong paternalism would argue that “people may have mistaken, confused, or irrational ends and it is legitimate to interfere to prevent them from achieving those ends” (Dworkin, 2016, “Weak vs. Strong Paternalism”). In this case the individual does not believe that the ends are rational and therefore interferes in order to prevent a person from achieving those irrational ends. Strong paternalists believe that what they are doing is in the best interest of the patient and do so despite the wishes of the patient.
Hard paternalism would allow “restrictions of liberty to prevent suicide or grave harm even when a person in question in fully cognizant of his actions and their consequences” (Paternalism, Encyclopedia Britannica, 2016). Soft paternalism, on the other hand, is concerned with “the autonomy of the person, justifying the restriction of liberty only to ascertain whether the person in question were indeed choosing to harm or endanger himself with full volition and knowledge of the facts; the soft paternalist would not deny the freedom to inflict self-harm or even death if that were an authentically free and knowledgeable choice” (Paternalism, Encyclopedia Britannica, 2016).

The type of paternalism employed by the physician depends on the context of the individual case. While paternalism is ultimately inevitable in cases of involuntary commitment, it is important to understand the different types of paternalism and how to effectively balance beneficence and autonomy. As shown above, paternalism reduces patients’ perceived autonomy and allows patients to feel as though their rights have been violated. Understanding how to utilize paternalism properly may help increase the protection of patients’ rights and welfare in cases of involuntary commitment.

Analyzing the intersection between academic literature and personal narratives is a vital aim of this thesis. Understanding the connection between the two mediums further demonstrates the problem addressed in this thesis; academic literature, policy, and practice all fail to adequately address the concerns cited in involuntary commitment personal narratives. Addressing this problem can help enhance the protection of individuals’ rights, interests, and welfare in cases of involuntary commitment. Chapter three reviews involuntary commitment personal narratives and the remainder of this thesis addresses a disconnect that exists between the two mediums.
CHAPTER THREE

INVOLUNTARY COMMITMENT PERSONAL NARRATIVES

Personal narratives are extremely important in the medical context and their use has increased significantly in recent years. As mentioned in chapter one, narratives allow readers to gain perspective and provide access to a voice that is often suppressed in cases of involuntary commitment: the patient. Through evaluation and analysis of involuntary hospitalization personal narratives, this chapter addresses the ethical concerns expressed by those who have experienced the practice firsthand. Given the ethical debate that surrounds involuntary commitment, it is extremely important to address the interests of all stakeholders.

My undergraduate studies in psychology sparked my initial interest in involuntary commitment, but it wasn’t until I read the book *Brian on Fire: My Month of Madness*, by Susannah Cahalan that I realized the power that narratives may have in this particular context. The work is a memoir that follows Susannah’s month of psychiatric hospitalization and is essentially her involuntary commitment personal narrative. This narrative gave me access to something that my previous academic studies surrounding involuntary commitment failed to do. It provided me with description and an answer to the question why. It highlighted the value of personal narratives especially for those suffering from mental illness.

The personal narratives analyzed in this chapter provide intimate details about the writer’s experience with involuntary commitment. This additional perspective is important for those in the field of bioethics and clinicians making commitment decisions because the information gained may help enhance the protection of individuals’ rights.
and welfare during the involuntary commitment process. The personal narratives used for this analysis were drawn from the bioethics journal *Narrative Inquiry in Bioethics* and from personal stories shared in the National Alliance on Mental Illness online forums. From my reading of these personal narratives, a variety of themes emerged. The most prominent themes apparent in this selection of narratives are individual freedom, caregiver treatment in regard to patient respect, and mental health stigma. This chapter is organized according to those topics.

**Loss of Freedom and Autonomous Choice**

The ethical concern cited most often in this selection of involuntary commitment personal narratives was loss of individual freedom. Although expressed in many different ways, this theme was evident in nearly every personal narrative reviewed. For many, the amount of freedom permitted during a hospital commitment dramatically influenced their overall experience. Additionally, freedom allotted during commitment appeared to set the stage for the individual’s recovery process. Given that autonomy and individual freedom serve as fundamental pillars in bioethics, understanding these ethical concerns from the perspective of patients proves extremely useful. These narratives highlight a variety of ways in which involuntary commitment compromises patients’ actual and perceived freedom. In addition, these narratives offer way in which freedom and patients’ perceptions of freedom can be maximized during the experience.

In the narrative “The Intervention of the Demon,” J. Carson writes: “Re-hospitalized meant my world narrowed down to a solitary confinement glazed block cubicle lockdown at the state hospital” (Carson, 2011, p. 5). Through imagery, the writer illustrates a scene that resembles a prison cell rather than a place conducive to the
psychological healing process. Unfortunately, this patient is not alone in experiencing extreme restriction of freedom. Another author states “There is another similarity between prisons and mental wards; they can be considered places of punishment, not help. When I entered a locked ward in mid-2008, punishment loomed large in my mind” (Anonymous three, 2011, p. 20). Many other narratives describe scenarios in which the patient experiences virtually no individual freedom. R Obin Driben in “Tortured Souls Do Not Rest” describes what he deems illegal acts that occurred during his involuntary hospital stays. I am in no position to judge the accuracy of his account, but according to his narrative it is clear that significant mistreatment occurred. Driben was hospitalized for many years, during which he was not allowed to leave his room except for supervised bathing. He was unable to make telephone calls, watch television, or attend therapeutic groups (Driben, 2011). Of all the narratives examined for this analysis, the loss of freedom experienced by Driben was by far the most severe. Millman also reported a prison like atmosphere that he found terrifying. In his narrative Millman reports that they were considered “lucky” if they were able to go outside on supervised walks. (Millman, 2011, p. 18). In the piece “Homesick” by an anonymous author, a similar hospital experience is described:

I felt like I was waking up in a dream state from lack of sleep. The hospital was a traumatizing experience. I was put on Haldol and Cogetin that put me in a blackout that seemed to last for days. When I woke up I could barely move my hands, arms, and legs. […] By summer of 2004, I found myself in a private hospital where I also had a bad experience. My psychiatrist there told me that I’d be on Depakote for the rest of my life. When I asked to sign the form to leave
after three days, she told me if I did that she would have me committed.

(Anonymous one, 2011, p. 10-11)

The same author wrote, “When I got out of the private hospital, I felt like my soul had been ripped out of me” (Anonymous one, 2011, p. 11). “It’s a terrible thing to lose autonomy and control over one’s life” (Anonymous one, 2011, p.12). This excerpt resembles many involuntary commitment narratives. Aside from issues associated with the involuntary commitment environment, this quote also alludes to the issue of behavioral medication use in psychiatric hospitals. While behavioral medication is often necessary for the safety of both patients and staff, many report in their narratives that they were used to quell “bad” behavior. The misuse of medication represents an avenue through which caregivers can further limit the physical freedom of patients. Novosielski also writes about the reduction of physical freedom in his narrative “The Power of Human-To-Human Contact”. “The use of restraints can be justified by the rationale that they are sometimes necessary to keep kids from hurting themselves or others. Unfortunately, sometimes the hospital put us in restraints for no valid reason, instead of out of necessity of keeping us safe. For physical and mechanical restraints were sometimes misused as behavior modifications, a disciplinary method of controlling or punishing us” (Novosielski, 2011, p. 24). In some of the cases examined in this chapter, the loss of freedom experienced is astounding. While a certain level of freedom loss is expected with involuntary commitment, what is described above often exceeds what most would deem acceptable.

While many describe actual experiences in which their freedom and autonomous choice were severely limited, narratives also expressed both fear and anxiety associated
with involuntary commitment. Eugene Doe, author of “Bent but Not Broken writes”, “I was so afraid that if I ever went “in,” I would never get “out,” much like you see in those “roach motel” commercials on television. In other words, I thought I would never taste freedom again, alive” (2011, p. 6). Another author wrote, “The fear of passing through a locked door, unable to leave is far closer to prison than any hotel outside of a horror movie” (Anonymous three, 2011, p. 20).

The fear and anxiety involuntary commitment patients experience stems from both the injustices that occur in psychiatric hospitals and also the stereotypes regarding mental health treatment. The following excerpt effectively represents the anxiety many patients who were involuntarily committed wrote about.

Huddled under a blanket in my bed on the mental ward, I felt terrified and thrilled. I knew I needed help; the hospital represented a possibility to finally get it. But a mental patient is also disenfranchised and isolated by definition -- away from the world I was totally vulnerable. [...] My thoughts ran at high speed: would the doctors blame me, drug me, shock me, kill me? If they did, who would stop them? This place existed only to heal people, and yet I knew people were abused in psychiatric facilities. The stakes were terrifyingly high. (Anonymous three, 2011, p. 21).

Compared to the majority of other narratives, V. Bernard’s narrative is a bit unique. Although Bernard mentions that he spent nearly 10 years in and out of psychiatric hospitals, the majority of his narrative is written about an alternative form of treatment. The following describes Bernard’s experience at a residential working farm for
individuals with psychiatric illness. She wrote in the narrative “Dreaming: A Recovery Story”:

I was given freedom to roam the hiking paths on my own; I could use an ax to chop wood; I was given responsibilities working on the farm from picking up the chicken eggs to being a waitress in their diner. I felt that, for the most part, I was being treated with respect as a human being trying to get better rather than as a criminal suffering from something that was optional. (Bernard, 2011, p.3)

This positive experience represents the potential power that freedom and agency can have on both individual morale and the healing process in general. A majority of those who experienced very strict, prison-like experiences in psychiatric hospitals did not mention treatment benefit. Many describe being prescribed medication that made them feel numb or didn’t allow them to feel at all. The restriction of freedom that occurs during involuntary commitment is an assault on who we are as human beings. It diminishes self-identity and does so in an environment that is completely unfamiliar. Increasing patient freedom in involuntary commitment may aid in the protection of both individual rights and patient welfare because it allows patients to reclaim a part of their identity.

Patient-Provider Relationship: Patient Respect and Communication

Another major ethical concern expressed through narrative in this context is the treatment patients received from their health care providers. The use of the term treatment in this context refers to the patient–provider relationship, communication, and empathy rather than medical treatment. The drastic impact that the quality of the patient-provider relationship can have on the patient’s healing process is evident in this selection of
narratives. This relationship was a significant theme expressed in all of the narratives. Poor treatment or failure to acknowledge the patient’s concerns and wishes served as a significant area of ethical concern for patients. J. Carson in his piece “The Intervention of the Demon” recounts the following interaction with mental health care professionals responsible for his care.

[The staff] appeared to give me no hope. They stayed mum over my agonized questioning about my condition. They said my goals of college and other aspirations were “not realistic.” I felt my life slip deeper and deeper into a black hole. (Carson, 2011, p. 5)

This quote demonstrates the power of acknowledgment. Acknowledgment is also a major theme in this section. Patients who were not acknowledged by staff members generally felt less respected. The following quote supports that claim:

When I presented the staff with my discomfort they told me that I was afraid of something on the outside and this is why I was reacting this way. My response was, “No pal, I am responding this way because I am reacting to something on the inside.” They insisted they were right, of course, I was the “crazy” one. (Kerins, 2011, p. 17)

Another author wrote:

He told me that he was the doctor and he would prescribe medications he believed would “most benefit my current illness.” When I balked at his decision to yet again prescribe Lithium, he got up from his chair, stormed out of the room, paraded down the corridor and walked out the locked door. From the other side of
the door, he shouted that if I didn’t take the medications he prescribed, he would have me committed to a state hospital for a six-month observation. Well, of course I took the Lithium. (Kelley, 2011, p. 14)

Aside from exposing a blatant disregard for the patient’s opinions about his/her healthcare needs, this quote also displays the power dynamic that further complicates involuntary commitment. Novosielski explains the imbalance of power by very simply saying, “They had power and authority, we didn’t. Their point of view had validity, ours didn’t” (2011, p. 23). It is important for all physicians to understand the significance of the imbalance of power that exists in the patient-physician relationship; however, that fact is particularly true for those working in mental health care. In the case mentioned above, the physician is using power to install a scare tactic. Threatening to use involuntary commitment as a form of punishment when patient and provider wishes do not align is highly unethical. The imbalance of power that exists between patients and physicians in cases of involuntary commitment and mental health treatment are expressed by many narrative authors. One wrote: “The attending was patient but beleaguered. I had the impression that, for him, scientific rationality took great precedence over believing what I said about my own life” (Anonymous Three, 2011, p. 22). Charles Kelley mentions a similar experience with physicians. “It has been my experience that some of these doctors were well meaning but dull and some were simply arrogant, believing their opinions were infallible because they held advanced degrees” (2011, p. 14).

While some wrote about the negative impact of a poor patient-physician relationship, others noted that acknowledgment by their care providers was monumental
for their treatment. These patients’ wishes and concerns were addressed, and through that recognition, patients felt respected:

My hospital stays always seemed to make things better. I was treated well, especially by the counseling staff and the nurses. They always listened to me when I was able to open up and talk. […] I always left the hospital with a plan. The counselors, social workers, nurses and doctors, worked closely with me to I would have a plan of action for when I left the hospital. The brilliant part of this was it was actually meant for me to be able to carry it out. (Anonymous two, 2011, p. 13)

Many also wrote about perceived understanding and empathy. Patients who felt like their caregivers placed value in their opinions and wishes also reported feeling respected by those same caregivers. For example, Novosielski wrote:

I will also describe a treasured experience when a staff woman Dawn who engaged in human-to-human contact with us and, with fairness and integrity, fostered honest, open communication and mutual care and respect. The kids liked her because she was gentle and relaxed. This enabled us to feel human, like children, which was healing. (Novosielski, 2011, p. 26)

An additional author wrote: “They [the staff] were all genuine and well-picked for the job. Even people who were agitated and out of control were treated with fairness, regard and respect” (Zion, 2011, p. 27). “I also found that the doctors were respectful. They really listened to me” (Zion, 2011, p. 27). These quotes demonstrate the power of listening. When patients felt as though their caregivers listened to them, they reported a
perception of respect. Respect was also reported when just one caregiver acknowledged the patient’s concerns. The following quote demonstrates the influence that acknowledgement from just one caregiver can have:

I also remember another professional nurse who would talk with me, listen to what I had to say, console me and went beyond the call of duty. She went over the charge nurse’s head and was instrumental in getting my psychiatrist changed to the doctor I mentioned who diagnosed me correctly. If it was not for her efforts, I might still be sick and suffering. (Kelley, 2011, p. 14)

Another wrote:

To my surprise, the doctor said I didn’t deserve to be hurt, and I was right to dislike victimization. Then he said I’d get better. I realized this was what I wanted: permission to believe in my own experience, to feel reasonable feelings, to heal. Like a prisoner or a lover in a hotel room, I had imagined a greater aloneness than truly existed. Trapped by others’ negative perceptions, I felt liberated by his clarity. (Anonymous Three, 2011, p. 22).

For the individuals who wrote these narratives, acknowledgment allowed for a shared sense of humanity. Although physicians must engage in some restriction of patients’ freedom in involuntary commitment, this quote demonstrates that one can do so while still allowing patients to feel respected:

I was always happy when a staff person didn’t treat me as a walking pathology seething with weird symptoms and bizarre behavioral patterns. It was a pleasure when they treated me as a human and I got to treat them like they were human in
return. I treasured those occasions when our encounters and communications transcended our roles and we related to each other as people aware of our shared humanity. (Novosielski, 2011, p. 23)

Another wrote:

As my thoughts swirled within my head and my defense mechanisms prepared themselves, a gentle nurse approached me and smiled warmly saying, “How are you feeling, Mr. Zion?” He could tell by my facial expressions that I was feeling inordinately angry, but he gave me only salvation: He treated me as he would have wished to be treated. This act of virtue calmed me and helped me to realize I was truly in the right place. (Zion, 2011, p. 26)

The above quotes demonstrate the impact that acknowledgment and empathy can have on a patient’s experience with involuntary commitment. Bernard, in his work, mentions: “It worked for me. I began wanting and trying to get myself better. I began wanting to get better because of how I was treated by the “providers” there” (2011, p.3). Caregivers’ acknowledgement of patients as human beings helps foster positive relationships. These quotes demonstrate the impact that provider/patient relationships can have on patients’ experience with health care experience. Ensuring that adequate communication occurs between patients and providers is essential.

Mental Health Stigma

The stigma that surrounds mental health is the third major theme present in virtually all of the personal narratives. In some narratives there is just a brief mention of stigma; however, others were extremely obvious. In addition to stigma, a majority of the
narratives speak about fear. The fear that patients express in the narratives points to a breakdown in patient physician communication. Patients go with unanswered questions into a situation that is often times completely foreign. From the narratives examined, it appears that physicians do very little to quell the fears of those experiencing involuntary commitment. Doe describes the fear she felt before her hospitalization in the following quote:

My hospitalizations were all very different but also very much the same in that I suffered from a combination of fear, anger, and depression to a point where I was a danger to myself (or others) or that I could not take care of myself to a point of sheer negligence. I was so afraid that if I ever went in I would never get out much like you see in those roach motel commercials on television. I thought I would never taste freedom again, alive. (Doe, 2011, p.7).

Below, an additional author describes her experience with mental health stigma in the medical setting:

Although it was a serious staph infection, as soon as I mentioned I had a psychiatric history, I was put in the psychiatric evaluation section, even though the infection was rapidly worsening and I was terrified to be in the hospital where I was afraid I would worsen due to super-bugs. Revealing that fear and my psych history was, of course, a huge mistake on my part. I had a terrifying experience where I was forced to disrobe, had all of my belongings taken from me and, when I asked for the doctor one too many times (because I wanted to go home), was pinned down by four orderlies and shot up with Haldol and put into a blackout. (Anonymous, 2011, p.11)
One author also wrote about the stigma surrounding mental health diagnosis and the impact that can have:

The diagnosis was a medicalized way of invalidating my authority over my own life -- this time with scientific evidence, not physical threats. The stigma of diagnosis deepened my sickness. (Anonymous three, 2011, p. 22)

Many narratives speak about the fact that the existence of a mental health disorder and the need for involuntary commitment does not diminish the ability to get well and patients’ potential as human beings. An anonymous author wrote, “human rights are for everyone. Being sick doesn’t mean you can’t get well. Nothing takes away your right to say “no” (Anonymous three, 2011, p. 23). That same author also wrote:

I wished for a doctor who had spent more time diagnosing my potential, not my present. I wanted him to use the DSM-IV, but also Goethe: “If we treat people as they are, we make them worse. If we treat people as they ought to be, we can help them become what they are capable of becoming.” (Anonymous three, 2011, p. 23)

Loss of freedom, treatment by health care professionals, and mental health stigma serve as the most prominent ethical concerns cited in this selection of involuntary hospitalization personal narratives. The quotes provided demonstrate the importance of addressing these areas. These ethical concerns generally had a significant impact on patient care, and understanding that impact from the perspective of the patient is extremely important for those involved in the involuntary commitment process. This final quote is from a patient speaking about his life after involuntary commitment. I think this
quote demonstrates the power that caregivers have to increase quality of care through empathy:

My only lingering resemblance to a psychiatric inpatient is my knowledge that most circumstances are earthly, ambiguous, and beyond all stereotypes; and that it is often empathy, not identity, that determines how healthy we are. (Anonymous three, 2011, p. 23)
CHAPTER FOUR
EVALUATING THE INTERSECTION

Analysis of both academic literature and personal narratives surrounding the process of involuntary commitment was quite revealing. Not only do both mediums present areas of ethical concern, they point to ways in which mental health professionals can increase the protection of individual rights and welfare during involuntary commitment. While some narratives reveal egregious mistreatment during involuntary hospitalization, others demonstrate success stories that remind mental health professionals of the necessity of commitment. Aside from abortion, it is hard to determine an area of health care more controversial than involuntary commitment. While many can relate to a general loss of freedom, one cannot truly understand involuntary commitment without experiencing it firsthand.

The narratives examined in this thesis reveal both ethical concerns and stigma that litter involuntary commitment and ultimately prevent academic literature from providing a holistic view of the experience. While academic literature provides access to theory about the ethical principles at stake during involuntary commitment, narratives help provide data that can be used to interpret that theory. In addition, narratives can be used alongside both qualitative and quantitative studies to aid in the interpretation of results. In short, narratives help address the question why. They allow readers to understand both the concerns that affect patients and the failure to attend to those concerns.
Ethical Concerns Addressed in Both Academic Literature and Narratives

Both academic literature and personal narratives cover the issue of autonomy and individual freedom extensively. Both the history of involuntary commitment law and current academic literature emphasize lack of freedom. As chapter two mentions, autonomy and individual freedom have been an issue surrounding involuntary commitment from the commencement of mental health treatment. While it is safe to say that involuntary commitment standards have improved significantly from those in place during the rise of the first mental health institutions, current literature and narratives suggest that the United States can do more to protect the rights of those involuntarily committed.

In the academic literature examined in chapter two, patients reported that they were not involved in the decision making process and felt that their rights were violated during involuntary commitment (Valenti et al., 2014). That same study found that paternalism left patients feeling out of control and overpowered by staff (Valenti, 2014). Narratives provide specific details about how each patient’s freedom was restricted. In addition, the narratives address the positive impact that respecting individual freedom can have on patients’ experience with involuntary commitment. For example, Bernard’s narrative cited in chapter three is a perfect example of that impact. He mentions that he had the freedom to roam and hike, which allowed him to feel as though he was being treated as a human rather than a prisoner (Bernard, 2011). Aside from demonstrating the power that freedom has, the use of narrative in conjunction with academic literature in this context allows for a deeper understanding of why those rights are important during the healing process. Although many patients recognized their need for involuntary
commitment and subsequent treatment, many believed that they could have benefited from treatment without the drastic restrictions often imposed on their freedom. This fact demonstrates that perhaps mental health professionals do not understand the distinction between autonomy and freedom. Many of the narratives depict providers that deprive freedom because of patients’ lack of autonomy. But, lack of autonomy does not discount an individual’s right to personal freedom. Perhaps a better understanding of that distinction may increase the protection of patient welfare in cases of involuntary commitment.

Though indirectly, academic literature makes note of the power imbalance that is present in cases of involuntary commitment. Throughout history, physician power in these cases has proven troublesome. In the early years of involuntary commitment, physicians had virtually all admitting power. Patients who were diagnosed with a mental illness were treated as if they lacked all decision making capacity. As societal views about the mentally ill shifted, individuals with mental illness were seen as humans rather than animals. More attention was paid to individual treatment than the fact of confinement. Although commitment now served the interest of the patient rather than the public, patients were still not afforded a voice. To this day, the imbalance of power between patients and physicians continues to influence treatment success.

The narratives examined in this thesis frequently addressed this imbalance of power and how it affects their experience with involuntary commitment. For some writers, this power was abused and made patients feel as if their opinions and wishes were irrelevant. For others, it appeared that caregivers were aware of the imbalance and through acknowledgment and respect were able to eliminate the negative impact other
patients reported. This concern was also expressed by narrative authors as an issue of paternalism. The narratives analyzed in this thesis offer practical solutions to a problem that academic literature just mentions as existing. Patients reported that acknowledgment, empathy, listening, and understanding by caregivers allowed them to feel respected and created an environment conducive to the healing process. This is one example in which narratives provide data that can be used alongside theoretical ethical issues cited in academic literature.

The academic literature surrounding involuntary commitment revealed major shifts in the purpose for using this mental health practice. The mentally ill were initially committed to provide protection for the public. This then shifted to a protection for patients because physicians believed that mental illness negated individuals’ ability to make treatment decisions. Protection then translated into a desire to provide treatment and address patient needs. The need for treatment standard ultimately led to the dangerousness standards that are still in place today. It wasn’t until the late 20th century that beneficence, or doing good for patients, was considered a practical aim of involuntary commitment. Academic literature generally considers involuntary commitment nonmaleficent in that it provides protection for those who pose a threat of danger to themselves or others. What’s interesting is the fact that majority of the narratives do not mention ethical concerns with the fact of commitment itself but instead the experience of psychiatric hospitalization as a whole. In fact, narrative authors often recognized their need for treatment.

While cases of commitment misuse exist, the narratives examined here mention the fact of commitment very briefly. The major ethical concerns expressed were
associated with treatment during involuntary hospitalization. This points to a potential flaw in the involuntary commitment system. Health care professionals must ensure that the beneficent intention for committing patients transfers into the hospital setting.

Imbalance of power, lack of adequate communication, and lack of patient acknowledgment represent areas in which physicians can improve the patient provide relationship. Failure to do so may prolong or even worsen patient suffering. It is possible that through inadequate relationships, involuntary commitment may cause more harm than good. It is important to use narrative alongside academic literature in order to establish practical solutions to these problems. The practice of “moral treatment” that Doreathea Dix brought to the United States in the middle of the 19th century resembles the patient-centered care physicians attempt to provide today. Patient-centered care requires treating patients as people. It involves listening, respecting, informing, and allowing patients to be active participants in their health care (Epstein & Street, 2011). Adhering to patient-centered care would address many of the concerns narrative authors wrote about. In addition, it may help create an inviting environment that is conducive to the healing process.

Addressing Skepticism

An obvious area of concern with using involuntary commitment narratives in this context is the fact that there isn’t a way to verify that the narratives are one hundred percent accurate. Skepticism may be more common in this context because the narratives are written by individuals who often have been diagnosed with disorders of thought. I think it is important to address this issue, but the fact that narratives generally address the same ethical concerns cited in academic literature signifies a certain level of validity.
That in itself doesn’t mean that an individual will not write an involuntary commitment narrative that is completely untrue, but even if that is the case, every narrative has value.

Using narratives allows individuals to gain an increased understanding about a particular situation, and they are not necessarily used to point blame. If an untrue narrative talks about injustice or ethical concerns, it can still be used to influence practice in the future. Due to the fact that narratives mimic the ethical concerns established in the academic literature, skepticism should not play a significant role in this context.

Outpatient Involuntary Commitment

It is important to note that while this paper focuses on involuntary inpatient commitment, involuntary outpatient commitment also serves as a treatment option for individuals suffering from a mental health disorders who have a significant need for treatment. Like involuntary inpatient commitment, involuntary outpatient commitment is mandated by the judicial system. Commitment standards vary depending on the state, but a majority of the criteria include the presence of a mental illness, significant need for treatment, threat of danger to self or others, and a history of repeated psychiatric hospitalizations. Outpatient commitment is for patients who are chronically ill but not imminently dangerous. According to the Treatment Advocacy Center, involuntary outpatient treatment is court supervised community based mental health treatment (2016, Promoting Assisted Outpatient Treatment).

Instead of forcing patients into psychiatric hospitalization, involuntary outpatient treatment typically includes a court mandated treatment plan. Those plans are developed by patients and their health care providers together (2016, Promoting Assisted Outpatient Treatment). Treatment plans typically include medication and individual therapy.
management (2016, Promoting Assisted Outpatient Treatment). Like involuntary inpatient commitment, outpatient commitment raises ethical concerns. Both acts restrict autonomy and personal freedom, although the extent varies depending on the type of commitment and the circumstances of the individual patient. While the ethical considerations associated with each commitment type vary because of the difference in environment, it is important to mention that this exists as an option for court mandated mental health treatment. Involuntary outpatient commitment serves as a form of treatment that appears to allow more individual freedom and autonomy than psychiatric hospitalization. Given the above analysis on the impact that autonomy and freedom can have on patients’ perception of the involuntary commitment process, evaluating involuntary outpatient narratives serves as an important area for future research.

Psychiatric Advance Directives

Psychiatric advance directives (PADs) serve as an additional resource that can be used by mental health professionals to increase the protection of individual wishes and welfare in cases of involuntary commitment. Although advance directives are not considered narrative in the traditional sense of the word, they do provide information that can be used during treatment to enhance the protection of patients’ wishes. PADs provide physicians with concrete data regarding the patient’s treatment preferences. According to Tiffany Shrode in The Encyclopedia of Clinical Psychology, psychiatric advance directives are legal documents that are used in cases of hospitalization (2015). PADs are completed by a competent individuals and are used to convey the preferences of the patient should they lose competency (Shrode, 2015). In addition to stating preferences
regarding treatments, medications, and location of care, individuals can also designate a health care proxy in their psychiatric advance directive (Shrode, 2015).

In the article “Front Line Workers’ Attitudes towards Psychiatric Advance Directives” by Kim et al., the authors state that proponents of these advance directives believe that the documents may increase communication between patients and their physicians (2008). Doing so may potentially increase the quality of the physician-patient relationship. Proponents also believe that access to preferred methods of treatment during a psychiatric crisis may increase treatment adherence and strengthen the therapeutic alliance (Kim et al., 2008). Like narrative, advance directives may have the ability to empower patients and provide them with a voice. They are recognized by legal statutes and many individuals demonstrate their satisfaction with the directive on the National Resource Center on Psychiatric Advance Directives. For example, one author wrote:

I told my therapist that I had done a PAD and wanted to bring a copy to her to see what she thought -- and she thought it was great. She thought it was wonderful that I had gotten very specific about my treatment preferences. I've also talked to my general physician about my PAD. My case worker and basically everybody has given me the thumbs up. They thought it was great for me to do this. That kind of made me feel better. (NRC PAD, 2016, http://www.nrc-pad.org/pad-stories)

While PADs provide patients with an opportunity to express their opinions, the narratives listed on the website stress the need for a quality patient physician relationship
in order for the document to be successful. Like personal narratives, PADs need to be read and respected by those in the mental health profession.

Implications for Mental Health Treatment

The information gained from this thesis is important in terms of the perception of mental health treatment. The ethical concerns cited in both narratives and academic literature suggest a breakdown within the involuntary commitment experience. The fact that the majority of people in the narratives I examined recognized their need for treatment and did not necessarily contest the fact of being hospitalized suggests that the problem is not the fact of commitment alone but the treatment received once the patient has been hospitalized. That said, not all narratives reveal unethical practice. Narratives that explain “success” stores remind those in the mental health field of the necessity of involuntary commitment and the good that it can provide for patients.

The unfortunate fact that many of the narratives demonstrate is the idea that patients may continue to experience harm after being involuntarily committed. Whether through loss of freedom, poor relationship with providers, or mental health stigma, the ethical concerns that patients raised in these narratives may extend patient anxiety. This clashes with the beneficent intentions behind involuntary commitment and psychiatric hospitalization. Not only do these ethical failures potentially prolong harm, but negative experiences with involuntary commitment may have larger implications for the perception of mental health treatment. Rehospitalization is common for individuals with severe mental health disorders, and it is my concern that the treatment described in the narratives above may cause patients who have a significant need for treatment to avoid
seeking it altogether. The narratives that spoke about stigma suggest that this may also be true for individuals with a mental health history seeking general medical assistance in a hospital setting.

While I understand that the narratives used in this thesis represent a small sample, the fact that the majority speak about consistent ethical concerns is powerful. It suggests a need for more extensive research in the area of involuntary commitment and psychiatric hospitalization personal narratives. Doing so may allow for more directive conclusions than this thesis can provide. That said, I understand that this small sample size serves as a limitation. While this thesis does examine academic literature and personal narratives, the results are not necessarily directive in nature. Instead they point to areas of concern and areas that need further investigation.

Value for Mental Health Professionals

As mentioned above, the information in this thesis is not necessarily directive. That said, the narratives and academic literature suggest areas in involuntary commitment that need improvement. General ethical concerns cited in the academic literature and personal narratives address communication between patients and their caregivers. The above data suggest that through acknowledgement, recognition of patient concerns, and respect for patient opinions, caregivers can establish positive relationships with patients subjected to involuntary commitment. The narratives here provide insight regarding the patient experience with involuntary commitment.

This thesis serves as a reminder of the aspects of treatment that patients find important and valuable. Narratives can be used by mental health care professionals to
evaluate their own practice. Self-reflection alone is extremely powerful. Encouraging mental health professionals to take a step back and evaluate their communication with and treatment of involuntary commitment patients may help aid in the protection of patients’ rights and welfare.

Areas for Future Research

Preparation for this thesis revealed many areas for future research. As mentioned above, ethical concerns cited in both academic literature and involuntary commitment personal narratives were largely associated with hospital treatment and not the fact of commitment itself. I think it is important to recognize this distinction, and future research should use narratives that specifically focus on the fact of commitment alone. Doing so may allow for a better evaluation of commitment policy. Because the narratives I examined here do not make that distinction, it is difficult to determine how changes in policy would positively affect patient experience with involuntary commitment. The narrative here would suggest that changes regarding treatment of patients during psychiatric hospitalization would be extremely beneficial. Hospital policy needs to ensure that the beneficent reasons behind the use of commitment translate into the subsequent mental health treatment patients receive. Research regarding the fact of commitment alone is necessary in order to achieve that goal.

Additional areas for further research include the use of caregiver narratives. While physician narratives are quite common, it may both useful and enlightening to analyze narratives from other mental health professionals involved in patient care. For example, narratives from nurses, social workers, case managers, and therapists would all be useful in establishing a descriptive picture of involuntary commitment. It would also be useful
to increase the sample of narratives used in order to establish results that are more generalizable. Research involving narratives that discuss involuntary outpatient commitment and the use of psychiatric advance directives would also be extremely useful in understanding psychiatric care from a patient perspective. Analyzing narratives in this context is of particular importance because of the stigma that surrounds mental health. Confronting stigma requires understanding and sensitivity, and narratives can be used to help accomplish that aim.

Conclusions

Involuntary commitment is one of the most controversial medical practices in psychiatry today. Although the practice is necessary to protect those who pose a significant threat of danger to themselves or others, the narratives examined in this thesis and involuntary commitment academic literature suggest that improvement may be necessary. Although some narratives demonstrate “success” stories that remind those in mental health about the necessity of involuntary commitment, other shed light on aspects of the experience that most would consider unethical. The use of narratives in this context is extremely important because it gives the patient a voice in an environment in which the patient voice is often suppressed. In addition, narratives provide qualitative data that can be applied to the theory described in involuntary commitment academic literature. The two mediums should be used together to address areas of concern and to uncover ways in which caregivers can adequately address the needs and rights of patients. This thesis reveals the problem that exists in this context; academic literature does not address the concerns cited in the narratives I examined and involuntary commitment patients are subject to serious ethical violations during involuntary hospitalization. The data analyzed
in this thesis can help address that problem. This thesis suggests that increasing patient freedom and autonomy to the extent possible, establishing effective communication and patient-provider relationships, and avoiding the influence of mental health stigma may improve patients’ rights and welfare in cases of involuntary commitment.

This thesis suggests areas in the involuntary commitment process that need improvement. Changes in this medical practice can be done through three different levels: policy, the implementation of that policy, and through the patient-physician relationship. Because many patients recognized their need for treatment, I do not think that changes to policy are needed. The policies in place are designed to provide protection for individuals in their most vulnerable state. That said, the implementation of PAD’s in policy may improve patients’ experience with involuntary commitment. The information revealed in this thesis suggests that altering implementation of policy or the patient-physician relationship in this context would positively impact involuntary commitment for patients. Majority of ethical concerns cited in narratives and not addressed in academic literature were the result of a poor relationship between patients and health care professionals. This reveals narratives practical use in this context. Physicians should use narrative to influence their interactions and relationships with patients who have been involuntarily committed in order to ensure that patients’ rights and welfare are protected to the greatest extent possible. Narratives allow readers to see and understand in ways they could not have imagined. Access to that information can improve physicians’ interactions with patients, an area nearly all of the narratives I examined identified as ethically concerning.
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