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Involuntary Psychiatric Interventions: A Breach of the Hippocratic Oath?

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In this article the author argues that involuntary psychiatric interventions are inherently dangerous and potentially harmful to their subjects, thus challenging the Hippocratic ethical principle of "first do no harm." Damages arising from coercion in common clinical situations are analyzed, as well as the motives of psychiatrists for persistently promoting an expansion of involuntary interventions. Alternate strategies to coercion are explored.

En este artículo el autor arguye que las intervenciones psiquiátricas involuntarias son inherentemente peligrosas y potencialmente dañinas a sus sujetos, desafiando así el principio ético Hipocrático de "primero no dañe." Se analizan los daños que surgen de la coerción en situaciones clínicas comunes, asímismo los motivos de los psiquiatras de persistentemente promover una expansión de intervenciones involuntarias. Se exploran estrategias alternativas para la coerción.

l'auteur soutient que les interventions psychiatriques involontaires sont intrinséquement dangereuses et potentiellement néfastes pour les sujets. Elles s'opposent donc au principe éthique d'Hippocrate, "D'abord, ne pas nuire." Les dommages qui résultent de la coercition utilisée dans la clinique sont analysés, ainsi que les motifs des psychiatres qui préconisent l'expansion des interventions involontaires. Des alternatives à la coercition sont discutées.

The controversy over involuntary psychiatric interventions is usually presented as a conflict between civil libertarian interests to safeguard personal autonomy and concerns about individual health and public safety. However, this view is problematic. The actual conflict may be between two contrasting definitions of health: medical/authoritarian and subjective/empathic. The paternalistic view in which health status is determined "objectively" by a doctor conflicts with an

empathic assessment based on collaboration between doctor and patient. Given that doctors in clinical practice remain primarily responsible for the health of individual patients and not of society as a whole, we should examine whether involuntary and coercive interventions by physicians are compatible with medical ethics as codified in the Hippocratic Oath. For the purpose of this article "coercive" and "involuntary" are used interchangeably, even though differences may exist between coercion as perceived by individuals and as sanctioned by law (see Monahan et al., 1995).

The relationship of involuntary intervention and medical ethics is becoming increasing relevant as, for instance, the power to impose psychiatric interventions is broadening under outpatient commitment laws, and patients who feel victimized are growing more insistent about having their damage recognized by the medical profession. This article argues that subjective and objective experiences of harm from coercive interventions challenge basic ethical principles of medicine. If coercive interventions indeed carry a significant risk of harm, then we must ask what alternate, nonauthoritarian stance doctors could reasonably take when confronted with people in extreme emotional distress.

Discussions about involuntary interventions have been primarily legal or utilitarian, the former based on constitutional arguments, the latter on evaluations of outcomes (Chodoff, 1988; Wertheimer, 1993). These two approaches are insufficient to develop moral guidelines for psychiatric practice. Also, most studies of coercion ignore the issue of its concurrent or long-term effects on the health and well-being of patients (Blanch & Parrish, 1993). Even the well-publicized, recent studies on coercion supported by the McArthur Foundation have yielded only scant data on its actual effects (Lidz, 1998). Consequently, this article discusses how coercion and involuntary interventions may directly and indirectly cause harm.

THE CURRENT RELEVANCE OF THE HIPPOCRATIC OATH

The original, "pagan" Oath of Hippocrates (about 450 B.C.) aimed to supplant a shamanic tradition in which "doctors could as easily murder as cure, or could supply a potion for a man to murder his enemy" (Clements, 1992, p. 367). Undoubtedly, the Hippocratic tradition combined its ethical stance with a guild orientation aimed to enhance physicians' status in Greek society. By the Middle Ages, the Hippocratic tradition had been incorporated into the Roman Catholic medical ethic, as exemplified by the "Oath According to Hippocrates as a Christian May Swear It" (Leake, 1975). Greek and Christian versions of the oath were based on the argument that "expertise in knowing the good was possible, and the empirical world of natural events could be investigated to identify the good objectively" (Clements, 1992, p. 213). This tradition prevailed until the explosion of scientific knowledge of the 20th century: in 1966 about one fourth of American medical schools still administered versions of the oath to their graduates (Levine, 1971). However, by the early 1970s, as Clements (1992) argues, the Hippocratic principle of beneficence (which relied on paternalism and a fundamental trust in doctors to correctly diagnose and treat illnesses) was challenged by the principle of personal autonomy.

In recent years, social, political, legal, economical, and scientific forces have further impinged on doctors' ability to rely on their own judgments when prescribing treatments. Given this new complexity, in which some authors speak of "systems" or "health" ethics rather than medical ethics, one might question the relevance of ancient Hippocratic ethics to the issue of involuntary interventions (Clements, 1992). However, regardless of the number of systemic variables impacting medical decision making, doctors should still be bound by a set of moral guidelines that govern their behavior toward patients, with the aim of eliminating to the greatest possible extent from their practice interventions that are harmful to patients.

INVOLUNTARY INTERVENTIONS CHALLENGE THE HIPPOCRATIC OATH

Paternalistic and self-serving as they may have been, Hippocratic ethics placed important restrictions upon the behaviors of doctors. The famous section of the oath which admonishes doctors to refrain from harm, known in Latin as *"Primum non nocere,"* reads in one translation as follows: "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them" (Jones, cited in Leake, 1975, p. 213). Edelstein (cited in Temkin & Temkin, 1967, p. 6) translated the original Greek differently: "I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice." Despite differences, both translations concur that doctors have a responsibility to protect patients from harm stemming from their own treatment.

Further in the oath the doctor is again asked to foreswear injurious behavior: "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves" (Edelstein, in Temkin & Temkin, 1967, p. 214). Jones (in Leake, 1975; p. 213) substitutes "keeping myself free from intentional wrong-doing and harm . . ." for "remaining free of all intentional injustice." This dual admonition—to refrain from doing harm *and* to assure that no harm would occur from other sources—should be a key standard in assessing the impact of involuntary interventions. Hippocrates' writings apparently do not contain an explicit reference to the use of force by doctors in dispensing treatments.

The Hippocratic principle of "First do no harm" has received scant attention in the literature on involuntary interventions. Wettstein (1987) refers to the ethical theory of "nonmaleficence," but fails to consider in what ways coercion itself might be considered "maleficence." Most other authors who are apparently attempting to justify involuntarism, ignore the issue of nonmaleficence, putting the entire weight of their arguments on the notion of delayed and secondary benefit (see Chodoff, 1988). Incidentally, the theory that coercion is justified since patients will ultimately be thankful for having been forced into treatment (Stone, 1975) is not supported by evidence, which shows that only a small minority of involuntary patients exhibit this change of mind (Beck & Golowka, 1988; Gardner et al., 1999). Curtis and Diamond (1997) provide an exceptionally balanced discussion of the ethical quandary of coercive interventions.

Contemporary versions of a physician's oath exist, such as the 1948 Declaration of Geneva, which barely resembles its Hippocratic ancestor and no longer includes a specific reference to refraining from harm. Instead, it states that "the health of my patient will be my first consideration," and "I will not permit considerations of religion, nationality, race, party politics and social standing to intervene between my duty and my patient." This is supplemented by the pledge that: "even under threat, I will not use my medical knowledge contrary to the laws of humanity" (Leake, 1975, p. 277).

Crimes against humanity perpetrated by doctors in Nazi Germany made it clear that mere lip service to the Hippocratic tradition would not prevent medical atrocities (see, among many others, Breggin, 1993; Drobniewski, 1993). Indeed, it may be argued that leaving the definition of "good" and "health" to doctors can lead to medically sanctioned torture and murder. However, Cameron (1992) suggests that the Geneva revision lacks the religious and philosophical obligations which are central to the Hippocratic Oath, and is therefore even more vulnerable to infractions. In any case, the Geneva declaration mentions two instances when involuntary interventions run counter to their intended benefit:

1. whenever social forces outside the doctor-patient relationship intervene, and
2. whenever a doctor's intervention breaks with the "laws of humanity."

Outside forces and prejudice are almost always involved in involuntary interventions (e.g., pressures from police, family, community, etc.). For example, African American men are more frequently committed to psychiatric institutions than any other group, regardless of diagnostic and mental status variables (Chen, Harrison, & Standen, 1989; Tomelleri, Lakshmenarazanam, & Herjanic, 1977). Community sources of coercion have been identified as contributing more to perceived coercion than the behavior of hospital staff, including psychiatrists (Cascardi & Poythress, 1997; Pescosolido, Gardner, & Lubell, 1998). This suggests that doctors might be obligated to counterbalance the pressures stemming from community sources, instead of automatically acting on them. Furthermore, involuntary and coercive interventions might be considered human rights violations (Szasz, 1978). Indeed, in December 1991 the United Nations adopted a set of "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" limiting but not precluding involuntary interventions (see Rosenthal & Rubinstein, 1993). Of course, psychiatric interventions against political opponents are routinely considered human rights violations—unlike force used against persons with nonmainstream beliefs in psychiatric custody.

Clinical Harm From Involuntary Interventions

In reviewing studies that assess the short- and long-term impact of coercion on its subjects, it becomes apparent that virtually none address the interaction between coercive interventions and the emotional state of the coerced person. This omission is particularly significant given the assumption that a state of emotional or interpersonal crisis would increase vulnerability to harm from coercion. Investigators seem primarily interested in determining how various parties define coercion and what its victims think about it 30 minutes to 1 year later

(Monahan et al., 1993). While the John D. and Catherine MacArthur Foundation has funded a series of investigations on coercion, to date, these have focused on process variables leading to coercion, methodological issues in measuring the nature and impact of coercion, and posthoc studies of attitudinal and perceptual variables (e.g., Bennett et al., 1993; Gardner et al., 1993; Hiday, Swartz, Swanson, & Wagner, 1997; Hoge et al., 1993; Monahan et al., 1993, 1995).

Even studies that do examine the outcomes of coercive interventions fail to consider specific interactions between psychological variables and the impact of coercion, particularly for individuals who report negative effects (Hiday, 1992). Instead of further exploring these negative effects, some researchers have attempted to show that negative attitudes about coercion correlate with certain "negativistic" dimensions of illness or personality (Hoge et al, 1990; Schwartz, Vingiano, & Bezirganian-Perez, 1988). The first American study focusing on the relationship between coercion and hospitalization outcome (Nicholson, Ekenstam, & Norwood, 1996) reports finding "no evidence that outcomes for 'coerced' patients were worse than outcomes for patients whose hospital admission was characterized by minimal or no coercion" (p. 214). The authors arrive at this conclusion even though 50% of all involuntarily admitted patients in their sample were excluded from the analysis (p. 208). A Scandinavian study using measures of coercion that were developed in the MacArthur studies (Kjellin, Anderson, Candefjord, Palmstierna, & Wallsten, 1997) found that 67% of "committed" patients experienced "some" or "only ethical costs." This was also true for 47% of voluntarily admitted patients, indicating that the negative effects of coercion are experienced even among patients admitted under ostensibly voluntary procedures.

A small minority of researchers have looked at the psychological effects of coercion, but without taking into consideration the patient's prior state of mind. Another recent Scandinavian study has actually demonstrated unfavorable psychological treatment outcomes of coercive interventions (Kaltiala-Heino, Laippala, & Salokangas, 1997). These authors conclude that "coercive treatment arouses negative feelings in the patient, creates negative expectations about the outcome of treatment, and fails to result in a trusting relationship between the patient and the professionals" (p. 318). Two theoretical concepts have emerged over the years explaining the various negative responses to coercion:

1. "reactance," which includes anger toward the source of restriction, an effort to restore freedom, and an increased attractiveness of foreclosed options (Brehm, 1981) and
2. helplessness, which often goes along with depression, anxiety, and the cessation of efforts to alleviate the situation, leading to the long-term pattern of "learned helplessness" (Seligman, 1975).

Few will dispute that most people who are subject to coercion are experiencing some type of crisis. Frequently, a coercive intervention arises from others' perception of an undesirable change in the person's behavior or attitude, which seemingly require psychiatric intervention. At other times, the individual is overwhelmed by internal or external events. A great variety of personal, interpersonal, and social problems result in the final common pathway of involuntary intervention. One way to begin disentangling this complex set of factors is to distinguish between those developments that precede first-time psychiatric interventions and those

that affect people who have already been exposed to voluntary or involuntary psychiatric intervention. Almost half of all involuntary admissions affect people who have never been hospitalized before, indicating that many initial psychiatric contacts lead to coercive measures (Hiday, 1988).

Adolescent Crises

Many first contacts with psychiatry occur during late adolescence, when children are expected to make steps toward adulthood, move out of the parental home, engage in romantic and sexual relationships, and prepare for their careers. It is also a time when many young people struggle with their identities and face major personal crises. This can take the form of extreme confusion, a search for meaning, introversion, depression, and family conflict. Some people experience "psychotic" symptoms, ranging from the fragmentation of physical and psychological boundaries to extreme internal preoccupation and hallucinatory experiences. Such occurrences are often very frightening to someone already undergoing a difficult transition (Arieti, 1974). To be confronted by coercive psychiatric measures in the midst of such experiences is likely to aggravate and pathologize the confusion, raising the specter of mental illness in the midst of adolescent turmoil. Without a great deal of empathy, respect and understanding, a young person in such a situation is likely to resist any form of intervention, wanting to pursue his or her search for meaning and identity, rather than being forced into a depersonalizing mold (Gutstein, Rudd, Graham, & Raytha, 1988). Armstrong (1993) has pointed out that when adolescents are forced into psychiatric institutions, their crises, which may have been transitional, are likely to be prolonged and aggravated by this type of coercion.

Someone experiencing extreme alterations of perceptions and thinking for the first time is usually in a state of considerable terror and is not likely to understand why he or she is being forcibly held in an emergency room or injected with mind-altering drugs (Sullivan, 1974). Anger and flight might be sensible responses but will usually escalate the coercion and aggravate the emotional distress. Another response might be capitulation to perceived punishment for one's emotional experiences. Either response is likely to have a deleterious influence on the further course of events, often resulting in "chronicization"—a persistent cycle of institutionalization and trauma.

Melancholy

People who are extremely sad, beyond, for instance, what is culturally accepted after the loss of a loved one, to the point of having trouble conducting their usual activities, often feel guilty and responsible for their "failures." This can take extreme proportions, as when a person feels like he/she is carrying the burden of the entire world or is responsible for all evil (Wolfersdorf et al., 1990). To coerce someone in this state of mind is likely to reinforce the expectation of punishment, potentially triggering a suicide attempt (De Jong & Roy, 1990). Marcia Hamilcar's 1910 personal account of being forcefully removed from her home (in Peterson, 1982) and institutionalized for depression is one of many

examples. In these personal accounts the mental institution and its "treatment" methods are often seen as legitimate punishment for the wrongs a person in such a guilt-ridden state believes himself or herself to have committed.

Repetition of Trauma

A growing body of first-person accounts (e.g., Deegan, 1994; McKinnon, 1994; Sonn, 1977) and scholarly reviews including research studies (Craine, Henson, Colliver & McLean, 1988; Muenzenmaier, Meyer, Struening, & Ferber, 1993; Rose, Peabody, & Stratigeas, 1991; van der Kolk, 1987) are drawing our attention to the problem of women (and to some extent also of men) with a history of childhood or adult traumatization who are experiencing abuses in the mental health system. The notion that people who struggle with memories of physical and sexual abuse should be adversely affected by physically coercive psychiatric interventions seems self-evident (Stefan, 1994). In the literature on post-traumatic stress disorder there is much evidence that any situation bearing resemblance to the circumstances of the original/earlier traumata can trigger extreme fear (McFall, Nurburg, Ko, & Veith, 1990), and in women who experience multiple personality or other dissociative disorders, it can lead to fragmentation and self-destructive acts (Doob, 1992). Why this should not hold true for instances of forcible drugging, four-point restraint, the process of seclusion which usually involves being taken down and stripped by male and female attendants, remains to be demonstrated by those who want to draw a line between "social and familial" traumatization and injuries inflicted in the name of "treatment" (Norris & Kennedy, 1992; Stefan, 1994).

Interestingly, coercion and institutionalization are not considered traumatic per se in the trauma literature, unless they are perpetrated for political reasons on persons not considered mentally ill (Chodoff, 1988; Koryagin, 1989; Stover & Nightingale, 1985). In fact, the possibility of traumatization by psychiatric interventions such as forced detention or drugging is not even mentioned in the most comprehensive, 800-page handbook on traumatic stress syndromes (Wilson & Raphael, 1993). Williams-Keeler, Milliken and Jones (1994) consider the experience of psychosis as one possible etiology for post-traumatic stress disorder. Forced psychiatric intervention, especially in someone with a history of significant earlier traumatization, can aggravate, unmask or even cause a form of iatrogenic post-traumatic stress disorder.

Fear of Persecution

Paranoia is the psychiatric term for the extreme fear of others, especially those in authority. This state of heightened alertness and sensitivity to danger, to the point of becoming convinced that sinister forces are scheming to inflict harm, can lead to withdrawal, sleeplessness, reluctance to eat and other potentially hazardous behaviors. Most individuals experiencing such fears are likely to stay away from psychiatric settings, shunning their intervention. This is precisely why they suffer incomparably when forcibly submitted to psychiatric

intervention. Many, who are already terrified, are further panicked by physical restraint and forced drugging. Their worst nightmares come true when they are apprehended, restrained, and dragged into an emergency room where unfamiliar doctors ask them invasive questions, decide to keep them against their will, and place them in a ward full of other individuals in distress, many of whom could be perceived as threatening. Such perceptions often lead to altercations and further physical and chemical restraints. Numerous personal accounts of this type of experience corroborate its fundamentally traumatic nature (e.g., Cameron, 1979; Schreber, 1903; Trosse, 1741).

Panic and Mania

Another group of individuals who experience psychiatric coercion are those who suffer from extreme anxiety and panic states. They are likely to feel considerably worse when they realize that they are trapped. Finding themselves prevented from leaving until a psychiatrist has completed their evaluation, they easily become "agitated," thereby further aggravating their situation. Unfortunately, this outright consequence of coercion may be used retrospectively to justify the coercion which precipitated the behavior in the first place.

In the state of mind psychiatrically known as mania, the person is driven toward ever more daring acts in a kind of self-generated euphoria. Whenever such persons encounter obstacles, they tend to become irritable, even angry and possibly assaultive. Clearly, individuals in such states are highly challenging to their surroundings and to anyone trying to help. Not surprisingly, individuals diagnosed with bipolar disorder (mania and depression) tend to experience coercion more acutely than others (Pescosolido et al., 1998). Intervention usually comes late and with extreme severity. These are the well-known situations when a person is wrestled to the ground by a number of strong arms, tied down, and injected with large doses of tranquilizers. Many people have died during such psychiatrically sanctioned assaults (Appelbaum, 1999; Black, Winokur & Bell, 1988; O'Halloran & Lewman, 1993).

Suicide

Persons planning or attempting to commit suicide are often victims of coercive interventions. The coercion in this instance usually occurs either because a concerned friend or relative has notified the authorities, or because the individual has decided to seek help. In both instances suicidal persons are detained until they have successfully convinced the psychiatrist that they are not about to kill themselves. This is considered by many professionals as the only way to take suicidal threats and sentiments seriously and to prevent charges of negligence should someone actually commit suicide after an intervention by a mental health professional (Appelbaum, 1988). But in most cases someone discloses a suicidal preoccupation to a friend or a professional precisely because he or she is afraid of acting on this impulse, wants to talk about it, and seeks a better solution. If such a person encounters mistrust resulting in commitment, he or

she is likely to conclude that the next time a suicidal feeling recurs it may be better to stay away from "helping" professionals. This decision can increase the chance of a completed suicide.

Having been told by a professional that the only way to avert suicide is by being locked up, rather than by seeking alternate life-affirming strategies, these persons are also likely to further loose confidence in themselves. Thus, instead of bolstering their inner strength and self-confidence, psychiatry gives the message that they lack control and must be under surveillance. Some evidence on detrimental aspects of involuntary hospitalization for suicidal individuals supports these intuitive conclusions (Litman, 1991). According to various authors, involuntary commitment might actually increase the risk for suicide in the period immediately after admission (Roy, 1985; Sundquist-Stensman, 1987; Tsuang, 1978).

Family Conflict

Many involuntary interventions occur when family members are in conflict. When coercion and commitment occur as a way of responding to family tensions and distress, including concerns about the well-being of the identified patient, family relations may suffer further. In the case of elderly family members placed in an institution against their will, severe depression and even suicide may result (Boucher & Tenette, 1989). The detrimental effect of commitment on family relations has been demonstrated by studies that provide evidence for the common occurrence of "closure," a regrouping of the family without the banished member, which renders the person homeless and without support, suddenly dependent on psychiatric institutions (Scott, 1967). When a family member petitions for commitment or signs consent for unwanted medications or procedures such as ECT, the coerced individual may react with great anger and long-term resentment. This can lead to irreversible family disruption, much pain and disappointment on both sides, and a downward social drift and loss of support for the new "ward of the state." This might also be a factor in precipitating violent acts toward family members that occur after forced treatment.

Forced Administration of Psychotropic Drugs

There is some evidence that the coercive intramuscular administration of psychotropic drugs is associated with a greater incidence of physical adverse effects, thus potentially endangering the life and health of the patient. Kjellin and associates (1993) report substantial differences in rates of adverse effects between committed and voluntary patients, as judged by psychiatrists (82% vs. 63%). Severe adverse effects were reported by 48% of the committed versus 30% of voluntary patients. "Rapid tranquilization"—the abrupt injection of large, toxic dosages of a potent neuroleptic drug, usually haloperidol—has caused serious concomitant side effects, including death from neuroleptic malignant syndrome

(Lazarus, Dubin, & Jaffee, 1989). One possible mechanism for this drug-related toxicity is the massive rise of creatinine phospho-kinase (CPK), an enzyme produced by the destruction of muscle tissue, which can lead to kidney failure and other deadly complications (Keshavan & Kennedy, 1992). There is no doubt that the physical restraint of an actively resisting individual, followed by deep intramuscular injections, has caused injuries and deaths (Robinson, Sucholeiki, & Schocken, 1993).

Most coercive interventions aim to achieve the administration of psychotropic drugs in the short term and to enhance "compliance" in the long term (Geller, 1995; Miller, 1999). However, it is likely that forced medication often has the opposite result, discouraging patients from accepting treatment while hospitalized, and leading to avoidance or cessation of treatment in the community (Curtis & Diamond, 1997; McPhillips & Sensky, 1998).

Long-Term Effects of Coercion

Initial responses to coercion, such as a fight-flight reaction, are repeatedly broken down by involuntary interventions and ensuing conventional treatment programs. When the same person is subjected to further coercion, even without exhibiting active resistance, the repetitive acts of domination may induce a learned helplessness, submission to coercion becomes accepted as an unavoidable part of life. This process will render it increasingly less likely for the person to emerge from the status of a chronic mental patient and to assume a meaningful role in society (Lauterbach & Stecher, 1988). Thus coercive interventions can be seen on a continuum from "early spirit breaking" to "lifelong patienthood."

Bill Nordahl, an advocate from New Jersey, describes this pattern succinctly:

> When I was involuntarily committed to a forensic psychiatric institution it was clear to me that the mental health system was saying to me in effect: 'You're crazy and you're dangerous.' When they offered no therapy that was helpful, they were saying in effect: 'Your situation is hopeless.' No matter how we fight against it, we all tend to believe what is said about us. To the extent that I internalized this message . . . this was what I tended to create in my life. It is clear that this did not benefit me or society. (Blanch & Parrish, 1993, p. 14).

PSYCHIATRIC MOTIVES FOR COERCIVE INTERVENTIONS

Why do so many conscientious psychiatrists continue to practice coercive interventions rather than actively opposing them and searching for alternatives? Several possible factors, simultaneously present in various degrees, may account for this unique psychiatric persistence.

Promulgating the Medical Model

Consciously or unconsciously, psychiatrists may use coercion as a way to promulgate—indeed, to enforce—their view of the medical nature of the presenting problem (Chodoff, 1988). Without the power to enforce their interventions, psychiatrists might be less successful in convincing their patients and the public of the medical/biological nature of emotional distress. It is to be expected that the greater the level of uncertainty and complexity in psychiatry, the greater the degree of paternalism which underlies coercive interventions.

Psychiatry embodies medical uncertainty *par excellence.* It is the only medical specialty that has continuously suffered from the lack of a "substrate" or a clear biological basis for the conditions it has set itself up to treat. Ironically, whenever a bona fide substrate has been identified, as in the case of syphilitic encephalitis, psychiatry has had to forfeit the entire disease and its treatment to other medical specialties. Consequently, psychiatric practice currently rests—at the scientific level—on uncertainty bolstered by the hope for irrefutable and yet "non-neurologic" substrates. Under these conditions of fundamental uncertainty and paradox, psychiatrists practice their particular brand of medicine, based on the ability to forcibly diagnose and treat (see Valenstein's 1986 discussion of psychiatry's perennial attempt to compensate for this dilemma with fantastic, often tormenting interventions).

Patients' Denial of Illness

Underlying many, if not most, coercive interventions is the premise that the person cannot or will not accept the idea of being ill as an explanation for his or her situation. "Denial," "lack of insight" and other such deficits are widely seen as features of the person's illness (especially psychosis). They are used to justify forceful interventions including the recent expansion of outpatient commitment laws (Cuesta & Peralta, 1994; Geller, 1999). Of course, whether actual deficits or alternate coping mechanisms are at work in the so-called denial, and whether coercion is likely to improve or worsen these ostensibly morbid processes, remains speculative.

In all of medicine there is not one example where force is justifiably used to help a patient accept a medical diagnosis and where such force is considered by doctors to be an essential element of treatment. One apparent exception is the threat of contagion from persons with infectious diseases who refuse treatment—but here the goal is not to develop insight: it is to protect the public from extremely communicable diseases, such as tuberculosis. So far this has only been applied to airborne pathogens (for a perspective on contagion which analogizes it to mental illness, see Wertheimer, 1993). In psychiatry we have no qualms about handcuffing someone to a chair without charging him or her with a crime and then, amid protests, injecting the person with an unfamiliar substance in order to combat the symptoms of a morbid condition the person probably does not appreciate, accept or interpret in pathological terms. Could this really be the only way to drive home that this person may be suffering from a "mental illness," or is this type of approach more likely to harden the resolve to keep things private, to distrust doctors, to fear for one's life, and to withdraw from society?

The Power to Control

It is of course true that some persons who come to the attention of psychiatrists have in one way or another challenged the authority of the state or the rules of civility. In our society, having made the distinction between those infractions that are punishable by law, and those that are attributable to psychiatric conditions, psychiatrists are charged with asserting the power of the state by enforcing treatment conditions. This power to control individuals who are perceived as out of control is a very formidable tool, which psychiatrists employ whenever they find justification in the person's behavior or in reports by others. We do not know whether the practice of psychiatry promotes authoritarianism or whether physicians inclined toward paternalism are more likely to choose the specialty of psychiatry. This is not a frivolous question. Whether the element of coercion in psychiatric practice is seen as part of the public health/*parens patriae* function, or rather as a gratuitous, if not sadistic trait, is an important question that needs to be seriously addressed, given the numerous perspectives of users who have poignantly expressed their extreme fear and rejection of involuntary treatment.

Fear of Legal Liability

A major constraint on psychiatrists to hold someone involuntarily is the fear of liability (discussed extensively by Appelbaum, 1988). Several successful lawsuits have charged psychiatrists with malpractice and negligence due to the release of a patient who may have later committed suicide or harmed someone. More recently, however, a number of cases have been settled or adjudicated in favor of plaintiffs who felt they were being detained inappropriately and harmed by this intervention (Appelbaum, 1995). This may tip the balance of liability back toward less coercive interventions. On the other hand, it may simply lead psychiatrists to be more careful when justifying coercion (Miller, 1992).

A "Burning House"

The argument that certain conditions, in particular psychotic states, are inherently harmful to the person and the surroundings, has been put forth as a major and frequent justification for early, and if necessary, involuntary interventions (Wyatt, 1991). This recommendation rests on the assumption that if left "untreated," that is, not treated with neuroleptics, these conditions will invariably lead to deterioration and dangerous behavior, much as a burning house is likely to destroy itself and its neighborhood. This argument assumes that noncoercive methods are not likely to have beneficial effects in these situations. The work of Loren Mosher and others (Mathews, Roper, Mosher, & Menn, 1979) contradicts this point, as do studies looking at persons with schizophrenia who have survived with adequate support in the community without forced interventions (for example Gillis & Keet, 1965; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987).

Lack of Alternative Resources

A lack of adequate noncoercive resources, such as crisis services and assertive case managers, has been cited as a major rationale for the use of coercive interventions. This argument is ethically unacceptable. If psychiatrists are truly compromised in their ability to administer the appropriate noncoercive clinical treatments, they should refuse to work in such settings. Doctors working in medical emergency rooms that lack essential resources have had the courage to walk out of such untenable conditions. The Italian experience, where psychiatrists led the way toward abolishing dehumanizing long-term institutions including many coercive practices, is an example of doctors standing in the way of prevailing doctrine (Mosher & Burti, 1989). John Connolly's program of institutional treatment without mechanical restraints in the 1840s, when virtually no chemical methods were available, stands as a pioneering effort against psychiatric coercion (Connolly, 1973). More recently, Michael Ford and other psychiatric administrators in New York State have begun to regard the use of restraints and seclusion as an indicator of failed treatment (New York State Commission on Quality of Care, 1994). By doing so they succeeded in reducing these practices in their institutions dramatically in comparison to other facilities where the use of coercive interventions remained considerably higher for similar patient populations.

Peer Pressure

The prevailing doctrine of psychiatry fully authorizes and encourages the use of coercion whenever "clinically indicated." In fact, there is no mention of the Hippocratic principle—"first do no harm"—in the ethical guidelines promulgated by the American Psychiatric Association. Even a chapter dedicated to the topic of involuntary commitment in the authoritative volume on psychiatric ethics makes no mention of the possibility that coercion may be harmful and therefore unethical (Bloch, Chodoff, & Green, 1999). It is part of psychiatric lore, if not science, that one of three reasons to commit almost always exists—a potential for danger to self or others, a denial of illness, and a lack of capacity to consent voluntarily. Given these unswerving assumptions among their peers, it is not surprising that only a small minority of psychiatrists have taken an active stand against involuntarism and have searched for noncoercive alternatives.

Toward a Noncoercive, Hippocratic Psychiatry

Legal or programmatic alternatives outside of psychiatry that may ameliorate the situation described in this paper, and even result in virtually coercion-free systems of care, have been considered elsewhere (Blanch & Parrish 1994; Mazade, Blanch, & Petrila, 1994; Stroul, 1991; Sydeman, Cascardi, Poythress, & Ritterband, 1997). The primary concern in this article is what psychiatrists can do to reduce or eliminate the use of coercion.

The first and widest-reaching measure would be for psychiatrists to withdraw from front-line interventions where the temptation to use coercion is the greatest. In other words, psychiatrists could refuse to work in clinical settings where they are asked to utilize coercion, unless they are prepared and authorized to do everything within their power to prevent this. Psychiatric emergency rooms and triage units are basically unsuited for the practice of noncoercive psychiatry and should be eliminated from the panoply of mental health services. It may be ethically and clinically sounder to separate restrictive functions from therapeutic activities more clearly. In this case, actions which are punishable by law could be dealt with through the court system along with proper protection of due process, while voluntary treatment could be provided all along.

Psychiatrists could refuse to prescribe psychotropic medications to persons who are physically restrained. The combined experience of restraints and neuroleptization often results in severe muscular dysfunction and is among the more traumatizing medically sanctioned interventions. In addition, psychotropic drugs are often ineffective in restraining a highly agitated individual (Anderson & Reeves, 1991). Refraining from these practices would require that psychiatrists become familiar with nonviolent techniques to assist persons in extreme emotional distress, which could include noncoercive holding, talking down, creating a physical outlet, and the conflict resolution strategies. Soteria House is a good example of how such techniques can become an effective component of treatment for acutely psychotic individuals (Mosher & Vallone, 1992).

Lastly and most important, psychiatrists should be at the forefront in the search for noncoercive interventions. In fact, there is a small, but significant tradition of advocacy for noncoercive alternatives among psychiatrists, starting with the 18th century British hospital superintendent John Conolly who proved that his institution could run entirely without physical restraints (Connelly, 1973). Leonard Stein (1976) and Loren Mosher (1994) are two psychiatrists who made it their mission to provide noncoercive, noninstitutional alternatives in crisis situations. Some lesser known pioneers are Edward Podvoll (1990) who initiated the Windhorse Project in Naropa, and Paul Polak, who proposed the use of foster-family crisis intervention as an alternative to hospitalization (Polak & Kirby, 1976). Thomas Szasz (1978) has devoted a great deal of his writings to arguments against coercive interventions by psychiatrists, as did Peter Breggin who proposes conflict resolution and empathic treatment as alternatives to coercion (Breggin, 1992, 1997).

Some of the most important lessons for psychiatry today come from different quarters—the movement of ex-patients and survivors of coercive interventions, who have made it their aim to prevent coercion for themselves and for their peers and who are in the process of developing nonhospital, noncoercive alternatives which merit our fullest support. Crisis-residential settings are being developed by survivors in California, New York, Connecticut, The Netherlands, and Germany, among others (Dumont, 1993; Wehde, 1991). Comprehensive community support alternatives are being designed and developed by survivors of coercive interventions (Chamberlin & Rogers, 1990). Various forms of advanced directives are being promoted and field-tested by survivors at risk for involuntary interventions (Lehmann, 1993; Rogers & Centifanti, 1991).

Considering this rich trove of alternatives to coercion, it is not acceptable for psychiatrists to claim that they can do nothing to change the system. Existing models have demonstrated significant success in this area (Breggin, 1991; Breggin & Stern, 1996; Neugeboren, 1999). New models need to be developed in collaboration with survivors of coercive interventions. Psychiatrists could be at the forefront of these alternatives instead of trailing behind as the principal advocates for increased coercion and outpatient commitment.

We now return to the Hippocratic Oath to present one interpretation of its controversial passage, "First do no harm." It would seem that as medical doctors, psychiatrists should be obliged to safeguard patients from damaging interventions that might be initiated by practitioners who do not subscribe to this oath. Whereas in the days of Hippocrates these might have been called shamans, today they are the public officials and mental health professionals who believe that forcing people into treatment "helps" them. Therefore, any physician wanting to observe the Hippocratic Oath must stand in the way of these practices and do the utmost to search for noncoercive solutions. Perhaps these "conscientious objectors" would then be considered, as Ron Thompson (1994) has suggested, "Hippocratic Oath Practitioners" in contrast to those who practice social control under the guise of psychiatric treatment.

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