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Coercion of Voluntary Patients in an Open Hospital

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The long history of the open hospital, with its goal to limit the coercion of patients, has recently been reviewed.[6,7] The open hospital may also be a field of study for more subtle forms of coercion that might go unnoticed in other hospitals. The absence of outright locked doors tends to draw attention to these more indirect forms of control over the patient. In an environment dedicated to the elimination of coercion, the staff and the patients will then be exquisitely sensitive to any which continues to manifest itself. In addition, the absence of the locked ward means that any coercion must be directed by an individual doctor against an individual patient, making it more painfully obvious to everyone in the hospital.

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This ironic situation provides fertile ground for studying coercion. It might also be used by some as evidence for the inadequacy of open hospitals and by others as evidence for the insidiousness of coercion even within ideal circumstances. The topic is so charged with dramatic ethical, legal, and therapeutic considerations that I might best explain my own bias at the start. I am ethically committed to the principle that coercion should be limited as much as possible but believe that the actual extent of this limitation cannot be decided until we know considerably more about the effects of coercion upon the patient.

Definition of Coercion

By coercion is meant any action, or threat of action, which compels the patient to behave in a manner inconsistent with his own wishes. The compelling aspect can be direct physical or chemical restraint, or it can be indirect threatened recriminations or indirect "force of authority" which convinces the patient that no other legal or medical alternative is available to him.

Coercive behavior falls into the general category of manipulative behavior, in which one person feels that his actions are determined by someone else, despite his own wishes. Coercion may be considered the experience of an unusually constraining or intimidating alternative, so that the individual feels his freedom of choice is pre-empted.

This is a practical definition in which the reference point is the patient's feeling of being compelled. It is meant to define a common element in the patient's response to such diverse experiences as enforced confinement to a locked ward; self-imposed restriction to an unlocked ward for fear of certification to another hospital; self-imposed restriction to an unlocked ward after receiving the impression that one has no legal right to leave the ward; or self-imposed restriction because one believes that no other medical alternative is available. The focus must be upon the patient's feeling or response, otherwise the patient is subjected to another imposition

whereby he loses even his right to decide what is coercive. Defining coercion from the patient's point of view also takes into account individual variations: some patients may not feel coerced by any of these alternatives, either because they do not fear them or because they do not wish to leave the ward, while other patients will be particularly sensitive to the alternatives either because they strongly wish to leave the ward or greatly fear the threats presented to them.

Definition from the patient's point of view is not without ambiguities. For example, it will often be difficult to distinguish between different levels of response in the patient. The patient may say that he feels coerced, while he behaves as if he is not, or the patient may deny feeling coerced while he acts as if he is. Equally difficult, the patient may perceive coercion in a situation where few others would. These problems cannot be avoided, since coercion is relative to the individual, and to the situation. Life itself exists along a continuum of coercion in which the individual often feels that his behavior is in part determined by direct constraints or threats. The definition cannot do away with the ambiguities and relativity inherent in the situation, but it can draw attention to the patient's response to various constraints, pressures, or threats within the hospital environment.

Description of the Open Hospital

The doors of the hospital and all its wards are all open during the day from 8 AM to 8 PM. Otherwise, the setting is like that of other acute treatment hospitals with active residency training programs. The Syracuse Psychiatric Hospital is part of the New York State Department of Mental Hygiene. It is located in the midst of the city of 250,000, near the Syracuse University Campus, and side-by-side with the State University of New York Upstate Medical Center, from which it draws its staff and residents. The average daily census is 55 patients, and the average stay is 45 days, although some patients stay several months. Each therapist has from six to ten patients most of the time, providing ample time for intense psychotherapy with selected patients. While the bias of the hospital is toward psychotherapy, many patients also receive tranquilizers, and 10% eventually receive electroconvulsive treatment.

The patient population represents a somewhat modified cross-section of the city's more acute psychiatric problems. Some of the city's unusual management problems or recurrently rehospitalized patients may be sent directly to a larger state hospital, but others will be admitted to Syracuse Psychiatric Hospital (S. P. H.) and subsequently sent on to one of the other state hospitals.

Of the several admission forms provided by the laws of New York State, three accounted for all admissions to S. P. H. in 1962. In keeping with the hospital's attitude, 82% of last year's admissions were voluntary. These voluntary patients can be held for 15 days against their will, at which time they may be required to give ten days' notice before leaving the hospital (Chapter 27, Mental Hygiene Law, in the consolidated laws of New York State, available in 1962). As the only appropriate community facility, the hospital does accept a certain number of involuntary admissions. Of these 18%, most are admitted involuntarily by the hospital admitting officer at the request of a responsible member of the community, usually the family physician. The remainder of the involuntary admissions are by a community health officer. The hospital did not admit any court certified patients during the year.

During the past year, 93.2% of the patients admitted were eventually discharged to return to the community. The remaining 6.8% were committed to one of the two larger state hospitals serving the area. This certification is made by the court, after either the family or the Commissioner of Public Welfare has signed the appropriate papers. At least one patient has been certified each month during the past year, so that each patient who stays a month or more witnesses the certification of one or more other patients.

The alternative to admission to S. P. H. is usually admission to one of the larger state hospitals. Few individuals qualify for admission to the Syracuse Veteran's Administration psychiatric wards, the community's one private sanitarium, or the community's one general hospital with a private psychiatric ward. Similarly, the alternative to discharge from S. P. H. is certification to one of these same two large state hospitals. Thus other alternatives at the time of admission and discharge are usually limited to admission or certification to a larger state hospital. The larger state hospitals thereby figure importantly in the patient's attitude to his hospitalization in S. P. H.

The larger state hospital most familiar to the patients and the staff, and symbolic of "The State Hospital," is located about one hour's drive from Syracuse outside a nearby city. The hospital is among the best known and respected within the large and progressive New York State hospital system. The attitudes of the S. P. H. patients and psychotherapists toward this hospital will be described as the topic of coercion is elaborated.

The Physician's Use of Coercion

There are many reasons why the resident therapist may at times feel the need to act against the patient's will, even in the open hospital.

First, he may believe he has an ethical, professional, or religious responsibility to help the patient, even if the patient does not want help. The physician may believe that the patient, like a child, is unable to make the best decision for himself, and therefore must have someone else "take over" for him. The physician knows that patients often resist the initial efforts of their therapists, only to thank them later. He knows that many patients, and society in general, *expect* him to take this responsibility. He may perceive at times that the patient often *wants* him to be coercive. In addition, his medical training has conditioned him to trust his own judgment in determining what will be of benefit to the patient.[9]

Second, the therapist may be motivated to coerce the patient by a sense of responsibility toward the patient's family and toward the society. The therapist may wish to mitigate the patient's hostility, or to restrain the patient from physically or psychologically harming others. He may also wish to rehabilitate the patient into a socially and economically productive human being. He may believe these goals at times transcend the patient's immediate, and perhaps irresponsible, wishes.

Third, the therapist may be concerned about placing himself in legal jeopardy if he does not accept responsibility for his patient and society. For example, he may fear being sued by the family of a patient who harms or kills himself. He may also place his residency appointment in jeopardy if he does not at times coerce his patient. In any contemporary hospital, no matter how "open" its attitude, his superiors will at times hold him responsible for his patient's welfare and the society's welfare. Thus, legal and professional survival add impetus to any other motives which might influence him to coerce his patient.

Fourth, the therapist may be motivated to protect or enhance his own self-image and prestige through the actions of his patient. Thus, he may wish to coerce his patients into avoiding or performing certain acts. A patient who kills someone else, or who kills himself, can deal a severe blow to the resident therapist's self-image and prestige. To a lesser extent, a patient who does not respond in an appropriate fashion to psychotherapy is bound to reflect upon the therapist. An example of this is found in a recent paper which encourages psychiatrists to use the relative number of patients who sign out Against Medical Advice as a reflection of the resident's ineptitude.[4] Such an attitude on the part of supervisors is bound to encourage trainees to coerce their patients into more acceptable forms of behavior. At S. P. H. any such arbitrary "grading system" would be frowned upon. Nonetheless, the residents sometimes feel that the proportion of their patients certified reflects upon them. While few residents, if any, would rationally accept

so gross a standard of therapeutic success or failure, most would admit to embarrassment and a sense of failure when one of their patients is certified to a larger state hospital. When it appears that a patient is "in danger of getting certified," a strong impulse then arises to modify the patient's behavior by restricting his liberty, by threat of certification, by electroconvulsive treatment, or by heavy tranquilization.

Fifth, the therapist might coerce the patient for motives entirely inappropriate for the situation. To give an example with infinite variations, one resident became aware that he refused his patient weekend passes in part because he resented her wish to visit home rather than to attend the Saturday therapy session. Many motives to coerce might result from counter-transference of various intensities, many of which the therapist-in-training might not recognize. There is little reason to presume that first or second year residents, or really anyone, would be immune to these motives. Supervision by more highly trained psychiatrists might mitigate some of these motives, if the supervision and the supervisor were oriented in this way. On the other hand, the supervisor usually has his own coercive powers over the trainee, setting an example for one individual to coerce another. In addition, since the supervisor's use of coercion will depend in part upon his evaluation of the trainee's patient, the resident may feel the need to coerce his patient into behavior consistent with the supervisor's expectations.

Finally, the therapist may feel that the existence of the larger state hospitals creates a situation in which, in order to avoid even greater coercion, he must himself act coercively upon the patient. For example, he may anticipate that certain acting out by his patient will eventually lead to certification by the staff. He might then compromise his own antipathy to coercion by using a little "prophylactic coercion," hoping a few restrictions on the patient's liberty, or electroconvulsive therapy, will discourage further acting out. Similarly, if he has a very low opinion of the larger state hospital, he may feel that the "danger of being sent away" is greater than the danger of temporarily coercing his patient. He may feel that separation from the psychotherapy would harm the patient at a crucial time when the patient is acting out. However, even if the therapist has no desire at all to coerce the patient, he may indirectly increase the threat of coercion by communicating his own anxiety about the threat to the patient. For example, the therapist may tell the patient, "I would not want to see you committed, but I feel you should know that your present behavior will lead the hospital administration to advise your commitment."

If the physician decides to use coercion, three basic methods are available to him: restriction of liberty, certification to a larger hospital, or treatment with electroconvulsive therapy and large doses of medication. Each of these can be coercive when used as threats, as direct constraints, or as punishments. In each case, the patient feels compelled to act against his will.

Despite the absence of locked doors, control over the patient's physical liberty remains the most frequent means of coercion. The physician may limit the patient's freedom to move around the hospital, he may refuse weekend passes, or he may insist that the patient remain in the hospital for the full 25 days stipulated in the voluntary admission form. In many instances, nearly every therapeutic hour with a hospitalized patient will revolve around direct or indirect bargaining for increased liberties with improved behavior. For example, the patient may request a pass to leave the ward, and the physician may respond that the patient's behavior still lacks sufficient self-control. No matter what the therapist's attitude, the coerciveness of the implication cannot be avoided—if the patient does not change his behavior, he will not be given more freedom.

From the physician's point of view, coercion through real or threatened physical restriction is often very taxing and very disagreeable. Although most patients will not defy his legal authority, he must on occasion further implement his restrictions to the

ward. This is very difficult in an open hospital and places a great deal of strain upon the ward personnel who are directly responsible for watching the patient's movements, and for restraining him, somehow, without the locked door. The use of restrictions on liberty is also frankly contrary to the "open door" attitude, and often extremely repugnant to the physician.

The second means of coercion, threatened or actual certification to a larger state hospital, is so pervasive that it hardly needs to be mentioned by the therapist. This threat is so obvious and overwhelming to many patients, that the physician has little power to increase or ameliorate it. Nearly everyone on the staff is very reluctant to certify anyone, but more than one patient is still certified every month. The effect of this on the remainder of patients will be discussed in the next section.

The third means of coercion is threatened or actual treatment with drugs or electroconvulsive therapy. Many patients will bargain to diminish their drug doses, much as they will bargain to decrease their physical restrictions. Many dislike the associated side-effects of phenothiazines, including the dryness of the mouth, chapped lips, blurred vision, stuffy nose, and gastrointestinal symptoms, as well as the more disturbing changes in motor control and affect which almost invariably accompany larger doses. The use of drugs is entirely the prerogative of the physician and is most often a clear method of restraint when the patient is suicidal or homicidal. From the physician's point of view, the drugs have many disadvantages in restraining doses. First, the side-effects often interfere with psychotherapy. Second, it is sometimes difficult to make the patient take the drug. Third, the use of the drug for coercion prejudices the patient against any further use of the drugs.

Electroconvulsive therapy is a more potent means of coercion. In my own experience, most patients have terror of the treatment. Those few who have requested the treatment, still expressed a great fear of it. At S. P. H., the patient and the therapist usually both dislike the use of electroconvulsive therapy. Most patients refuse to sign permission, and the hospital then asks the patients' nearest relatives to sign. The legal implication of the family's consent has never been tested in New York State and is not clearly stated in any law. The device is nonetheless a strong inducement to the patients, who believe it legally binding. This is an example of coercion by implying to the patient that he has no other legal alternative.

In summary, the resident therapist may have many motives to coerce his patient. Some may be characteristic of all human relationships. Some are basic to current legal and social attitudes toward the mentally ill. A number are characteristic of an open hospital which must operate in a fundamentally closed society, represented by the larger state hospitals. If the physician decides to use coercion, he has three basic means: (1) control over the patient's liberty and length of stay in the hospital; (2) certification to a larger state hospital; (3) treatment with drugs or electroconvulsive therapy. Each of these may be used coercively as threats, punishments, or a means of restraint.

The Patient's Response to Coercion

Most patients sign a voluntary admission to the hospital. However, many of these admissions occur as a result of direct or indirect coercion by the patient's family. The patient may be brought to the hospital in a chaotic fashion by his family in the midst of a disintegrating social situation. Usually one or more other members of the family have decided that the patient's admission is the only feasible and immediate solution to the situation.

Often the patient will balk at the last minute when he is told that admission means he can be held for 25 days against his will. At this time, the family may pressure the patient by threats to certify him, or by threats to withdraw support. More rarely, the patient will be accompanied by the police or parole officer who may exert more direct coercion.

On occasion, the resident admitting officer for the day will admit the patient involuntarily at the request of the family and the family physician. More often, the resident is caught up as a passive observer in the family conflict. If he has interviewed the patient through the formal preadmissions clinic, or if he can ascertain quickly that the patient is grossly psychotic, he may also urge the patient to accept a voluntary admission. He may ameliorate the patient's fear of being held 25 days by emphasizing the open doors, and by implying that the patient could not really be held against his will, even though the law permits it.

Very likely more patients would balk at signing the voluntary admission if aware that they could be committed from S. P. H. to a larger state hospital, or that they might feel intimidated to stay considerably longer than the 25 days, or that they might be given electroconvulsive treatment against their will. For this reason, the admitting officer seldom mentions these eventualities at the time of admission. However, soon after admission the patient learns about these possibilities from direct observation of other patients, from discussions with other patients, or through his own experience. This is one of the reasons why the patient often begins to clamor for discharge within ten days or two weeks of hospitalization. He is afraid that the longer he stays the more danger there is that one or more threats will materialize. His fears usually culminate at the time of the official staff meeting which takes place about two weeks after each patient's admission.

Of all the fears, fear of commitment to the large state hospital is by far the most pervasive and intense. From his own prior knowledge and from hospital scuttlebutt, the patient learns that the larger state hospital (1) carries a greater social stigma; (2) has much tighter controls on personal freedom, including locked doors; (3) is more isolated from friends and family, with more limited visiting hours; (4) places more emphasis on chemical and electroconvulsive therapy; and (5) tends to hold patients for longer periods.

Beyond these specific fears about the larger hospital, there is an indefinable awe. In part, it stems from the not-too-distant past when most large state hospitals were "snakepits." In part, it stems from a fear of being mentally ill. Commitment to the larger hospital implies a degree of mental illness far greater than implied in the original voluntary admission to S. P. H. Similarly, the patient may feel that commitment implies incurability. On top of all this, the patient often looks upon commitment as an outright rejection by his physicians and family.

Fear of commitment to the larger state hospital can be reinforced by some commitments of other patients which he is likely to witness in the small hospital. Often the other patients will display overwhelming anxiety concerning their commitment. They may be given large doses of drugs, or transferred to the third floor for closer observation just prior to commitment. Then they are whisked off to the other hospital, leaving behind a wake of spreading fear throughout the hospital.

For many patients, the fear of commitment to the larger state hospital becomes a major motive during the hospital stay. Thus the smaller hospital, despite its open doors, becomes in some ways an annex or way station to the other hospital. For some patients, the threat becomes as real as if the smaller hospital were no more than a ward attached to the larger hospital.

The patient who lives under the threat of commitment, as well as the threat of a prolonged hospitalization, greater restrictions, or electroconvulsive therapy, soon develops ideas about what kind of behavior is likely to cause these threats to materialize. These ideas are often thrashed out in patient bull sessions in preparation for staff meetings. They include the following: (1) failure to respond satisfactorily to therapy, or failure to show an interest in therapy; (2) unmanageable or destructive behavior; (3) suicidal attempts or repeated suicidal threats; (4) immoral acts; (5) behavior disturbing to other patients; (6) repeated attempts to run away from the hospital; (7) any behavior which antagonizes hospital doctors, nurses or

personnel; and (8) any behavior which antagonizes the patient's family.

The fear that running away will lead to eventual commitment to the larger hospital is especially important, for it most directly modifies the hospital's "open door policy." It effectively "locks the door." The patient may realize that he would rarely be forcibly returned to the hospital after running away, but he may feel that the hospital would thereafter deny him readmission. This would limit his future alternatives to the larger hospitals. Indirectly, then, the fear of the larger hospital might compel him to stay on in the ward.

In summary, the patient learns, soon after admission, that his voluntary status leaves him vulnerable to certain eventualities, the most disturbing being involuntary electroconvulsive therapy and certification to a larger state hospital. He also tries to find out what kind of behavior will cause these threats to materialize, so that he can modify his behavior accordingly.

Illustrations of Cases

The following cases are illustrations of how coercion may effect different patients and their physicians.

The first patient is a 20-year-old girl who became suicidal, stuporous, and mute during her first few months at college. She was diagnosed schizophrenic and was voluntarily hospitalized three times in rapid succession during the next several months. She felt that each hospitalization brought her closer to being "sent away," yet she herself recognized the need for each hospitalization, and may have unconsciously wished for commitment and more prolonged treatment at the larger hospital. Prior to her third voluntary admission, her out-patient therapist had to reassure her that she would again be discharged if she showed some improvement. After a few weeks, her new hospital therapist felt she was making progress, but the hospital administration felt it was time to commit her for long-term treatment. Her new therapist told the patient he himself was against her commitment. The patient confided she imagined the larger hospital as a kind of Hell, and she threatened to run away. However, when the commitment papers were finally signed, she did a turnabout, and tearfully thanked everyone for committing her. She asked for tranquilizers to make her transition to the new hospital easier.

The second patient is a 26-year-old man who had developed paranoid schizophrenia during his first year of college. At that time he had been admitted voluntarily and then given electroconvulsive therapy against his wishes. He bitterly remembered these treatments and partly for this reason refused voluntary admission a second time. He was brought in involuntarily. After several weeks of psychotherapy his paranoid ideation ceased to function overtly in the patient-physician relationship. When his period of involuntary hospitalization drew to a close, he reluctantly agreed to sign a voluntary admission for continued hospitalization. In retrospect, he probably did this out of fear that he would otherwise be committed. When the therapist subsequently had to leave the hospital prior to the completion of therapy, the therapist decided to commit the patient for further treatment at a larger hospital. The patient again became acutely paranoid. At first he denounced his therapist but then tried to mollify him. He was finally placed on large doses of chlorpromazine to prevent his fleeing the hospital prior to commitment.

The first patient was always reluctant to be admitted voluntarily, for fear of eventual certification, and when certification did occur, she threatened to run away. Eventually, her basically passive-dependent orientation led her to "accept what's best." In the second case, the patient resisted admission at the start, but accepted voluntary status later on during his hospitalization. Very possibly, he thought that he would be certified if he refused voluntary status, as he would have been. When he was eventually certified, his basically paranoid orientation led him to reincorporate the therapist into his paranoid system. However, when he realized that the display of paranoid ideation and hostility would only further insure his certification, he attempted to mollify his therapist.

Often, the threat of commitment is itself potent enough to obviate the need for commitment. The third case, an addict to meperidine (Demerol), was admitted involuntarily at night when the doors are locked. In the morning, after several hours of unmanageable behavior, he fled past the attendant. The police were called to pick up the patient, who was thought dangerous to his wife. They were instructed to return him to jail in preparation for more speedy commitment to the larger state hospital. However, the policeman turned out to be an old high school chum of the patient. He warned the patient about the danger of commitment and returned him to the hospital. Despite the apprehension of the doctors, the patient was docile after this.

The vast majority of patients would not yield such clear-cut illustrations of coercion. One example, from an unusual follow-up opportunity, demonstrates that responses to coercion may be concealed from the therapist. The patient is a 35-year-old mother of four children who came in voluntarily after several months of bitter struggle

between herself and her husband. In the last days before admission the patient had become agitated, threatened suicide, and finally became mute and stuporous. Rapport seemed to develop quickly between the patient and the therapist, and the patient made a remarkable symptomatic improvement after ventilating her rage and receiving support for her self-esteem. She appeared as the victim of an extremely sadomasochistic relationship. After the patient's discharge in two weeks, she somewhat reluctantly entered into a weekly family therapy project with the same therapist. During the first session, one daughter told how the patient's husband had threatened her with commitment to a larger state hospital just prior to her voluntary admission. During the second session, another daughter made a slip of the tongue which uncovered that the patient had always included the therapist among those hostile male figures whom she had to resist passively. She had put up a front of rapport during her hospitalization to insure her speedy discharge and to guard against the threat of commitment to the larger state hospital. To what extent some kernel of rapport did exist could not be ascertained against the background of motivation to deceive.

Comment

The proportion of patients actually affected by direct and threatened coercion, and the degree to which these patients accordingly modify their behavior, require some quantification. Many psychiatrists have already stated the opinion that so long as the threat of coercion exists, most or all patients will respond to it.[1-3,5,8,10,11] I have the impression that nearly every patient is affected by the threat of coercion but that only the more intact patients are able to modify their behavior in response. Thus the case illustrations present two schizophrenic patients who were unable to disguise their symptoms despite the threat of coercion, and a drug addict and a neurotic patient who were able to modify their behavior and, in the latter case, to disguise the response to the coercion. Beyond this kind of impression, it is not at present possible to quantify the degree of response, since every patient, voluntary or involuntary, is subjected to the same threats. Under these conditions, there are no control groups upon which to base a study of the effect of coercion.*

* The recent initiation of "informal admissions" at S. P. H. may change this situation. These patients have a status similar to medical patients.

Because the effects of coercion are not fully understood, it is not easy to decide if we should, or could, do away with all coercion in mental hospitals. However, there are some cogent reasons to do away with the pretense about coercion and to recognize, as some have already done,[1] that the voluntary mental hospital experience is thoroughly permeated with coercion. If we gloss over the implications of coercion, we put the patient into a dangerous double bind. On the one hand, we tell him he is voluntary and encourage him to establish a relationship of mutual confidence. On the other hand, we use actual restraint, certification, and undesired treatments to control or intimidate him. On top of this, we then close our eyes to the problem and thus indirectly warn against too much concern about the realistic ambiguities of the situation. As one patient confided, "Is it true, Doctor, that you get committed if you look too eager to go home?" Naturally, openness and frankness about the pervasiveness of coercion is likely to help the physician as well as the voluntary patient, for it encourages a feeling of greater self-respect on the part of the physician and removes a taboo from important areas of the patient-physician relationship.

A concrete step can be taken to increase frankness and honesty in this regard. A requirement could be made that the patient be informed prior to admission about the possibilities of involuntary treatment, restrictions on liberty, and certification. In New York State this would be little more time-consuming or difficult than the current requirement that the patient be told prior to admission that he can be held for 15 days against his will at the discretion of the staff, and that he may then be required to give ten days' notice before leaving.

After being given this information, some patients might choose not to sign a voluntary admission. This occasionally happens now, when the patient is told that he can be held against his will. In keeping with the spirit of the voluntary admission, this should be the patient's prerogative. If the patient eventually does need involuntary hospitalization, the community then has means for obtaining this

more directly through the various forms of mental hospital commitment. In New York State, for example, there is no lack of these forms and therefore little reason for physicians to fear for the future of patients who might refuse voluntary admission.

Frank recognition of the implications of voluntary admission would seem justified on ethical grounds, as well as on therapeutic grounds. Hopefully, frank recognition might also lead to codification of more real legal distinctions between voluntary and involuntary admissions in our state laws pertaining to the mentally ill. This would further the goal of a more frank and unambiguous patient-physician relationship. It would also make possible comparative studies of the effects of voluntary and involuntary hospitalization, studies now hampered by the absence of truly voluntary admissions.

Summary

An open hospital environment provides the opportunity for observing the more covert and indirect means of coercion found in most mental hospitals. Coercion is viewed from the patient's point of view as any action, or threat of action, which makes the patient feel compelled to behave in a manner contrary to his own wishes. Special attention is given to restriction of liberty around the hospital, certification to a larger and more remote state hospital, and involuntary treatment with drugs or electroconvulsions. Each of these can function coercively as a direct means of constraint, as a threat, or as a punishment. Case illustrations are given. The therapist's wish to coerce the patient is also presented.

A suggestion is made to inform voluntary patients prior to admission about the eventualities of coercion in the hospital. This would establish a more frank patient-physician relationship at the start and encourage future definitive legal distinctions between voluntary and involuntary patients.

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