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# Hospitalization as experienced by the psychiatric patient: a therapeutic jurisprudence perspective

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## 1. Introduction

The purpose of this article is to investigate the subjective experience of hospitalized psychiatric patients regarding the troublesome aspects of psychiatric hospitalization. Our discussion envisions a decision maker working under legal mandate pertaining to his discretion concerning hospitalization and aiming to promote the psychological well-being of the hospitalized individual.

Therapeutic jurisprudence, as a perspective on the law in general and mental health law in particular and as an academic movement, has sought for the past 25 years to promote the psychological well-being of the individual through both substantive legal norms and legal procedures.<sup>1</sup> It has also been criticized for not explicitly incorporating the perspectives of both voluntary and involuntary consumers of the mental health system.<sup>2</sup>

It makes sense to postulate that empowerment of these consumers will determine to a certain degree the success of therapeutic jurisprudence in fulfilling its aims.<sup>3</sup>

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<sup>1</sup> D. Wexler "The Development of Therapeutic Jurisprudence—from Theory to Practice" *Revista Uricada Univ. De Puerto Rico* (1999a) 691. D. Wexler "Therapeutic Jurisprudence and the Culture of Critique" *10 Journal of Contemporary Legal Issues* (1999b) 263.

<sup>2</sup> John Petrila *Paternalism and the Unrealized Promise of Essays in Therapeutic Jurisprudence* *10 NEW YORK LAW SCHOOL J. OF HUMAN RIGHTS* (1993) 877.

<sup>3</sup> Joel Haycock *Speaking Truth to Power: Rights, Therapeutic Jurisprudence and Massachusetts Mental Health Law* *20 NEW ENGLAND J. ON CRIMINAL AND CIVIL CONFINEMENT* (1994) 301. See also Bruce Winnick *Symposium: Therapeutic Jurisprudence and the Civil Commitment Hearing* *10 J. CONTEMP. LEGAL ISSUES* (1999) 37. Alexander Greer, Mary O'Regan, and Amy Traverso *Therapeutic Jurisprudence and Patients' Perceptions of Procedural Due Process of Civil Commitment Hearings* David Wexler and Bruce Winick (eds.) *LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* (1996) 923. Tom R. Tyler *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings* *46 SMU L. REV.* (1992) 433.

Relating to the evolving aims of a therapeutic perspective on the law, one can postulate that it is important not only to see law as a therapeutic agent, but also to see the consumers of mental health services as important allies. Their subjective experiences should be explored and integrated into the mental health jurisprudence.<sup>4</sup>

One can attempt to draw from the consumers' subjective experience considerations, which can make law more therapeutic. This article is an attempt to do that in relation to the legal decision concerning psychiatric hospitalization whether in civil commitment proceedings or in criminal proceedings in which diversion is considered.

Myths that developed in popular culture about mentally ill persons<sup>5</sup> serve to construct a border between "us" and "them" and thus to protect ourselves from the danger we perceive to be personified in the mentally ill person. Through myths, we are liable to dehumanize the patient as the "other" and justify his social exclusion.<sup>6</sup> We are all consciously and unconsciously exposed to the subtle workings of these myths. Exposing ourselves simultaneously to the accounts of the patients may serve to humanize the "other" and bring us closer to a recognition that our understandings are also personalized understandings<sup>7</sup> and create a margin of doubt as to our fundamental assumptions about the patient who is for us always "the other." This is particularly important in light of the tendency ingrained in our culture not to allow that "other" the benefit of benevolent doubt, a tendency to use dismissing, belittling doubt more as a value than as an intellectual tool.<sup>8</sup>

The personal pain stemming from receiving mental health services, which in democratic society have to be either permitted or mandated by law, is sometimes unavoidable,<sup>9</sup> and this is just an instance of the inevitable pain and violence involved in the legal interpretation of fact and law and its enforcement.<sup>10</sup> However, at other times it is avoidable, but only if we turn away from a tradition of neglect of the personal side of mental illness, a tradition of silencing people suffering from severe mental illness. The history of neglect is regrettable especially in light of research findings that perceptions of systemic fairness are driven in large part by the

<sup>4</sup> Haycock, *ibid.*, at p. 317. see also Francis J. Mootz *Psychotherapeutic Practice as a Model for Postmodern Legal Theory* 12 YALE J.L. & HUMAN. (2000) 299.

<sup>5</sup> Such as the myth that they should be segregated in large distant institutions and that their presence threatens the economic and social stability of residential communities or the myth that they are different and perhaps less human. Michael Perlin *Mental disability law, theory and practice, 'us' and 'them'*. *Symposium on Mental Disability Law: 'where the winds hit heavy on the borderline'*. 31 LOY. L.A. L. REV. (1998) 775.

<sup>6</sup> Perlin, *supra* note 5. Martha Minow MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION AND AMERICAN LAW. Cornell University Press (Ithaca, 1990).

<sup>7</sup> Mootz, *supra* note 4. Minow, *supra* note 6. Garry Bellow and Martha Minow *Introduction: Rita's Case and Other Law Stories*. Garry Bellow and Martha Minow (Eds.) LAW STORIES. University of Michigan Press: (Ann Arbor, 1998b) 31.

<sup>8</sup> Wexler (1999b), *supra* note 1. Deborah Tannen THE ARGUMENT CULTURE-STOPPING AMERICA'S WAR OF WORDS. (New York, 1999).

<sup>9</sup> Michael Perlin *A Law of Healing* 68 U. CIN. L. REV. (2000) 407.

<sup>10</sup> Robert Cover *Violence and the Word* in Martha Minow, Michael Ryan, and Austin Sarat (Eds.) NARRATIVE, VIOLENCE AND THE LAW—THE ESSAYS OF ROBERT COVER, University of Michigan Press. (Ann Arbor, 1998b) 203.

degree that people judge that they are treated with dignity and respect.<sup>11</sup> If we are to overcome a culture of “doctor/judge/lawyer always knows best” and an assumption that mental health has once more become purely and securely benevolent, we have to be educated to these dangers<sup>12</sup> and it seems difficult to achieve such an aim without recourse to research findings concerning the consumers’ personal experiences.

Indeed, some researchers have generated a growing interest in the inner world of people with severe mental illness. In an editorial in *Journal of Nervous and Mental Disease*, Brody<sup>13</sup> warns the psychiatric profession about the danger “of losing the humane outlook that has characterized its development.” Other major psychiatric journals such as the *Schizophrenia Bulletin* and *Psychiatric Services* now include first-person accounts of the experiences of people with severe mental illness. An issue of the *Schizophrenia Bulletin*<sup>14</sup> focusing on first-person accounts, subjective experience, and careful observation and description illustrated how people with severe mental illness experienced and coped with their disorders. Hatfield and Lefly<sup>15</sup> provide a comprehensive summary of how mental illness feels to mentally ill individuals, relying primarily on patient-authored literature.

As part of this new trend, there has been growing emphasis on the importance of patients’ experience of psychiatric hospitalization, which is widely overlooked or poorly understood, and its relative neglect in commitment proceedings. Such a trend can be seen as derivative of a therapeutic jurisprudence outlook. It has led to the advocacy of specialized courts geared to meet the challenge of radical reform.<sup>16</sup>

<sup>11</sup> Perlin, *supra* note 9.

<sup>12</sup> Haycock, *supra* note 3. Winnick, *supra* note 3.

<sup>13</sup> Eugene Brody *The Humanity of Psychotic Persons and Their Rights*. J. OF NERVOUS AND MENTAL DISEASE (1995) 183, 195.

<sup>14</sup> 15 SCHIZOPHRENIA BULLETIN (1989).

<sup>15</sup> Agnes Hatfield, Harriet P. Lefley, and John S. Strauss *SURVIVING MENTAL ILLNESS* (New York, 1993).

<sup>16</sup> Winnick, *supra* note 3, Greer, *supra* note 3, Tyler, *supra* note 3, Michael Perlin ‘*Make Promises By The Hour*’: *Sex, Drugs, the ADA, and Psychiatric Hospitalization*. *Symposium: Individual Rights and Reasonable Accommodations under the Americans with Disabilities Act*. DE PAUL L. REV. (1997) 947. Leroy L. Kondo and Dale Ross, *Therapeutic Jurisprudence: Issues, Analysis, and Applications: Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders* 24 SEATTLE UNIV. L. R. (2000) 373.

Kondo and Ross advocating for the establishment of mental health specialty courts (MHCT) explain:

Proponents of therapeutic jurisprudence support MHCT judges and other concerned advocates in participating proactively in the adjudication process as ‘healers’ in a court ‘that restores people to their integrity and overcomes undesirable conditions,’ rather than merely accepting the traditional, generally passive approach to decision-making. Proactive MHCT judges therefore should be expected to exhibit a greater degree of patience, respect, and empathy in their implementation of the judicial process. *Ibid.*, at pp. 445–446.

For links to such courts created in Florida and Washington, DC, and an overview of their place within a vision of the therapeutic jurisprudence movement, see the site of the International Network on Therapeutic Jurisprudence: [www.therapeuticjurisprudence.org](http://www.therapeuticjurisprudence.org).

An important incentive for this emphasis is the recognition that these patients are a population that is “classically voiceless,” friendless, and with few contacts in the “free world,” that they are to be seen as belonging to a “discrete and insular minority” worthy of special legal protection,<sup>17</sup> and that they are persons with mental disabilities who are liable to be socially excluded and silenced due to their classification and labeling as such.<sup>18</sup>

Another incentive for this emphasis is found in the growing legal recognition that hospitalization can at times have antitherapeutic effects.<sup>19</sup>

Research on the psychology of procedural justice<sup>20</sup> and preliminary studies that have explored the attitudes and experience<sup>21</sup> of people participating in commitment proceedings and hospitalized in psychiatric settings have stressed the importance of the consumers’ subjective experience of commitment proceedings and psychiatric hospitalization, which often differs dramatically from that of the committing judge and psychiatric staff.<sup>22</sup>

In the following sections are a description of the method, a presentation of a qualitative analysis of first-person accounts collected through interviews with persons recently discharged from psychiatric hospital, and discussion of the results with an analysis from a patient-centered therapeutic jurisprudence perspective.

## 2. Methods

Individuals who were hospitalized for severe mental illness with psychotic features at the four hospital facilities in the Yale University Department of Psychiatry were asked to participate in the Yale Longitudinal Study if they were between 18 and 55 years old and had no evidence of organic brain disorder or severe alcohol or drug abuse. These patients, originally a cohort of 49, were first assessed during their first posthospitalization year; 43 (87%) completed the bimonthly follow-up interviews during the year.

Subjects ranged in age from 20 to 39, with a mean age of 28 years. As for DSM-III-R diagnoses, 51.2% ( $n=22$ ) received a diagnosis of schizophrenia, 30.2% ( $n=13$ ) a

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

<sup>19</sup> *Wyatt v. Stickney* 325 F. Supp. 781 (M.D. Ala. 1971). Michael L. Perlin, Keri K. Gould, and Deborah Dorfman *Therapeutic Jurisprudence and the Civil Rights of Institutionalized Mentally Disabled Persons: Hopeless Oxymoron or Path to Redemption* 1 PSYCH. PUB. POL. AND L. (1995) 80.

<sup>20</sup> Tyler, *supra* note 3.

<sup>21</sup> Greer, *supra* note 3. Frank R. Farnham and David V. James *Patients’ attitudes to psychiatric hospital admission* 355 *Lancet* (2000). 594 P. Gregoire *The Phenomenology of Psychiatric Hospitalization: The Patient’s Experience and Expectations* 82 ACTA PSYCHIATRICA SCANDINAVIA (1990) 210.

<sup>22</sup> Gary Wirt *Causes of institutionalism: Patient and staff perspectives* 20 ISSUES IN MENTAL HEALTH NURSING (1999) 259.

Table 1  
Demographic characteristics of sample ( $N=43$ )

Demographic variable	Category	<i>n</i>	%
Gender	Male	25	58.1
	Female	18	41.9
Marital status	Never married	33	78.6
	Married	2	4.8
	Divorced	7	16.7
Race	White	35	81.4
	Black	8	18.6
Hollingshead–Redlich social class	I	3	7.0
	II	3	7.0
	III	9	20.9
	IV	12	27.9
	V	16	37.2
DSM III-R axis I diagnosis	Schizophrenia	22	51.2
	Schizoaffective	13	30.2
	Major affective	8	18.6

diagnosis of schizoaffective disorder, and 18.6% ( $n=8$ ) a diagnosis of a major affective disorder with features. The average number of previous hospitalizations of the sample was 4.5. Table 1 displays demographic data for these 43 subjects.

### 3. Instruments

The qualitative analyses were based on data collected<sup>23</sup> from 41 of the 43 subjects. Two subjects were eliminated due to technical problems with their audiotaped interviews.

An initial set of interviews was conducted during patients' hospitalization. After hospital discharge, subjects were interviewed bimonthly for a year using the Yale Longitudinal Follow-Up interview. All the interviews were recorded on audiotape. At the completion of each follow-up assessment, the investigator conducting the interview composed a narrative summary of the interview, which was dictated and transcribed.

The analysis included open-coding case analysis; reviewing of all the interview data; breaking down, examining, and comparing the data for similarities and differences, trying to understand the phenomenon as reflected in the data of each interview; and giving instances names or "conceptual labels" that best captured their essence. The conceptual labels that were placed on discrete happenings, events, and other instances of phenomena were preliminary and tentative at first, serving as flexible working tools. Each segment of data

<sup>23</sup> The authors wish to thank Prof. David Wexler, Prof. A.J. Stephani and Prof. John S. Strauss for their helpful comments on earlier drafts, and Dr. John S. Strauss, Dr. Courtenay M. Harding, Dr. Paul B. Lieberman and Dr. Jaak Rakfeldt who generously shared their data.

Table 2  
Most frequently mentioned topics related to hospitalization

Analyst-constructed topics	<i>n</i>
A. Troublesome aspects	
1. Passivity	14
2. Confrontation with the personal meaning of hospitalization	14
3. Loss of	12
a. how previously perceived by others	
b. “the ease” to meet basic environmental demands	
c. self-esteem	
B. Helpful aspects	10
1. Provides a sense of safety	
2. Interactions with people dealing with similar problems	

(phrase, sentence, paragraph) in every interview was then coded with as many conceptual labels as needed to describe the content of that specific data segment. The conceptual labels were then “grounded” into more abstract categories characterized by unifying “conceptual labels.” This process resulted in analyst-constructed categories<sup>24</sup> selected to elucidate the findings. These analyst-constructed categories are open to challenge and discussion throughout the analysis by presenting them along with the first-person accounts from which they emerged. The process was described in detail elsewhere.<sup>25</sup>

#### 4. Results

Being hospitalized for a psychiatric condition is certainly a major milestone in the course of one’s life. Describing the impact his hospitalization had on him, Ron said “It shook my foundation, made me uncertain about everything.” On the most basic level, leaving the familiar environment in which one lives, the routine and activities in which one is engaged, and becoming a patient in a hospital with its novel set of rules and expectations can be quite traumatic. Furthermore, hospitalization bears a powerful statement about one’s limited competence and capacity for independence. In addition, the experience can threaten one’s self-concept by promoting negative appraisals of self. Understanding the experience of hospitalization requires shifting attention to the subjective meaning it holds for the person: how he or she constructs the experience and makes sense of it. These aspects of patients’ experience of hospitalization are

<sup>24</sup> Michael Q. Patton. *QUALITATIVE EVALUATION AND RESEARCH METHODS* (2nd ed., 1990).

<sup>25</sup> David Roe and Ayelet Ben-Yishai *Exploring the Relationship between the Person and Disorder among Individuals Hospitalized for Psychosis* 62 *PSYCHIATRY: INTERPERSONAL AND BIOLOGICAL PROCESSES* (1999) 370.

often overlooked or poorly understood. The analyst-constructed topics most frequently mentioned by participants are outlined in [Table 2](#) followed by a discussion.

## 5. Troublesome aspects

### 5.1. *Passivity*

Most participants (87.5%) reported experiencing profound passivity, which was generated by the inactive role traditionally offered to patients in a psychiatric hospital. The sharp contrast in roles and distribution of power between staff and patients and the well-defined rules and subtle message that a “good” patient is a “compliant” patient contribute to the experience of passivity. On a less abstract level, simply having little to do can produce a sense of hopelessness and helplessness. The overwhelming sense of passivity seems to be the case in the following three accounts—Peter: “All you did was just sitting around and there was nothing for you to do. There was no program. There was no program to keep you busy and occupied and stuff”; Dan: “It’s not good being on this chronic ward. . . . I stagnate. All I do is sleep and eat and I have no exercise, no opportunity to work out. The food is fattening, so I feel I am getting more out of shape,” and Eric: “It [the hospital] might have gotten me used to laying around and being kind of lazy, making me more lazy than I should be.”

Passivity may intensify already existing doubts about one’s skills and abilities, which then make it more difficult to take the risks that are essential to begin reconstructing a fuller life. Eric, for instance, described how the toxic consequences of passivity made it difficult for him to return to work: “I have not used them [skills] for a while. It’s hard to get a job without experience.” The lack of opportunity to engage in productive activities that preserve existing strengths eat at the heart of confidence and can generate a loss of self. Peter described this experience as follows: “When I was in the hospital, you know, it was like not me being Peter. Somebody else being Peter thinking for me, and I wasn’t doing any of the thinking, you know, I was just sitting there, you know. I was like a lump on a log. That’s what it felt like.”

### 5.2. *Confrontation with the personal meaning of hospitalization*

If mental illness in general is associated with stigma and shame, then psychiatric hospitalization is the ultimate blow. What formerly may have been perceived as a problem, suspicion, or threat suddenly becomes real, confirmed, and defined. This theme was illustrated by Ben, who described his experience of hospitalization as follows: “It is sort of like, ‘these things do not happen to me,’ that sort of feeling, ‘I can’t believe that this is happening to me, I can’t believe that I am having this problem.’”

Peter described his experience as follows:

You know, before I went into the hospital I could think half way straight. But after I came out of the hospital, it was like somebody just tore me apart and left me out in the middle



of the street... It's like a million different things coming to me at once, you know, somebody throwing it right in my face and saying, 'Here it is.'

The symptoms of psychosis may be experienced as irregular, internal, elusive, and dynamic events. Hospitalization is a landmark in that these experiences are classified, subjected to treatment, and gain social meaning. Examining the qualitative information from the participants' interviews reveals that hospitalization generates painful confrontations. Most outstanding are the confrontations with the lack of shared reality and the subjective meaning hospitalization holds.

Behind the "objective fact" of being hospitalized hides the "personal meaning" of hospitalization. Recognizing the subjective meaning often includes confronting painful issues that one may have preferred to avoid and which have now "caught up." This phenomenon was described by one participant as follows:

Yeah, well there is another stressful life event. My sister is getting married October 12th and my birthday is October 21st, and that's what made me have a psychotic episode. Apparently I couldn't deal with the fact that my sister [long sigh] had her life in order, and [pause] and I am so far from having my life in order and my thirtieth birthday is coming up.

In this excerpt Debbie describes enduring tremendous pain and distress regarding her younger sister's wedding, the meaning it held for her, and how it made her feel about herself and her life. She had defined reaching age 30 as a time when perhaps marriage and having children and things that she dreamed about would no longer be possible for her. This gave special significance to that birthday. The issue was exacerbated by the fact that her younger sister, with whom she had unsuccessfully competed throughout her entire life, was about to get married, already had a successful career, and was happy. The subjective meaning of these events seems to have created such internal stress that she decompensated.

Another dimension of the role of the personal meaning of hospitalization is illustrated in the following vignette:

Jacob carried a diagnosis of paranoid schizophrenia for which he had already been hospitalized 13 times before his current admission. In a research interview, he said that the worst thing about his current hospitalization was "accepting that I have a problem, accepting what I am, that I do have a problem. Like I was never in a setting for this long of a period where other people showed the same signs as you show, as I show."

From a solely descriptive perspective, there would seem to be little difference between one's 14th hospitalization and the 13 that preceded it. By adopting a more phenomenological perspective and trying to understand the experience of hospitalization from "inside," the static experience appears to hold a dynamic meaning. The meaning of the experience in turn can determine its impact.



For many participants hospitalization was so dramatic and intense that its deeper implications began sinking in only later. Trying to understand and make sense of their psychotic episode and hospitalization, the events that preceded it, and circumstances that contributed to it often induced a painful reevaluation of their life. This was illustrated by Chris' account:

I guess that I am looking at my life in the hospital and in therapy and I have been very critical of a lot of things, and it's like I have not found a replacement for all of those things I am rejecting. All those great jobs [she used to have], I'm looking at them in a very bad way, . . . I feel very inadequate. . . . I do not know if I do not have the clarity because of the depression, or whether it is simply such an overwhelming task, you know. Whether anything will lift and make it all easier. Right now I feel like there is a lot of closed doors.

### *5.3. Concrete losses derivative of the change in one's perception of one's being*

The experience of psychosis and its consequences often generate painful losses. Even within this general context of loss, hospitalization stands out; as Eric put it, "you go into the hospital and you lose what you had."

Following is a review of the major themes of loss that emerged from participants' accounts.

#### *5.3.1. Loss of how previously perceived by others*

Hospitalization often generates a change in the way one is perceived by others and a loss of one's former public image. Being confronted with others' responses can be an extremely difficult and painful experience. Jackie said that what she found most painful during the period that followed her hospitalization was "finding out who my real friends are and who is there to support me and who is not." She went on to describe the impact of this experience in more detail:

It's changed my life. It's changed my life, not really the treatment but being in a hospital, getting to know who your real friends are, how other people react to you being in treatment. Some people will understand and say 'that's great, you have to do what you have to do.' But some other people think that you are a mental case and you are crazy, and they won't ever talk with you again which I think is very unfair. Who are they to judge?

#### *5.3.2. Losing "the ease" to meet basic environmental demands*

Some participants felt that as a result of hospitalization and life in an unusual setting, they lost basic skills required in order to deal with "real-world" daily demands. As a result, some experienced trouble with mundane tasks which they had long ago mastered. Linda described this experience, poignantly attesting that "there was a certain ease about functioning that I

began to learn since the day I was born, and I had it, and now I have been without it for a year, 17 months, and it is very difficult to re-learn. Like when you come back and you don't know what slot to put the key in. . . .”

Losing “the ease” often transformed objectively uncomplicated activities into subjectively stressful and exhausting experiences as illustrated in Ben's comment: “When I first got out of the hospital, it was extremely difficult. Everything seemed to be a strain. Every interaction. My first day at work was hell.” Linda went on to describe how simple tasks that she used to find easy, like taking a subway ride, were experienced as very laborious during her first weekend out of the hospital after many months:

Just spending a day doing casual things was like exhausting. . . . I didn't have the energy to concentrate on those details, I was concentrating so hard on keeping it together. . . . I spent the last year watching television, basically, and smoking cigarettes. Really literally. And being out is like a struggle, a real fight for me, a lot of work, physically and emotionally.

### 5.3.3. *Loss of self-esteem*

After discussing the passivity and painful losses generated by the experience of hospitalization, it seems almost inevitable that participants' experience of self would be altered. Indeed, for most participants, hospitalization signified a major blow to self-esteem. Linda described her experience in saying, “I was so insecure in the hospital. . . . No one really had confidence in me. . . . I never really got a helping hand or anything. Everything was like ‘No, we don't believe in you,’ you know, rather than, ‘we believe in you.’”

A sense of just how bad hospitalization often made participants feel about themselves was revealed by the fact that hospitalization frequently served as a metaphoric landmark against which the participants often compared their current level of functioning. “Well I am not in the hospital” was a common reply to “how have you been doing?” In fact, participants frequently referred to “staying out of the hospital” as an important goal in its own right and a tangible sign of progress. Jacob referred to the last 3 years, during which he had not been hospitalized, as a record: “First time. Longest ever. I'm doing okay.”

The link between the hospital and the loss of self-esteem was also often expressed directly. Referring to her self-esteem, Jane said, “it dropped when I went into the hospital.” The tight link between hospitalization and loss of self-esteem is illustrated in Annie's experience: “At first, while I was in the hospital, my self-esteem was very low. It was as low as it could go. But now [out of the hospital] I have begun to feel better about myself.” Ben described a similar theme: “I feel like I have more self-esteem now than I had in the hospital. I felt that the hospital experience really took away most of my self-esteem and it is slowly coming back.” Just as the loss of self was associated with hospitalization, the construction of self was viewed as an important buffer and protector from relapse, as Annie describes: “If I didn't have some sense of self or self-esteem I would be in the hospital right now.”

#### *5.3.4. Transition*

Even when patients were optimistic and motivated, leaving the hospital and trying to resume life was not an easy task for them. The inherent difficulties of discharge are described in the accounts. Annie described the process of discharge as such: “Well it has been hard, actually I was having so much trouble they increased my session time to four times a week for a while.” Jackie stated, “I have been dealing, I have been living in reality, the real world. It is pretty difficult. I have been getting depressed a lot.” When asked what she thinks is getting her depressed she answered, “the bills, my not being in work, just having a lot of time.” Karen described her depression as stemming “from everything catching up with me, between being sick for the last seven months, and the hospitalization, and not knowing what is going on and not knowing about what was ever going to happen with me in the end.”

Some participants held a romantic and unrealistic idea of discharge, idealizing it and perceiving it as a magical and immediate end to their problems, which they may have preferred to think were generated solely by the hospital. Kim emphasized how her subjective experience of improvement was more like a process rather than a sudden event, which occurred gradually and over time, saying, “The one thing that has helped with my sickness is time. . . . It takes time to recover from a lost love and so it’s the same situation in sicknesses. You do not get better overnight.” For these individuals, the difficulties they came across at discharge were intensified as their hopes that their problems would suddenly disappear were demolished.

It seems there was an implicit equation in the patient discourse between symptom reduction and recovery in a broader multidimensional and long-lasting sense: Often the narrow focus on symptom reduction generated a marginalization of the often more incremental and subtle processes.

Trying to return to the “real world” and realizing what a long and winding road it is often yield loss of confidence, as Linda described: “It’s different, it is totally different. I use to have this supreme confidence, but now I sort of have to be a more solid being.”

Indeed, many participants appeared uncertain about themselves, their abilities, and their chances to become productive members of society and gain recognition from others as a person. The sense of uncertainty about one’s self was reflected in occasional questions participants suddenly directed to the interviewer. One participant (Peggy) suddenly asked, “Do you think the population is going to tolerate me?” Another man (Randy) spontaneously appealed, “Do you think that I could go back to school?” These incidents teach us something about the extent and depth of participants’ self-doubts during this period. Peter, who was having a relatively smooth and successful adjustment after discharge, said, “I feel quite normal right now. The only thing is the scar from the hospital, ah, that’s still there, I have been very open wounded.”

## **6. Discussion**

A stereotypic conceptualization of legal decision-making processes as uniform weighing of objective criteria through accurate formulae may lead to a dismissal of the first-person

accounts brought forward here as irrelevant or useless for these processes; they might be perceived as too fuzzy in a supposedly accurate objective legal world.<sup>26</sup> However, extensive literature<sup>27</sup> enables us to offer an alternative perspective: We propose that legal processes—inevitably forcing on us a choice between different accounts and their weaving and reweaving together by adversary parties and a human personal judge—pose a serious risk to the mental health patient. There is nothing new about the proposition that people suffering from severe mental illness are silenced, but we suggest that there is value in the novel recognition that just like the patient’s account, the experts’ accounts are subjective accounts competing for recognition as what is misperceived as objective truth and is in fact only another account aspiring to come closer to truth. The first-person accounts of mental health patients are liable to be normatively silenced being accounts of “the other,” “the outcast,” “the discrete minority,” or “the excluded” if we do not purposefully create a place for them within legal discourse as we do here<sup>28</sup>—law as a system has a propensity to exclude.<sup>29</sup> Relating to the participants’ first-person accounts inevitably utilizes the decision maker’s empathic capacity. Different stories invite empathy and antipathy towards different individuals whether we admit it or not.<sup>30</sup> Conscious purposeful empathy through focus on the account of the “other” may allow the decision maker an opportunity to overcome his own personalized culture-bound biases<sup>31</sup> and come closer to an understanding of the “other’s” counterstory,<sup>32</sup> thus minimizing his “otherness.” In our case, it is the recently emerging counterstory of the mental health patient, often socially excluded.<sup>33</sup>

<sup>26</sup> Minow, *supra* note 6. Peter Bayer *Not Interaction but Melding—The ‘Russian Dressing’ Theory of Emotions: An Explanation of the Phenomenology of Emotions and Rationality with Suggested Related Maxims for Judges and Other Legal Decision Makers* 52 *MERCER L. REV.* (2001) 1033. Peter Brooks *DEPLOYING LAW AND LEGAL IDEAS IN CULTURE AND SOCIETY: LAW, THERAPY, CULTURE* 13 *YALE J. L. & HUMAN.* (2001) 227. Jan M. Van Dunne *Narrative Coherence and Its Function in Judicial Decision Making and Legislation* 44 *AM. J. OF COMP. L.* (1996) 463. Robert Delgado *Storytelling For Oppositionists and Others: A Plea For Narrative* 87 *MICHIGAN L. REV.* (1989) 2411. Lynne Henderson *Legality and Empathy* 85 *MICHIGAN L. REV.* (1987) 1574.

<sup>27</sup> See e.g. Robert Cover *Nomos and Narrative* Martha Minow, Michael Ryan, and Austin Sarat (Eds.) *NARRATIVE, VIOLENCE AND THE LAW—THE ESSAYS OF ROBERT COVER*. The University of Michigan Press (Ann Arbor, 1998a) 95. Peter Brooks and Paul Gewirtz (Eds.) *LAW’S STORIES—NARRATIVE AND RHETORIC IN THE LAW* (New Haven, 1996). Bellow and Minow, *supra* note 7.

<sup>28</sup> Perlin, *supra* note 5, Mootz, *supra* note 4, Winnick, *supra* note 3, Delgado, *supra* note 29, Anthony Alfieri *Disabled Clients, Disabling Lawyers* 43 *Hastings L.J.* (1992) 769, 811. Anthony Alfieri *Welfare Stories* Gary Bellow and Martha Minow (Eds.) *LAW STORIES* The University of Michigan Press (1998, Ann Arbor) 31. Martha Minow *Stories in Law* Peter Brooks and Paul Gewirtz (Eds.) *LAW’S STORIES—NARRATIVE AND RHETORIC IN THE LAW* (New Haven, 1996) 24.

<sup>29</sup> Minow, *supra* note 30, Brooks, *supra* note 29.

<sup>30</sup> Minow, *supra* note 6, Minow, *supra* note 30.

<sup>31</sup> Bayer, *supra* note 29, Minow, *supra* note 30, Henderson, *supra* note 30.

<sup>32</sup> Delgado, *supra* note 29, Minow, *supra* note 6.

<sup>33</sup> E.g., Winnick, *supra* note 3, Greer, *supra* note 35, Kondoy and Ross, *supra* note 16, Bruce Arrigo and Christopher Williams *The Ethics of Advocacy for the Mentally Ill: Philosophic and Ethnographic Considerations. Conference on Therapeutic Jurisprudence: Issues, Analysis, and Applications* 24 *SEATTLE UNIV. L. R.* (2000) 245.

Law's unique nature makes it more difficult than we typically assume to recognize in legal decisions the individual's experience and the pain these decisions cause and to respond to these in a humane way.<sup>34</sup>

The typical nature of psychiatric hospitalization as experienced by the participants in the study emphasized the importance of overcoming such difficulty in the context of the decision concerning hospitalization through recourse to the patient's account. We purposefully speak of an account in singular here despite the richness and diversity of experience based on the assumption that we must be attentive to a counterstory of an excluded group in order for it to emerge. This general assumption is supported in our context by evidence of often-dramatic difference between the subjective experience of patients and the perceptions of hospital staff concerning hospitalization.<sup>35</sup>

Turning to our field findings, we learn that, in general, participants in the study were admitted to the hospital in a state of intense crisis and at a time when they exhibited psychotic behavior. The simple fact that essentially all of the participants were symptomatic at the time of discharge suggests that patients may gain much while in the hospital. Indeed, participants emphasized the beneficial effect of the sense of safety the hospital provided and the opportunity it offered to interact with people dealing with similar problems.

Participants' self-reports suggest that hospitalization is probably one of the most challenging experiences in the course of illness and recovery. The sudden change in physical setting, interruption of a familiar routine, and the fact that hospitalization usually occurs at one of the lowest points of one's illness, and often at the lowest point of one's life all together, contribute to its distinction. In addition, the losses associated with and generated by hospitalization are profound: being perceived differently by others, losing the ease to deal with basic demands, and the grief generated not only by the current interruption to one's life and routine, but also by the loss of future opportunities. Furthermore, the experience of hospitalization often confronts patients with hidden wounds, which become difficult to ignore.

Participants generally appeared pleased to leave the hospital. Gradually, however, participants came to realize that despite the progress they had made, several obstacles still stood in their way. Adjusting to life outside the hospital was usually difficult, and skills to deal with "real-world" demands often needed to be relearned after being lost during hospitalization. In addition, participants came to recognize that improvement was more like a process than an event that ended with discharge. This theme was best captured in the title that Ben applied to this period immediately following discharge: "Ben's life: getting better but still far to go."

The experience of psychiatric hospitalization points, therefore, to its unique characteristics, which the decision maker should attempt to take into account in the context of the specific patient's case.

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<sup>34</sup> Cover, supra note 10, Perlin, supra note 9. Dan Simon *A Psychological Model of Judicial Decision Making* 30 RUTGERS L. J. (1998) 1.

<sup>35</sup> Wirt, supra note 24.

In the American court case of *Wyatt v. Stickney*,<sup>36</sup> which is characterized as the most important case finding a constitutional right to treatment and the foundation of modern psychiatric jurisprudence in American law,<sup>37</sup> the court affirmed both the risk that psychiatric hospitalization may not help but rather hinder the curing of the individual of mental illness and that hospitalization cannot be justified unless one can point to therapeutic gains.<sup>38</sup> Using the rule set in this case as a starting point, we suggest that our research offers the decision maker practical tools to assess the relative therapeutic gains and losses of hospitalization and thus to make the law governing hospitalization more therapeutic.

In particular, he may be less prone to a dismissal of the patients' objections to hospitalization due to overpathologization. He may learn to recognize their universal nature and thus may feel more confident to relate to them through empathic understanding. Empathic understanding of the participant's account may come to be perceived less as a risk to the rational decision-making process and more as a decision-making tool.

Within this general framework, we now aim to utilize the participants' first-person accounts to formulate specific considerations pointing to potential drawbacks of psychiatric hospitalization.

Beyond the benefit of overcoming an unintentional bias in the estimation of credibility, the decision maker may benefit from such accounts by distilling from them specific considerations to be weighed when considering hospitalization in relation to other options. He may see how each of the options and how different professionals are responsive to the concerns to these considerations.

The succeeding sections summarize the considerations distilled from the participants' first-person accounts as to troublesome aspects of hospitalization.

### 6.1. *Passivity*

A sense of passivity originating from the experience of hospitalization can generate self-doubts and loss of self. These inner feelings in turn influence decisions and actions. The experience of self as passive, for instance, can discourage taking an active role in looking for a job, participating in treatment decisions, moving into a more independent living setting, or initiating social contact. Passivity, which discourages initiative, may hinder improvement and complicate one's future course and outcome.

We learn from the participants that the sharp contrast in roles and distribution of power between staff and patients and the well-defined rules and subtle message that a "good" patient is a "compliant" patient contribute to the experience of passivity. On a less abstract level, simply having little to do can produce a sense of hopelessness and helplessness.

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<sup>36</sup> *Wyatt v. Stickney* 325 F. Supp. 781 (M.D. Ala. 1971).

<sup>37</sup> Perlin, Gould, and Dorfman, *supra* note 19.

<sup>38</sup> *Ibid.*



## 6.2. *Confrontation with the personal meaning of hospitalization*

Although mental illness in general is associated with stigma and shame, psychiatric hospitalization may be commonly perceived as “the ultimate blow,” as most stigmatic, and shameful. What formerly may have been perceived as a problem, suspicion, or threat, suddenly becomes real, confirmed, and defined and this may be disheartening and disempowering to the individual struggling to overcome difficulties.

## 6.3. *Concrete losses derivative of the change in one’s perception of one’s being*

### 6.3.1. *Loss of how previously perceived by others*

As explained, hospitalization often generates a change in the way one is perceived by others and a loss of one’s former public image. Being confronted with others’ responses can be an extremely difficult and painful experience.

### 6.3.2. *Losing “the ease” to meet basic environmental demands*

Hospitalization can rob the patients of the most basic skills that are required to adjust to and deal with life outside the hospital. Leaving the hospital less symptomatic but also less competent is a mixed result. It is vital to consider these more subtle consequences of hospitalization because they have an important impact upon improvement beyond simply becoming “symptom-free” and may contribute to stress and symptoms after discharge.

### 6.3.3. *Loss of self-esteem*

It is inevitable that participants’ experience of self would be altered by hospitalization and indeed we learn from the participants that hospitalization generally signified a major blow to self-esteem.

These findings are consistent with Goffman’s<sup>39</sup> classic finding that changes in self-concept are important in creating and maintaining the patient role. He argued that psychiatric hospitals, in order to run more effectively, “convert” patients by stripping away their former identities and replacing them with a patient identity. In the course of this process, patients gradually come to believe and act according to the sick/patient role and thus find a basis for failing to adjust to life outside of the hospital into someone who is dysfunctional and devalued by self and others. Estroff<sup>40</sup> draws our attention to the frequency with which family members of persons with schizophrenia draw contrasts between the person they knew before the illness and the very changed person they now witness. It is as though schizophrenia is an “I am” phenomenon during which the self is engulfed by the disease and one’s identity taken

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<sup>39</sup> E. Goffman, *ASYLUM: ESSAYS ON THE SOCIAL SITUATIONS OF MENTAL PATIENTS AND OTHER INMATES*. (New York, 1961).

<sup>40</sup> Sue E. Estroff *Self, identity, and subjective experiences of schizophrenia: In search of the subject*. 15 *SCHIZOPHRENIA BULLETIN* (1989) 189–196.



hostage by the diagnosis. Patients often seem to “be” their illness. Such a patient has lost his or her sense of self, or the self has been so altered that it seems as though a different identity has taken over. It has been suggested that a person undergoing a psychotic episode may be particularly vulnerable to incorporating the patient role in his or her own identity because any identity, however negative, serves to organize experience more effectively than does no identity at all.<sup>41</sup>

#### 6.3.4. *Troublesome transition*

There is an implicit equation in the patient discourse between symptom reduction and recovery in a broader, multidimensional, and long-lasting sense: The narrow focus on symptom reduction often generated a marginalization of the more incremental and subtle processes.

The term role engulfment was modified by Lally<sup>42</sup> to engulfment to emphasize the subjective and intrapsychic aspect of the process of hospitalization.

Using qualitative methodology, Lally<sup>43</sup> identified three stages of the engulfment process. In the early stage, patients deny and minimize their psychiatric problems, compare themselves with less fortunate individuals, and thus view themselves as better off than others. In the middle stage, patients accept that they have psychiatric problems, but minimize their potentially devastating implications and meaning by focusing primarily on normality and the commonality of mental illness. In the final stage (“true” engulfment), an all-encompassing definition of self as “mentally ill” is established. Loss of hope, acceptance of a life with illness, and a deep sadness for the loss of a previous and future life without illness characterize this stage. Our findings and those of Lally seem to be mutually supportive—understanding of the meaning of hospitalization from the patient’s perspective. Such an understanding may enable law to be more responsive and less reactive or defensive in relation to the patient’s experience, despite the patient’s often socially deviant behavior. We may thus come closer to relating to the patient as a unique human being deserving dignity as such, a person whose story is heard and also understood.

<sup>41</sup> Michael Gara, Seymour Rosenberg, and Bertram Cohen *Personal identity and the schizophrenic process: An integration* 50 *PSYCHIATRY* (1987) 267–279.

<sup>42</sup> SJ. Lally (1988). HOW PSYCHIATRIC PATIENTS BECOME ENGULFED IN A MENTALLY ILL SELF-CONCEPT: ‘DOES BEING HERE MEAN THERE IS SOMETHING WRONG WITH ME?’ Unpublished Ph.D. dissertation, The University of North Carolina at Chapel Hill (Chapel Hill, 1988). SJ. Lally *Does being here mean there is something wrong with me?* 15 *SCHIZOPHRENIA BULLETIN* (1989) 253–265.

<sup>43</sup> *Ibid.*