Civil Commitment to Outpatient Psychotherapy: A Case Study

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Commitment to outpatient psychiatric treatment evolved in the courts to protect patients' right to freedom from compulsory hospitalization. This ruling has been criticized by the psychiatric profession, who prioritize treatment rather than liberty. The following case demonstrates the use of commitment as a therapeutic tool in the psychotherapy of a woman with severe borderline pathology. Although the use of coercion in psychotherapy is controversial, its potential use and its ramifications on transference and countertransference issues are dicussed.

The current option of legal commitment of patients to the "least restrictive alternative" treatment arose out of Chief Judge David Bazelon's decision in *Lake v. Cameron* in 1966.[1] This ruling states that an individual assessed to be both mentally ill and dangerous could not be committed to an inpatient psychiatric hospital if a less restrictive environment was available for treatment. For example, a nursing home is considered less restrictive than a psychiatric hospital, and outpatient treatment is considered less restrictive than inpatient care. This ruling resulted from the court's attempt to protect the patients' constitutional right to liberty. Although it grew out of the clinical deinstitutionalization movement, the legal ruling has received considerable criticism from the psychiatric profession.[2] The psychiatrist, acting as physician, places the treatment and care of patients as first priority; the law, however, finds liberty to be an unalienable right to be protected at all costs. This conflict between the patients' rights versus their needs causes continual friction between the legal and health care systems.[3,4]

The growing literature on outpatient civil commitment focuses on its use as an alternative to inpatient commitment.[5-9] Two studies have been done examining outcomes of cases utilizing commitment to a less restrictive outpatient setting. Hiday and Goodman[10] show a hospital readmission rate of 15 percent of patients during the outpatient commitment period. Their study, however, does not examine differences in diagnoses or methods of treatment. It merely shows that dangerousness was not sufficient in 85 percent of cases to cause an involuntary admission. Miller

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and Fiddleman[11] found outpatient commitment to be used in less than 5 percent of commitment cases in North Carolina, with the chief resistance to its use being the Community Mental Health Center staff's reluctance to treat unwilling patients. Patients under commitment were seen as noncompliant, chronic, and more dangerous than other clients.

Some psychiatrists view outpatient commitment as useful with chronic schizophrenics on long-acting neuroleptics or manic-depressives on lithium carbonate, in whom maintenance medication prevents relapse and the patients have impaired judgment regarding their need for treatment. Szasz[12] and others object to this use of involuntary treatment as with *any* coercion of the mentally ill. Commitment to outpatient psychotherapy is still more controversial. With few exceptions, external coercion is seen as too big a stumbling block to the patient's improvement.[13] The following case is an example of one potential use for outpatient commitment for psychodynamic psychotherapy.

Case Study

Mrs. G. is a 41-year-old white, divorced mother of three. Her symptoms of feeling "different" date back to adolescence and her persistent depression resulted in over 20 psychiatric hospitalizations, numerous suicide attempts, homicidal feelings toward and finally loss of custody of her children, chronic alcohol abuse, and eventually, permanent unemployment due to psychiatric disability. Over the years she had been evaluated by more than 15 psychiatrists and was prescribed tricyclic antidepressants, lithium, monoamine oxidase inhibitors, minor tranquilizers, and even amphetamine, all with little success. Her reputation as being unlikable and untreatable grew with each hospitalization.

In her most recent six-month hospitalization, in which she received intensive psychotherapy, a behavior modification treatment, and chemotherapy (imipramine and trifluoperazine), discharge was continually delayed because of repeated suicide threats. Her diagnosis had been "borderline personality, severe, with suicidal ideation and chronic depression." When she was finally discharged she discontinued her medication, refused any outpatient treatment, and drank heavily. One month after discharge, she became inebriated and loaded her gun in order to commit suicide. Her 19-year-old son convinced her to come to the hospital. On admission, there was no evidence of psychosis; however, her persistent feeling that she was in some way "different" from other people was intensified. Her numerous somatic complaints included tiredness and feeling as if something in her were "dead." She felt utterly hopeless about the future; she viewed suicide as her only method of solving her problems. She agreed to be admitted as a voluntary patient.

Upon admission to the psychiatric ward, several problems presented themselves. The patient was so disliked by the staff that "punitive" treatments (e.g., bedrest until discharge) were suggested. Staff expressed feelings of hopelessness and, although there was general agree-

ment that the patient remained a serious suicide risk, rapid discharge was anticipated. Staff education focused on how to approach the "disliked patient."[14] Her psychopathology was defined as her need to alienate people, which kept her isolated and victimized. The therapist's conviction that the patient was amenable to treatment seemed to alleviate some of the staff's despair.

The therapist began psychodynamic psychotherapy three times a week. The chief issues were the patient's narcissistic grandiosity, intense depression over her intrusive and highly critical mother, and anger at the incompetence of previous therapists. Although never expressing anger at the present therapist, she expressed pessimism regarding any successful outcome. She never missed a session. The most consistent difficulty was persistent somatization. Any inquiry as to how the patient felt was answered with complaints that she was tired or having menstrual cramps or a toothache. Throughout the entire treatment, the patient never moved from her somatic complaints to her emotional pains and conflicts. All the physical symptoms were taken seriously by the therapist, both in an attempt to establish an empathic relationship and also to be sure she did not have underlying physical pathology contributing to her psychiatric disorder.

Her endocrine workup did reveal a pituitary microadenoma that was producing hyperprolactinemia. At the recommendation of the endocrinologist, she was started on bromocriptine to reduce the serum prolactin. Her previous medications of trifluoperazine and imipramine were discontinued. She was given benzodiazepines as the occasion arose to control anxiety.

The goal of psychotherapy was to engage the patient sufficiently so that she might be able to continue as an outpatient. After four months, Mrs. G. agreed to continue in outpatient therapy after discharge. A discharge date was set for several weeks hence and, despite evidence of increased anxiety and hopelessness, the patient was discharged. The following day she was scheduled to see the therapist. Instead, however, she became drunk, missed the session, and then returned to the emergency room with suicidal intention. There were no beds available for readmission and, despite strong protest from the patient, she was placed on a temporary involuntary commitment and admitted to the local mental health center. The patient was initially furious because of this and she seemed to organize rapidly, agreeing to follow outpatient therapy if allowed to leave. The therapist proposed a 30-day outpatient commitment in order to avoid repeated temporary involuntary commitments on readmissions. The court agreed and the patient was discharged.

The therapy now changed considerably. The anger that had been reserved for previous therapists was now directed against the present therapist because of resentment at the commitment. All talk of suicide disappeared. Again the patient never missed a session, despite continually complaining. Her alcohol intake diminished and she began to take the

bromocriptine regularly as prescribed. She continued to complain of somatic symptoms and denied feeling any improvement; however, she looked markedly better than she had during the entire previous hospitalization.

Inspired by this small improvement with the commitment, this line of therapy was pushed. A petition was sent to the court for a six-month outpatient commitment that included not only the provision to come to therapy biweekly but, in addition, that the patient was to comply with several of the therapist's requests: to turn her gun over to the therapist, to clean her own house, to agree to regular home visits by the therapist to ensure she was taking care of her son, to search for work, to keep a journal of her progress in these efforts, and, finally, to become employed within two months of the court hearing. The patient and her court-appointed lawyer were present during the therapist's explanation for the need of this intense treatment in order to prevent Mrs. G's suicide. Despite her previous dissatisfaction with this arrangement, the patient remained silent during the hearing and offered no support to her lawyer, who argued against the commitment. The judge asked why inpatient commitment was not being requested if the patient was so ill as to require such an extensive treatment commitment. It was emphasized that hospitalization had failed in the past and that outpatient treatment seemed to show more promise. Although it was an unusual petition, the court granted the commitment with the provision that if the patient did not follow the treatment, she would be admitted to the state hospital for the duration of the six months.

The therapy continued as before, with the patient continually griping about the treatment and, yet, complying with all the provisions. Within two months she was employed babysitting for three toddlers. She invited her own children to visit her for the summer and kept functioning adequately. She even began to visit her neighbor who "understands my problems better than any doctor ever could." Her anger and negative feelings continued to flourish; she accused the therapist of having ulterior motives in treating her in order to compete with colleagues. When the six-month commitment was over she continued the treatment, now saying that she agreed to the sessions in order to further the therapist's education. She never admitted that the psychotherapy was beneficial or that there was any pleasurable component in being the object of concern and attention.

Therapy was terminated when the therapist began a pregnancy leave. The patient now showed a new interest that had not previously been noticed. She began to identify with the therapist and give advice about having children and being a successful mother.

At the time of outpatient termination she was readmitted to the hospital. The staff saw her as much improved since her admission nine months previously. She remained in the hospital for one month and was discharged with a referral to a new therapist, whom she saw only three times. However, she was able

to remain out of the hospital and functioning in the community with only three brief hospitalizations for alcohol treatment over the next two years. She was seen by the therapist most recently by chance in a general medical clinic where she was treated for a newly diagnosed mitral valve prolapse. She had been involved in a vocational rehabilitation program and was about to begin training at the local technical institute. She had once again had her children home for the summer and had done well. At the time of this last meeting, she inquired if, perhaps, she could resume treatment with the therapist in the future.

Discussion

First, the granting of such an elaborate and unusual petition required exceptional cooperation between the court and the therapist. A working relationship between the two had evolved over several years. The court's conviction that the therapist was dedicated to sound treatment and not seeking excessive monetary gains was essential to the granting of the order. The petition itself stemmed from the therapist's belief that the court was an ally in the treatment of the mentally ill. This cooperation was an essential ingredient to the satisfactory outcome of the case.

Secondly, the commitment had an impact on the therapeutic process in many ways. It had the effect of extending the relatively secure holding environment of the hospital to the outpatient setting. This patient's ego functioning was so weak that the support that is usually offered in a therapeutic relationship appeared to be insufficient to ward off overwhelming hopelessness and suicidal feelings. The concrete legal document provided an awareness of obligations and perhaps a feeling of security because of the definite limits. The therapeutic relationship included an intense negative transference, preventing the patient from coming to the sessions without feeling overwhelming depression. When the anger became targeted at the commitment, and indirectly at the therapist, it became not only more tolerable, but even expressable without a great deal of disharmony between thought and feeling. The patient was now able to identify a logical reason for the anger, apparently easing the internal conflicts. She externalized her commitment to the therapy into an "outside of herself" legal commitment. Without these limits, the patient had been unable to establish and enter into a therapeutic alliance.

The need for intimacy and being cared for made this patient so vulnerable that she was only able to tolerate a commitment to therapy if she disavowed it, proclaiming that therapy was useless and that she only came because she was forced to do so. This allowed the patient to maintain the victimized role with assurance that she would not be rejected.

The court commitment was double-faceted; not only was she obligated to see the therapist in treatment, but the therapist was committed as well. So the patient's anger and negative feelings had more free reign in expression because there was less fear of abandonment, rejection, and loss of love object. This

freedom apparently allowed these feelings to be worked through more effectively than before.

It is difficult to assess the degree of impact of the treatment of the pituitary adenoma on this woman's improvement. It is reported[15] that when emotional effects of lowering serum prolactin occur, they do so within six weeks of initiation of treatment. Because this woman was on bromocriptine several months before she began to respond in psychotherapy it seems unlikely that the hyperprolactinemia was a significant variable in the overall treatment.

This woman's constant complaining and denying any improvement aroused in the therapist countertransference feelings of inadequacy and failure, followed by anger and a desire to reject. The legal commitment decreased the therapist's fears of failing in the treatment of this severely suicidal and perhaps homicidal woman. It was a concrete way of admitting the patient for protection and inpatient therapy at a moment's notice without the cumbersome legal dealings of initiating a further hearing. The therapist also had society's support in the form of a legal document in this frightening endeavor. Being free of this anxiety went a long way in making the therapist more tolerant of this unlikable, ungrateful, and rejecting woman and in promoting a calm, thoughtful approach to the psychic material she brought to the sessions.

There remains the question of external coercion being countertherapeutic. In this case however, the patient had sufficient drive, verbal skills, and knowledge of the legal system that she could have convinced the court that she was not mentally ill and that the commitment was not justified. Her passive silence in the courtroom was admission, albeit nonverbal, of her desire and acceptance of treatment. Further, she had the option of testing the commitment by refusing to attend therapy or by remaining silent in the sessions. Instead she talked openly and with affect about her miserable life, including the compulsory therapy.

Conclusion

The many variables in this case prevent one from concluding that outpatient commitment was *the* key ingredient to a successful outcome. The personality of the therapist, the cooperation between court and hospitals, and the intrapsychic conflicts of this patient were all necessary elements in the orchestration of this unusual treatment. The case does suggest that outpatient civil commitment may be a useful therapeutic tool in situations such as weaning from a long-term hospitalization, setting limits on violent behavior, and establishing a working relationship in the face of a patient's overwhelming negative transference feelings. Further case reports and controlled studies are needed to evaluate this potential.

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