Patients' Attitudes Toward Having Been Forcibly Medicated

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Forced antipsychotic medication procedures are generally perceived to be clinically necessary options, albeit violations of individuals' bodies and autonomy. Previous studies have explored forcibly medicated patients' attitudes concerning these procedures, but as patients were interviewed while still in the hospital, this may have affected their responses. We interviewed consecutively forcibly medicated English-speaking acute-care inpatients after their discharge to the community. The interviews were conducted by telephone by a clinician not involved with their treatment. Of 65 such patients, 7 had already been rehospitalized, 3 could not recall the procedure, and 25 others refused the interview or were not locatable. Of the 30 who were successfully interviewed, only 47 percent had received any forced injections; the remainder had accepted oral medication under duress. Recollecting their experiences, 57 percent professed fear of side effects, 17 percent feared "addiction," and 17 percent objected to others' controlling them. Forty percent recalled feeling angry, 33 percent helpless, 23 percent fearful, 13 percent embarrassed, but 23 percent were relieved. Surprisingly, 60 percent retrospectively agreed with having been coerced, 53 percent stating they were more likely to take medication voluntarily in the future. Other forcibly medicated patients had poorer outcomes, such as rapid readmission or discharge to a state hospital: those patients may have harbored more negative feelings. However, a substantial fraction of the patients who were reached in the community appeared to support having received medication forcibly as inpatients.

Forcing an unwilling inpatient to receive antipsychotic medication has been perceived by some to be an unnecessarily coercive, perhaps traumatic, and possibly even punitive assault on a person's privacy, and, in view of possible adverse reactions including neuroleptic malignant syndrome and the extrapyramidal syndrome of tardive dyskinesia, an action fraught with medically dangerous potential. Such concerns led to legal limitations on psychiatrists' forcibly prescribing such medications, beginning with the landmark *Rogers* case in Massachusetts, which mandated a judicial review to determine whether nonemergent medication could be administered forcibly to inpatients.[1] In New Jersey, similar concerns

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led to limitations to be adjudicated through a clinical administrative process, rather than a judicial hearing and determination.[2] Concerned psychiatrists objected that these new limitations would cynically allow patients to "rot with their rights on."[3, 4] The psychiatric community has since accommodated to the new procedures, and it appears that review proceedings typically support psychiatrists' petitions to forcibly medicate in 70 percent to 100 percent of instances.[5] Nonetheless, other drug-refusing involuntary patients may never even be brought to a review, and it remains unclear what outcomes they experience.

Judicial concerns, while understandably responsive to disturbing accounts of poor psychiatric practice in some state hospitals in the 1960s and 1970s,[6] have often been grounded on a biased, distrustful view of physicians all too willing to engage in unneeded, intrusive, and risky practices, victimizing patients who could competently express autonomous wishes.[7] Judges may also overestimate risks of tardive dyskinesia.[8] Judges, however, do not work on inpatient units. (Such experience could be influential: the brief experience of a psychiatric clerkship persuaded medical students to subsequently view involuntary psychiatric treatment more positively.)[9] We have been aware of patients who, having been forcibly medicated and subsequently having improved clinically, clearly supported such earlier violation of their expressed wishes. One patient, in fact, indicated to us a desire to sue the previous facility in which he had been hospitalized for failing to medicate him against his wishes, thereby prolonging his incarceration in a psychotic state. Seide *et al.*[10] conducted a pilot study of 11 such patients' subsequent attitudes, which together with an earlier study by Schwartz *et al.*[11] are the only studies we are aware of that examined patients' attitudes after they had clinically improved, toward having been forcibly medicated. Both of these study designs included particular methodological limitations, some of which we undertook to address in this study.

Methodology

As in other states, New Jersey physicians may prescribe one emergent dose of medication forcibly at a time of immediate danger. This authority is generally perceived to be a noncontroversial necessity. In accordance with the *Rennie v. Klein* ruling,[2] New Jersey statutes also stipulate two possible procedures for more substantial forced medication of inpatients who have not been court-declared incompetent. One is an "emergency 72-hour" order, which may be instituted by a physician who determines that there is "a substantial likelihood that the patient will harm him/her self or others or that the patient's health will be significantly impaired, in the reasonably foreseeable future" and which may apply to a voluntary or involuntary inpatient for up to 72 hours. The other procedure is the *Rennie* nonemergent procedure, applying exclusively to involuntary inpatients and potentially lasting for the duration of hospitalization, which may be invoked by the institution's medical director in the case that he or she determines that such medication is "a necessary part of the pa-

tient's treatment plan."[2] *Rennie* follows the U.S. Supreme Court's *Youngblood v. Romeo*[12] standard in accepting the adequacy of qualified professional judgment in determining medical necessity, rather than requiring a judicial determination of incompetency, in overriding an involuntary patient's refusal of medication.

We studied adult psychiatric inpatients forcibly medicated by either the "emergency 72-hour" or *Rennie* procedures over a 15-month period (1993–1994) in a general county hospital with a 220-bed acute psychiatric inpatient service, serving a suburban, predominantly middle-class Caucasian community. We attempted to interview English-speaking patients who had received community discharges by telephoning them several weeks after their discharge, using a brief structured format that included questions about patients' recalled emotions and rationales for refusing medication and current opinions of their coerced medication experience (the latter questions were similar to those asked in the study of Schwartz *et al.*). Patients were asked to respond to all questions with one of three answers: agree, disagree, or unsure (Seide *et al.*, in our earlier unpublished pilot study, used a five-point Likert scale, but found it difficult to get some patients to respond definitively to shades of agreement or disagreement).[10] Interviewees could endorse multiple recalled emotions and rationales. We felt that by interviewing patients by telephone a suitable period after discharge, it would be less likely that they would feel they had to hide any negative feelings. We informed patients before their discharge that they might expect such a call. Interviewers (the three authors) had not been involved with the patient's inpatient treatment, and on contacting patients explained the purpose of the study, its confidentiality and lack of effect on their treatment, and encouraged honest replies.

After discharge, patients' charts were reviewed for clinical and demographic data, including the number of forced injections patients actually received via these procedures. Hospital records were also reviewed to determine the number of admissions and total hospital days these patients had experienced in the county hospital for the period of two years previous to the index admission date.

This study did not include any of the data of the earlier unpublished pilot study at our institution.[10] This protocol was approved by the Bergen Pines Institutional Research Review Committee. We used Systat Macintosh version 5.2.1 for statistical analyses. Chi-square and *t* tests were two-tailed; *t* tests used independent measures.

Results

Eighty adult psychiatric inpatients were treated with emergency 72-hour or *Rennie* forced medication over the study period, but only 65 met the study criteria (9 were transferred to another hospital, 4 were returned to jail from our forensic service, 1 was discharged to South America, and 1 patient was not English-speaking). We waited at least one to two weeks after discharge before attempting to contact the patient, but the process of successfully obtaining an interview not infrequently took several additional weeks. Of

Table 1
Patient Characteristics

	Interviewed (N = 30)	Not Interviewed (N = 35)
Average age (years)	42.1	41.9
Gender (females)	21 (70%)	20 (57%)
Ethnicity		
White	21 (70%)	27 (77%)
Black	5 (17%)	6 (17%)
Hispanic	3 (10%)	0 (0%)
Asian	1 (3%)	2 (6%)
Index hospitalization (total days)	50.8	49.8
Hospitalizations previous 2 years	1.5	1.7
Hospitalized days previous 2 years	44.1	44.6
Number of forced injections (mean)	1.0	1.1
Principal discharge diagnosis		
Schizophrenia, schizoaffective, schizophreniform	17 (57%)	22 (63%)
Bipolar, manic, or mixed	9 (30%)	8 (23%)
Other	4 (13%)	5 (14%)
Substance use disorder	4 (13%)	8 (23%)
Rationale for forced medication		
Suicidal	4 (13%)	5 (14%)
Violent	16 (53%)	23 (66%)
Rennie procedure used	13 (43%)	15 (43%)

the 65 patients meeting our criteria, 7 were readmitted too rapidly to be contacted while still outpatients, 19 patients were not locatable, 6 were contacted by telephone but refused the interview, and 3 patients were contacted by telephone but could not recall the forced medication procedure. The remaining 30 usable telephone interviews occurred an average of 30.3 days after discharge.

As indicated in Table 1, the 30 interviewed patients averaged 42.1 years of age, had a relatively lengthy index hospitalization of 50.8 days, reflecting both the severity of their illness and some delay in being adequately medicated, which was related to their refusal of medication (forced medication procedures were approved an average of 14.1 days after admission, although some patients had taken medication sporadically during this period). The interviewed patients had ethnic composition and discharge diagnoses similar to those of the general adult hospital population. Interviewed patients averaged 1.5 county psychiatric hospitalizations for 44.1 total hospitalized days within the two years previous to the index admission. During the index hospitalization, they received an average of only 1.0 intramuscular injections of medication via the forced medication procedures (although the medication was "forced," only 47% of the group actually received any of these injections at all; the others accepted medication orally when told they would

Table 2
Patient Interview Responses (N = 30)[a]

	Agree	Disagree	Unsure
	(%)	*(%)*	*(%)*
Rationales for refusal			
Feared side effects	17 (57)	9 (30)	4 (13)
Believed nothing was wrong with me	9 (30)	16 (53)	5 (17)
Feared being weakened by medication	6 (20)	19 (63)	5 (17)
Felt medication was "poison"	6 (20)	22 (73)	2 (6)
Did not want anyone telling me what to do	5 (17)	18 (60)	7 (23)
Feared getting "addicted" to medication	5 (17)	20 (67)	5 (17)
Was confused at time	3 (10)	22 (73)	5 (17)
Another patient urged me to refuse	1 (3)	25 (83)	4 (13)
Family member urged me to refuse	0 (0)	24 (80)	6 (20)
Recalled emotions at time of forced medication			
Angry	12 (40)	13 (43)	5 (17)
Helpless	10 (33)	15 (50)	5 (17)
Fearful	7 (23)	17 (57)	6 (20)
Relieved	7 (23)	15 (50)	8 (27)
Embarrassed	4 (13)	21 (70)	5 (17)

[a]In addition to sometimes providing ambivalent answers to a given question, patients also occasionally failed to answer at all or gave only an irrelevant response. For this table, all such responses are included under the "unsure" column.

otherwise receive injections). Most patients (67%) received medication under the 72-hour emergency procedure, but 13 (43%) of the 30 received medication via the *Rennie* procedure described above (for three patients, both procedures were applied). The rationales for implementing forced medication indicated serious suicidal risk in 4 (13%) of the patients, and violent and/or significantly threatening behavior in 16 (43%) (less emergent rationales were usually cited for the *Rennie* procedure). None of the patient characteristics listed in Table 1 was significantly different for the 30 patients interviewed compared with the 35 eligible patients who could not be adequately interviewed (using *t* tests and chi-square tests with Yates continuity correction).

As indicated in Table 2, patients' expressed rationales for having refused medication prominently involved fear of side effects (57%), which frequently included unrealistic concerns (20% stated the medication was poison, 17% feared getting "addicted" to it), and the belief that nothing was wrong with them (30%). (As patients could endorse multiple rationales, their responses total over 100%.) Patients generally rejected the possibility that others had significantly influenced them to refuse medication. Patients recalled feeling angry about the procedure (40%), helpless (33%), fearful (23%), and embarrassed (13%), but 23 percent felt relieved. As indicated in Table 3, 60 percent of patients retrospectively felt that having been coerced to take medication had been a good thing, 43 percent asserting that they should be forced to take it

Table 3
Patient Interview Responses: Retrospective Conclusions

	Agree	Disagree	Unsure
	(%)	(%)	(%)
Having medication forced was a good idea	18 (60)	9 (30)	3 (10)
I should be forced again if in a similar state	13 (43)	7 (23)	10 (33)
Would more likely take it voluntarily in future	16 (53)	8 (27)	6 (20)
Doctors should not be allowed to force medication	13 (43)	8 (27)	9 (30)

again if in a similar state. Fifty-three percent stated that they would be more likely to take it voluntarily in the future, but 43 percent also agreed with the proposal that doctors should not be allowed to force patients to take medication. Patients sometimes gave "unsure" responses, and we included in this category the occasional failure to give any response or to give only irrelevant responses. For all questions concerning rationales for refusal, an average of 16 percent of responses were in the unsure category, as were 20 percent of the responses to questions about recalled emotions and 24 percent of the responses regarding patients' conclusions about the forced medication experience.

Discussion

There has been little study of patients' retrospective attitudes toward having been forcibly medicated. Marder *et al.*[13] reported that of 12 inpatients who stated that they would have refused treatment if they had had the option, and who remained in the hospital receiving treatment for two weeks, 6 at that time no longer objected to taking medication. Schwartz *et al.*[11] interviewed 24 psychiatric patients in an acute-care inpatient New York City psychiatric service in 1986 at the time of their discharge, and reported that 17 (71%) supported their previously having received medication forcibly. Their subjects were principally involuntary patients who had received one or more "stat" emergent injections, rather than patients who were medicated under the provisions of New York's *Rivers* nonemergent forced medication procedure.[14] Interviews were conducted at the time of discharge, but critics argued that some patients might still have experienced a chilling effect from the hospital environment, desiring that they simply be discharged that day from their involuntary hospitalization without further problems (H. Schwartz, personal communication).

Aware of this criticism, Seide *et al.*[10] conducted a pilot study, attempting to interview 20 consecutively forcibly medicated discharged patients from our institution, using an earlier version of our current interview instrument in a telephone interview. These patients were medicated by the New Jersey 72-hour emergency or *Rennie* nonemergent procedures. Only 11 of the 20 could be interviewed, and 1 of these was actually interviewed before his discharge, as it appeared it would be difficult to reach him afterward. Of the 9 who could not be interviewed, 5 could not cooperate ade-

quately, 1 rejected the interview, 1 was already rehospitalized in another institution, 1 was unable to communicate in English, and 1 was not locatable). Of the 11 who were interviewed, 7 retrospectively strongly agreed and 2 somewhat agreed with their having been forcibly medicated (and also gave the same responses regarding whether they would be more likely to take medication voluntarily in the future). Eight of the patients recalled objecting because of fear of side effects (3 thought it was some sort of poison), but no patient agreed with the suggestion that other patients or family members had told them to refuse medication. This study did not include patients who only received "stat" emergent injections, and almost all of the interviews were performed after discharge, but the sample size was small, and several patients had difficulty choosing along a five-point scale of agreement to disagreement. Patients generally appeared to have little difficulty recalling the forced medication procedure, whether interviewed days or even one or two months after discharge. It was also clear from the pilot study that the attempt to minimize the potential chilling effect the patient might attribute to the interview process, by waiting a reasonable interval after discharge, resulted in a significant loss of successful interviews.

The present study attempted to improve on the pilot study, interviewing all patients only after discharge with a simpler questionnaire, employing a new, larger sample. We felt that the process of interviewing patients by telephone concerning events that had happened weeks earlier recommended several considerations. We tried to elicit all relevant expressed rationales and feelings, not reductively trying to identify one "primary" reason. Although denial of illness was reasonably straightforward to appreciate, we did not feel that we could always clearly distinguish between what might have been accurate reports about medication side effects from either metaphoric exaggerations or from definite delusions, in interviews sometimes limited by patients' nonacceptance of detailed questioning. Our study also principally sought to elicit patients' attitudes and beliefs and relevant changes in these, rather than to judge retrospectively how reasonable the beliefs about medication side effects may have been. Therefore, although patients' ideas about medication were sometimes delusional, we did not break these out into a separate category as several inpatient studies had done (rejection of medication based on delusional beliefs), but instead simply listed separately endorsement of statements such as medication was "weakening" or "poison" or "addicting."

Our principal finding in the current study was that, weeks after their hospital discharge, of those who expressed a clear opinion (discounting "unsure" responses), two-thirds of interviewable patients supported their having been previously forcibly medicated. This striking result is subject to two important caveats, however. We did not interview several patients transferred to other hospitals or back to jail, and in waiting for an average of one month after hospital discharge to minimize any paranoia or inhibitions that

might be inspired by talking to hospital staff, we lost the availability of patients to readmission, relocation, lack of recollection, and the simple absence of a perceived compelling reason to cooperate with an interview. It would not be surprising if the uninterviewed patients felt, as a group, more negatively about having been forcibly medicated. The second concern is that even by waiting for several weeks after discharge and despite our attempts to reassure them, some patients might still have been fearful and responded with answers more "socially acceptable" than they truly felt. Of course, these two caveats unfortunately work against each other in practice—the longer one waits the more comfortable patients should be, but the more interviews one will lose.

Of relevance to our findings is a recent study by Lucksted and Coursey[15] involving Maryland outpatients with serious mental illness who were attending psychosocial rehabilitation centers and who agreed to report their perceptions of having been forced to accept treatment. Fifty-four percent of their group (105 patients) cooperated adequately with filling out a questionnaire. Thirty percent of the patients (28 respondents to that particular question) reported having felt pressured or forced within the previous year to take medication, although only 2 had received injections against their will, reminding us of the wide scope of "force" as perceived by our patients in everyday clinical practice. In addition to negative emotions, in support of our findings, 12 of the 28 reported that the pressure made them feel others "were looking out for their best interest," and 15 agreed retrospectively that these efforts had indeed been in their best interest.[15]

As in our study, these results demonstrate that a substantial fraction of seriously psychiatrically ill patients retrospectively assert their support for having been coerced to take medication. It is inherently very difficult to insure that such patients' responses are completely free of a felt need to "say the right thing," but in studies such as ours, the longer one waits to interview after a hospital discharge to lessen this possibility, the fewer patients are available to cooperate with an interview. Moreover, speaking to the issue of patients' autonomy, we believe that forced medication frequently restores the capacity to make competent decisions and often results in a more rapid return of the freedom to be discharged from involuntary hospitalization. This fact was not lost on our hospital's public advocates, who have usually been more concerned about patients' continued involuntary hospitalizations than forced medication procedures, citing precisely this rationale.

Some of our additional findings are germane to previous reports associating psychotropic medication refusal with diagnosis, concern about side effects, and denial of psychiatric illness. Of the nine interviewed patients in our study who clearly retrospectively still disagreed with having been forcibly medicated, three patients had a principal diagnosis of bipolar disorder, manic (three of the eight patients so diagnosed in the interviewed group), and four patients were diagnosed with paranoid schizophrenia (of those six patients so diagnosed in the interviewed

group; another of the six patients gave an "unsure" response). The other two retrospectively disagreeing patients had principal diagnoses of schizoaffective disorder (1) and cyclothymia (1). Grandiosity, frequently encountered with both manic and paranoid schizophrenic patients, has been previously found to correlate with medication refusal. Van Putten *et al.*, using Brief Psychiatric Rating Scale (BPRS) ratings,[16] reported that habitual medication noncompliant patients who "wished to be crazy" differed from others most significantly in having ego-syntonic grandiose psychoses.[17] Marder *et al.*,[13] evaluating 31 California inpatients who during a 72-hour evaluation period did not actually have the right to refuse medication, found that those who said they would have refused scored significantly higher on BPRS ratings of grandiosity, excitement, and elevated mood. Hoge *et al.*[18] also noted increased BPRS grandiosity, excitement and hostility in their medication refusers. We did not objectively measure patients' grandiosity, but the above-noted diagnoses of our retrospectively still-objecting patients are suggestive of the relevance of this psychopathological dimension.

There is some literature documenting patients' reasons for refusing treatment, and our findings offer the opportunity to briefly discuss several representative references. Refusing patients' frequent identification of unwanted side effects as a rationale for their nonadherence is not entirely surprising and has been described before. Van Putten *et al.*[19, 20] highlighted their findings that dysphoric reactions to antipsychotic test doses strongly predicted later drug noncompliance and ineffectiveness. Falloon *et al.*[21] reported that a decrease in akathisia symptoms in study patients over time was actually attributable to such patients' reduced medication compliance. Appelbaum and Gutheil[3] detailed the reasons that 23 medication-rejecting inpatients offered in explanation of their refusal: 10 cited side effects, 9 gave delusional reasons, 8 referred to medication violating bodily privacy, 7 gave angry or irrelevant reasons, 3 cited their legal rights to refuse, and 9 gave no reason (multiple reasons were allowed). Hoge *et al.*[18] questioned 63 inpatients at the time they started refusing medication about their rationales for refusal. Thirty-five percent cited concerns about side effects, 21 percent denied that they had an illness, 12 percent asserted that the medications were ineffective, and 30 percent gave more psychotic and/or idiosyncratic reasons. DeLand and Borenstein[22] reported that of 18 medication-refusing forensic inpatients whose clinicians had petitioned for forced treatment under the *Rivers* procedure, 13 were refusing on the grounds that they did not have a psychiatric illness, 1 admitted illness but no need for medication, and 4 others gave "illogical or delusional" reasons. Of 20 *Rivers* petitions in another New York study,[23] psychiatrists recorded that 7 patients refused medication because they thought it was poison, 5 denied psychiatric illness, 2 offered "unconfirmed religious restrictions," and 2 gave no reasons. In a small study, Hassenfeld and Grumet[24] described the reasons that 10 treatment-refusing psychiatric inpatients offered: 4 cited unacceptable side

effects, 2 denied illness and therefore any need for treatment (one of whom complained medication "controlled" him), 1 alleged a brain cell allergy to all chemicals, and 1 refused not only medication, but food and drink. Rodenhauser *et al.*[25] ascribed 86 percent of 70 maximum security forensic inpatients' medication refusals to denial of their illness, but determined this by chart review rather than patient interviews. Unlike in our study, patients these investigators did interview were still acutely ill and hospitalized, and authors usually did not allow for multiple reasons, but most results were nevertheless, similar to ours.

Confirming our clinical impressions, denial of psychiatric illness (lack of insight), practically confounded with measured ratings of grandiosity and hostility, has also been reported to be associated with medication refusal.[13, 17, 18, 26] As noted in Table 2, 30 percent of our interviewed patients thought that nothing was wrong with them when they rejected medication.

The relatively infrequent rationale of suicidal behavior for psychiatrists' requesting forced medication in this group of patients (13%) reproduces a finding previously reported at our institution and, we believe, mainly reflects the fact that suicidal patients tend to be more tractable concerning taking prescribed medication in a hospital than hostile, aggressive patients.[27] Hoge *et al.*[18] also reported that inpatients who refused medication for longer than 24 hours were more likely to have threatened or actually committed assaults, but not more likely to have threatened or committed self-harm, as compared with an inpatient control group (only 5% of their medication-refusing group threatened or committed self-harm), and a study by Zito *et al.*[23] of 20 medication-refusing inpatients brought to court under *Rivers* found that the principal grounds for requesting forced treatment were violence or assaultiveness for 40 percent of patients, but depression and suicide risk for only 10%, although an earlier, smaller study by Zito *et al.* in Minnesota did not find this pattern.[28]

We have not only observed a change in patients' attitudes after clinical recovery, but have noted anecdotally that some patients go through another cycle of the same attitudinal shifts during a subsequent clinical decompensation. Such a state-dependence of expressed opinions muddies the idea of an enduring ability to make important decisions autonomously in the presence of serious, relapsing psychiatric illness. One innovative response to this dilemma could be the institution of a type of "advance directive." Indeed, such a statute has been enacted in Minnesota, and even though it is imperfect in its initial formulation, it may serve as a guide in encouraging similar legislation elsewhere.[29] This type of directive is sometimes called a "Ulysses directive" in colorful recollection of Homer's heroic voyager of *The Odyssey*, who, wishing to hear the irresistibly seductive sirens' song without risking drowning, bade his crew to leave his ears unstopped but have him tied to the mast of his ship, so that he would not drown himself in a moment of temporary madness. A "Ulysses directive," therefore, gives another individual the authority to approve psychiatric treat-

ment if the signatory were to become incompetent in a future episode of psychosis or mania. Although a psychiatric advance directive could in certain limited circumstances also serve to legally prohibit some treatment options for a given individual, its principal value would be to more expeditiously allow needed psychiatric treatment in jurisdictions where medication refusal is decided in court hearings.[29]

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