

PTSD FOLLOWING COMPULSORY ADMISSION

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SUMMARY

A woman developed post-traumatic stress disorder (PTSD) after being compulsorily admitted for psychiatric treatment. This report warns of such a possible development in certain situations following involuntary admission.

Keywords: autonomy, compulsory admission, PTSD, personality, suicide

INTRODUCTION

In DSM-III-R (American Psychiatric Association, 1987), post-traumatic stress disorder (PTSD) may occur following a stressor that is outside the range of usual human experience and would be markedly distressing to almost anyone. McGorry et al (1991) found a prevalence of PTSD in 35% of a group of psychotic patients 11 months after their hospitalisation. They suggested that involuntary admission, which often involved police, duress, forced sedation, restraint and seclusion, and finding oneself in a closed environment with a number of other psychotic or disturbed individuals, may predispose the development of PTSD. Physical restraint has been described by some patients to be parallel to the experience of rape or physical abuse (Blanch & Parrish, 1990). We report here a case of a woman who developed DSM-III-R PTSD following compulsory admission.

CASE REPORT

T.K., a 30 year old Chinese woman sought help in a psychiatric outpatient clinic of a local general hospital following the death of her pet dog which had been her constant companion for the past 15 years. Her husband, a drug addict, had also recently been detained at the drug rehabilitation centre.

The middle child of three siblings, she had since young felt unloved by her parents. Her parents' marital relationship which had all along been very poor had ended in divorce. To avoid conflicts during the marriage, her father would absent himself from their home. Her mother was especially punitive towards T.K. because she bore a strong semblance to her father. There was no childhood history of sexual abuse. Since her childhood, T.K. has found it much easier to relate to animals than to humans.

She is generally distrustful of fellow human beings and found animals to be more trustworthy, loyal and devoted.

After her secondary school education, she worked at various jobs, and while working as a veterinary assistant, she met her future husband who was a drug addict. Not long after their marriage, he was sent to a drug rehabilitation centre for a drug related offence. It was during this time, that her dog died. Feeling very miserable, lonely and deserted, she entertained frequent thoughts of killing herself so that her soul could go to purgatory to look for her dog; she believed her dog possessed a soul which had been sent to purgatory. Her state of ambivalence often caused her to be agitated. Her psychiatrist, believing that she was depressed and possibly psychotic because of the seemingly unusual reason for wanting to kill herself, had on several occasions suggested hospitalisation. T.K. had, however, vehemently refused each time. On one occasion, in a telephone call to her psychiatrist she expressed this desire to kill herself. Thinking that she might be in danger, the psychiatrist called for police intervention at her home – an act which the patient perceived as unwarranted and humiliating. Shortly after this episode, she went to the same clinic without an appointment and was seen by another doctor. Hospitalisation was again suggested whereupon she became very agitated and aggressive. Unable to calm her, and of the opinion that she was psychotic and suicidal, the doctor decided on involuntary admission. In the process she put up a vigorous struggle and had to be restrained and sedated. She was transferred to the state mental hospital. Evaluation was not possible until the following day because of her sedated state. She was subsequently reassessed by a different team of doctors. She was calm and co-operative, and admitted that she became upset because of the insistent suggestion that she should be admitted, an option which she neither wanted nor thought necessary. During this

second assessment, there was no evidence of any psychotic disorder or any obvious suicidality. She was discharged and given an appointment at our outpatient clinic.

She subsequently presented to us with complaints of poor sleep, impaired concentration and memory, and frequent outburst of anger and panic (PTSD-D). She had recurrent nightmares of being restrained and flashbacks of the events leading to her admission (PTSD-B). She avoided going to any hospital and refused to contemplate thoughts of having therapy within a hospital (PTSD-C). It was after much persuasion and reassurance that her right to refuse hospitalisation would be respected that she finally agreed to therapy at a community-based clinic. Her symptoms persisted beyond a month after her admission (PTSD-E). Her responses on the Impact of Event Scale (Horowitz et al 1979) indicated frequent intrusive thoughts and avoidant behaviour of any reminders of the event.

Her MMPI scores on scales F, Hypochondriasis, Hysteria, Psychopathic Deviate, Depression, Psychasthenia, Schizophrenia, Mania and Social Introversion were elevated beyond the critical level. Clinical presentation was that of an anxious, agitated and seclusive individual. Her profile also reflected low ego strength and ineffectiveness in dealing with the problems of daily life. She was depicted as a dependent and inadequate individual with poor self-concept, strongly dissatisfied with herself, yet lacking in skills necessary to improve her situation.

DISCUSSION

Heyd and Bloch (1990) commented that the ethical dilemma of suicide intervention is intensified by the fact that in either course of action, there is a price to be paid. To intervene would be forcing the person concerned to go against his or her will and at a loss of personal liberty. Not to intervene could result in irreversible loss of life. It could be argued in T.K.'s case that her wish to die was probably due to her grief over the death of her dog and, with psychiatric treatment, this attitude could possibly be changed. Intervention in terms of hospitalisation could therefore be justified even though it meant violating her autonomy and liberty. In this patient's case, there was an additional price in that she developed a post-traumatic stress disorder.

She was perhaps vulnerable for such a development. Breslau et al (1991) identified childhood separations and being female as risk factors for developing PTSD. T.K.'s father had been absent for most of the time during her childhood and her mother had been particularly punitive towards her. Such "microtraumas" of emotional neglect, humiliation, or misattribution of blame (Moses, 1978) may result in maladaptive character traits. Immature and

maladaptive coping mechanisms have been found to be predisposing factors in PTSD (Gleser, 1981). Her personality profile on the MMPI is typical of those who have suffered noncombat trauma (Berk et al, 1989). The high F index, one of the two markers of symptom overreporting (Hyer et al, 1989), has inevitably elevated her scores on the clinical scales. Besides the trauma of compulsory admission, her adverse early childhood experiences and the environment in which she grew up could already have predisposed her to the vulnerability to developing an immature personality and maladaptive coping skills.

Furthermore, the presence of prior adverse life events may render one vulnerable to PTSD. Kilpatrick et al (1984) who studied rape victims found that those who adjusted better and faster had significantly fewer negative life events. In a study of survivors of a firestorm, Koopman et al (1994) found that stressful life events before the fire were a major predictor of post-traumatic stress. T.K. had suffered two losses in a short space of time (her husband who was incarcerated and her beloved dog which died). These stressful life events that she had before her compulsory admission could have sensitized her to the effects of further trauma.

In this case, although compulsory admission could have prevented her from killing herself, it has led to PTSD. Psychiatrists on deciding on compulsory admission should be aware of this possible development in certain vulnerable individuals and the risk-benefit ratio of such an order should be weighed carefully. Perhaps before the drastic step of compulsory admission is considered, a psychodynamic approach at the beginning of treatment could have possibly been beneficial - to understand the patient's state of mind, to go along with her beliefs so that she feels understood and accepted and, when rapport and trust have been established, to deal with illogical or irrational thoughts using cognitive behaviour therapy, helping her to develop more effective and adaptive coping mechanisms.

In the event that admission is mandatory, the ward environment is a potentially important variable in influencing the development of PTSD. McGorry et al (1991) in their study of psychotic patients found a tendency to link the PTSD symptoms to the external or contextual aspects of the psychotic experience especially the experience of the acute admission unit. Staff should not just ensure the physical safety of the patients but should provide emotional contact which can counter the "isolation, confusion, and fear" which the patient may be experiencing (Wadeson and Carpenter, 1976). Another essential factor is staff training in the use of restraint and seclusion, not just in reducing injury to staff and patient but in understanding

patients' attitudes. This appeared to be the best option of ameliorating many of the negative aspects of restraint and seclusion (Fisher, 1994).

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