



# Involuntary Admissions, and Treatments (TSO) for Individuals Suffering from Schizophrenia: A Reflection on Patient Safety, and Quality of Care

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## Abstract

**Introduction:** Since the Italian Mental Health Act of 1978, public attention on the outcomes of Involuntary Hospital Treatment (TSO) for people struggling with Schizophrenia (SCZ) has increased. The practice is controversial because it goes against the Human Rights standards. Against this background, the author investigates factors linked to coercive measures, and personal experiences of acute care. He hypothesizes that limitation of freedom negatively affects the quality of the therapeutic relationship (TR). **Materials, and Methods:** Semi structured qualitative interviews (QIs) of individuals (n = 20) who were eligible for inclusion if the following criteria applied: [1] DSM-V diagnosis of Schizophrenia; [2] Having received at least one TSO; [3] Being outpatients; and [4] having emotional, and cognitive stability. The interview text was transcribed verbatim and analyzed by means of a phenomenological method. **Results.** The cohort described TSO as an unwelcome, and intrusive practice. Even if clinicians often justified the admissions, only a few patients gave an account of being told why their agency was eroded. Moreover, TSO damages Self-confidence, and trust in public services. Inasmuch, to prevent distress and avoid an outflow of so-called psychiatric refugees, the Italian government needs to improve joint crisis plans between patients, families, and medical equips. **Discussion.** The Republic of Italy does not have asylums but community-centers, and psychiatric wards within general hospitals. The Law No. 833 of 23 December 1978 established the possibility of a TSO for a period of 1–7 days in the simultaneous presence of [1] Psychiatric conditions that require urgent therapy; [2] Patient's refusal of assistance; and [3] Circumstances that do not consent other less-invasive strategies. To author's knowledge, this is one of the few qualitative reflections done on the pros and cons of adult Psychiatry, in Italy. The survey adds valuable information regarding degree, and predictors of loss of autonomy, dignity, and the possibility of interpersonal contact.

**Keywords:** Schizophrenia, TSO, Human Rights, Therapeutic Relationship, Law No. 833.

## Introduction

Almost one in four people suffer from ailments. Over half of them has symptoms that on average tend to have some aspects of disability. Functional, and behavioral impairments are well-known facts for care-givers, clients, and families. For all of that, how they manifest, and for how long is not clear. Likewise, it is not easy to characterize healing processes. Most persons who experience symptoms do not seek help from a physician. On the other hand, this research is focused on cases in which individuals with a severe mental illness (SMI) were ordered by a public court into involuntary hospitalization and involuntary treatment. To examine their experiences, the author interviewed 20 out-patients (age > 18 years) in the Republic of Italy. All participants (PTs) suffered from Schizophrenia, were joining self-help groups, and taking standard psychotropic medications. The qualitative interviews (QIs) were one-time events, semi-structured and with a median time of 60 minutes. The PTs were encouraged to tell their own life story in their own words, and as much as possible within a chronological/developmental framework. Outcomes imply that depressing someone's rights causes enduring psychological, and emotional sequelae. As full recovery is possible in a life-threatening psychotic attack, detention is sometimes morally acceptable and may indeed be necessary. Compulsory admission, however, does not necessarily imply a need for forced medication. Therefore, different programs in acute health care settings are required. Focusing on prevention, and on subjects's empowerment (e.g. betterment of patient/physician



partnership) could make national services more responsive to the challenges of modernity, and serve to future-proof the psychiatric workforce. Besides, no psychiatric education should be considered complete without the adoption of social science, and human rights instructions. One question that might be raised in response to the afore arguments is that deprivation of agency of those deemed to be unwell could be useful within crime-preventing strategies (e.g. towards citizens who have not previously committed a criminal offence, but who are still predicted to pose a threat of significant harm). Nevertheless, this could be controversial because Italian society has historically believed that a sanction – a reaction triggered due to the violation of or the compliance with a norm – should only be imposed for a past conduct. Importantly, what is presented in the following pages does not solve the controversy about TSO but rather offers readers a case in progress. As such it draws heavily on observations done in Europe, though similar reasoning has come into sight elsewhere.

### **Schizophrenia**

Schizophrenia, either described as a discrete identity or an umbrella term for a group of mental disorders, is one of the less understood psychiatric categories. With an onset at a young age (< 20s for men and < 30s for women), and a lifetime morbidity risk of 7.2 per 1000 people (Byrne, 2007), the malady can be neuro-developmental, and/or neuro-degenerative (Larson, Walker, & Compton, 2010). Aside from Self-experienced subclinical disturbances in mentation, the symptoms are categorized into three (overlapping) macro-categories: negative (e.g. apathy, and affective flattening), positive (e.g. hallucinations, and delusions), and cognitive (e.g. disorganized thought, and difficulties with memory). Schizophrenia covers the subsequent categories: [1] Paranoid; [2] Disorganized; [3] Catatonic; [4] Residual; [5] Schizoaffective Disorder; and [6] Undifferentiated (Kaufman et al., 1997). For the bio-medical paradigm, there are three sequential and cyclical stages: [1] Prodromal (beginning); [2] Acute (full blown); and [3] residual (recovery). The prodromal phase is the starting point of the psychosis. It manifests itself with subclinical behavioral, and cognitional dysfunctions that are rarely observable by others. Per contra, the acute phase is characterized by a more evident symptomatology. Depending upon various factors, hallucinations, and/or delusions can appear. Full blown Schizophrenia is a health emergency that requires neuroleptics to manage symptoms. Finally, the residual momentum is diagnosed when features abate (common scenario) or disappear (rare circumstance). Those in developing countries are less likely to have been chronically psychotic over the period of follow-up, and more likely to have no residual symptoms after 5 years, than those in the developed ones (Messias, Chen, & Eaton, 2009). Traditionally, a diagnosis is made on the criteria offered by the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), through an analysis of symptoms and the dating of the onset. Problems in sampling are given by heterogeneous presentations (Peralta & Cuesta, 2001) and the absence of even a middle-of-the-road consensus on the activating factors (Leung & Chue, 2000). As a further matter, the inherent heterogeneity of Schizophrenia is also the main obstacle to the formulation of an effective cure. Because of that, multimodal approaches based on drug therapy, and psychosocial interventions can only reduce life-threatening circumstances. The socio-personal impact of the ailment is appreciated through the following criteria: [1] Frequency; [2] Severity; [3] Consequences; [4] Availability; [5] Acceptability; and [6] Effectiveness of interventions (Tarricone et al., 2000). Compared to the general population, life expectancy span is between 12-15 years shorter due to cardiovascular events, comorbid diseases, and environmental biases.



### **The Italian Psychiatric Reform**

In 1978 the Republic of Italy (heretofore Italy) adopted the Law n. 180 to eliminate psychiatric hospitals and open Community Mental Health Services (CMHS). The legal landmark imposed that all compulsory admissions must be restricted to 15-bed diagnosis-and-cure centers (Burns, 2019) over a (renewable) period of 1-7 days. The Law 180 marked the formation of an institutional terrain on which 'madness' is faced up to, through public engagement (e.g. offers of job placement, proper housing, and opportunities to live together with other citizens). Consequently, it imposed that assessment, and treatment are on a voluntary basis (Barbui, et al., 2018) in out-patient departments. Mandatory procedures could occur when: [1] Urgent therapeutic interventions are required; [2] If such methods of healing are refused; and [3] Timely alternatives are not possible. By confronting the anachronistic prejudice stating that all ailments are, *ipso facto*, dangerous, the Law 180 prevented the encroachment of bias in legislation. Because the framework is meant for individuals who lack the critical faculty of Self-governance (e.g. those not guilty by reason of insanity or unfit to stand trial), those citizens who are dangerous but not deranged fall under the responsibility of the police, and of other institutions within the national criminal justice system (Casacchia et al., 2015). The reform was a consequence of the ground-breaking work, and political struggle of Italian psychiatrist Franco Basaglia (1924-1980), his students, and colleagues. Their genius was in discovering that persons with SMI could live a 'normal' life whilst accommodating their disorder(s) in the 'community'. To comprehend the breakthrough, we have to keep in mind that the asylums of the time were inhabited not only by persons with chronic psychoses, but also by those who ended up there for they had nowhere to go: homeless individuals, criminals, and children born to schizophrenic women (Basaglia et al., 1987). With the birth of Basaglia's *Psichiatria Democratica* (Democratic Psychiatry), two strands of thought developed: a social critique of the traditional establishment, and a certain aversion for crystallized administrative mechanisms. To conclude, the Italian experiment, although riddled with its own inconsistencies offered evidence that moving away from conventional custodial assumptions was beneficial (Scheper-Hughes & Lovell, 1986). There is much more to say about these topics but that - in essence- is what Basaglia, with the abatement of the wall between 'us', and 'them', hoped to introduce.

### **Italian Mental Health Services**

With the Law 180, Italy became the first developed country to formulate care on a networked system. On top of that, the issue of 'separate' versus 'integrated' legislation on MH was addressed by Italy incorporating the Law 180 into the National Health Service (NHS) general health law at the end of the same year (Mezzina, 2018). In this context, the Department of Mental Health (DMH) became the main supervisor of public, and private places. The DMH manages: [1] Community Health Care Centers (CMHCs); [2] Day Care Facilities (DCF); [3] General Hospital Psychiatric Units (GHPUs); and [3] Residential Facilities (RFs). Despite being a centralized, and theoretically egalitarian macro-structure, substantial service variations (e.g. in diagnostic testing utilization) exist between counties, and geographical areas. Regarding the impact of community policing, circa half of the people with severe conditions visit the centers. Yet, there's strong evidence that only a quarter of those with moderate disorders, and a fifth of those with sub-clinical disturbances join the programs (Lora, 2009).

### **Italian Judicial Basis for Involuntary Commitment**

The *Trattamento Sanitario Obbligatorio* or TSO (Medical Involuntary Commitment/ Hold) is a legal order that seeks to prevent harm (against the Self, the public or both), through compulsory admission to hospital. TSO



is started by a mayor (and/or councilors), at the request of two physicians (of whom one should be a psychiatrist). Its justifiability is linked to the concept of *parens patriae* which implies a political interference in the private sphere when the ability (of a citizen) to make autonomous decision is impaired, or when his/her will is against the common good. According to Law no. 6/2004, recipients of health services who are no longer, or are only partially, capable of protecting their own personal and/or financial interests, are granted a guardianship judge. Crucially, long-range social goals lay at the heart of this paradigm shift.

### **Compulsion & Coercion**

Compulsion is the adoption of force, and of threats to make someone accept a previously neglected offer. Even if it encompasses a large variety of practices, it is generally included in the notion of coercion. For Szmukler and Appelbaum (2008), an intrusion in Self-autonomy is acceptable when the presence of a comorbid psychotic or severe mood disorder is documented and when it promotes patients' best interest. International debates reveal a tendency to assume that therapy is something that the infirm people would have welcomed if their Self was not impaired (Sjöstrand & Helgesson, 2008). It has been noticed that the most frequent characteristics of the TSO-population are: [1] A low average level of education; [2] A prevalence of unmarried men, and married women; and [3] A vast number of unemployed among men, and housewives among women (Zepegno et al., 2005). The various weights given to a subject's decision-making capacity are reflected in the legality of pharmacological treatments. For instance, in Italy, the adoption of psychotropic agents is almost automatic, while other countries require a more articulated procedure to decide on care option. Further, emergency room psychiatrists may invoke both 'soft' and 'hard' evidence to support a SMI admission.

### **Human Rights.**

As indicated by Kinderman and Tai (2008), the central tenet of any discussion around TSO could be best rendered by the questions: what does the patient need, and what type of care is best compatible with his/her psychological, and physical profile? As usual, there are no simple answers but some guidance is found in the European Convention on Human Rights (ECHR), and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). Article 3 of the ECHR provides as follow: "*no one shall be subjected to torture or to inhuman or degrading treatment or punishment*" (Lehto, 2018: 45). One complicating factor is that there is no agreement about what constitutes 'inhumanity' or 'degradation' and, because of that, despite sympathetic concerns, and efforts to aid what is morally constructive, the advancement of a comprehensive, and measurable definition of institutionalized violence has been rather difficult (Kinderman & Butler, 2006). Inconstancies are also found in ECHR Article 5 when it states that 'everyone has the right to liberty and security of person', while affirming that those of 'unsound mind' can be detained (Sicilianos, 2014). These epistemological fallacies cause enduring problems for the courts as they are responsible for clarifying queries related to patients. Specifically, because of concerns about the recurring nature of ailments, and a presumption that a future relapse could result in an act of violence, they may err on the side of caution when determining whether an individual needs guardianship. It is also worth remembering that the Italian Court of Cassation, and the Italian Constitutional Court hold different positions about health and public safety. In today's correctional design, there is a fracture between those who think that psychiatrists and other therapists are responsible for sentencing policies, and those who place the use of welfare services aimed at guaranteeing the right to MH within the police.



### **Storytelling**

To examine the management of Schizophrenia, two methods that yield promising results are personal storytelling, and autobiographical writing. They offer precious insights into coping skills, and reasoning abilities. However, it was not until the beginning of twentieth century that formal efforts were made to utilize them. Nelson et al. (2014), and Ebisch et al. (2012) asserted that vulnerable subjectivity, and relationality emerge from spoken and written stories. Lysaker et al. (2007) argued that a person's efforts to discuss his/her problems can re-construct a sense of Self, and help him/her to regain agency. Cohen (2008) claimed that most people conceptualize psychotic alterity, in their own ways (e.g. in a narrative and/or dialogic form), and through the added perspectives of their interlocutors rather than by adopting grand scientific theories.

### **An aggressivity-reducing structure?**

On the topic of SMI, even so there is no doubt that positive steps have been taken to limit the power of Psychiatry, there is one factor that still dominate mass consciousness —the idea that undermining freedom reduces aggressivity (e.g. verbal threats, lies, and disorderly conducts). Yet, most scholars believe that the opposite might is true. By adding 'captivity-induced' trauma to the individual's list of reasons to feel shame, and retaliatory, the likelihood of potential misdeeds increases (Moore, 2000). Likewise, even when blocking movement or normal access to one's body could prevent some extreme cases (e.g. people with an impaired capacity to effectively engage in an act of communication), the cost is too high from a Human-Rights perspective. From this point of view, Italy shows a less developed awareness of the need of Self-determination (whose value has been declared but not convincingly protected).

## **Materials and Methods**

### **Aim of the Study**

The author describes how a representative sample of psychiatric out-patients make sense of TSO, and test the hypothesis that: high perceived coercion in custodial settings is a predictor of poor engagement with mental personnel during therapy, and after discharge from hospital(s). It is anticipated that the discussions will contribute to the laying of a foundation for standard practice in the monitoring of progress toward achievement of Human Rights in public health care.

### **Research Questions**

The enquiry is inspired by the following research questions (RQs): [ 1 ] What do out-patients feel about TSO? [ 2 ] What kind of ethical challenges do clinicians face in their daily activities? And [ 3 ] How can we refine psychiatric care? The RQs are solved through interpretative phenomenological analysis (IPA), as it is an effective way for appraising complex circumstances that are emotionally laden (Biggerstaff & Thompson, 2008).

### **Theoretical Framework**

What can be deducted from the PTs' stories is Horwitz's theory of social control (Horwitz, 1982) which tells us that, Psychiatry alters (or tries to) the Self of those deemed unwell, through coercion, and conciliation. The first occurs when adherence is secured against non-compliance, through punishment. The second manages deviance through formal discipline, and by projecting onto psychiatric users a consciousness formed around invisible, yet ubiquitous, threats. Horwitz's guidelines can be deleterious, because by underestimating individual capacity for transformation, they damage the very emotional, and cognitional reservoirs for a change in thinking.



Moreover, when a system of governance grounds itself in the authority of experts, and advances its own 'Truths' as dogmas, then such apparatus becomes the scaffolding for a form of authoritarianism. At this level, it matters little to know whether this type of control is intended or not as it is in either case obvious that the social universe is shaped by certain aspects of the relations that make it up. Thus, to envision Psychiatry, is to see the intimate relationship between power and knowledge (Bergen, 2000). Its hegemonic status is evident in the medicalization of everyday life. *De facto*, in the past twenty years, the number of therapies has soared to disturbing levels. And drugs are seen to be so imperative that the failure to prescribe would be thought of as negligent, even perhaps legally indefensible (Medawar & Hardon, 2004). Aside from a diagnostic culture transforming human beings into psychiatric identities, PTs' testimonies called to mind the works of Groeben, and Scheele (1982), on how we formulate *quasi*-objective assumptions around illness that run parallel to scientific postulates. These counter-discourses allow an additional explication of events, as well as the prediction of future incidents, and contribute to Self-stability. Precisely, they reveal that [1] Subjects who consider themselves as mentally ill display greater compliance with therapy, than those who do not view themselves as such; [2] Subjects who attribute their malady to biological conditions display greater compliance with therapy than those who explain their illness by psychosocial factors; and [3] Subjects who expect a chronic course of ailment are less compliant than those who anticipate an improvement or fear relapse.

#### **Bibliographic Databases**

To define the area of concern, the author conducted a review of the scientific literature (LR). The main sources consisted of books, conferences' proceedings, and peer-reviewed articles identified *via* Scopus. A general web search was also performed on Google Scholar (GS), and CHODARR (Community Health Online Digital Archive & Research Resource). For each database, queries were performed using the term "Schizophrenia\* AND compulsory measures in Italy\*", seeking for all literature published from 1978 to date. This was later supplemented through additional searches using more specific terms: (Italian psychiatr\* AND Human Rights) and (Law 180\* AND psychiatr\*). The titles, and abstracts of all identified material were inspected for their relevance. Papers were accepted if they met at least one of the following criteria: [1] Mentioning the characteristics, experiences, and/or the functions of de-institutionalization; [2] Reporting the effect of coercion and/or compulsion on in-patients, and out-patients.

#### **Participants**

The cohort was made of 20 adults (50% males – 50% females), aged 31–45 years old, with a confirmed DSM-V diagnosis of Schizophrenia (mean duration 15 years). All of them had previously undergone diagnostic assessment. Pre-analysis Plans (PAP) revealed that 60% had 1–10 years of education and 40% had 11–14 years of schooling. Nearly 50% was unemployed. 30% held menial positions. The remain 20% had (part-time) administrative jobs. In the sample, the distribution of education, and labor did not show significant gender differences. Screening revealed that 100% had a history of at least 1 TSO but no (known) suicide attempts. 70% went to group and individual therapy. 30% saw regularly one psychiatrist or a psychologist. Six of the 20 PTs reported growing up in middle class households, 12 in working class families, and 2 in poor families. Ethnic or immigrant backgrounds were not recorded. Inclusion criteria were: [1] Italian nationality; [2] Having experienced (non-penal) coercive measures; [3] Adult onset of Schizophrenia; [4] Being an out-patient; and [5] Being capable of giving written informed consent to participate in this study. The interval between the TSO and examination varied. The mean time elapsed was 11 months and the range were 3 months – 2 years. Persons



with histories of significant head injuries, Substance Abuse Disorders (SAD), and/or a diagnosis of mental retardation (IQ <70) were excluded. The author was independent and not involved in the treatment of any of the PTs.

### **Instruments**

To gather qualitative textual data, the author adopted semi-structured interviews. Unlike structured, and non-structured techniques, this format – a middle-road between two opposite ends of a *continuum*– leads respondents to stress subjective feelings, attitudes, and knowledge with little guidance. The interviews lasted around 60 minutes, and took place in public spaces chosen by the PTs. Perceptions of trauma were assessed by asking the PTs if, when, and how they perceived neglect, abuse(s) and/or harassment (Paksarian et al., 2014). To avoid general statements, interviewees were told to describe concrete situations. The whole process was video-recorded, and transcribed *verbatim*. The author performed the research alone or, when requested, with the help of a third party (e.g. a member of the family). In this case, the moderator was supplemented with the questions, and he/she concurred in forming an accepting atmosphere (Sjöstrand et al., 2015).

### **Procedures**

To form the sample universe, health care centers (providing a wide spectrum of services to care for acute and chronic needs), and NGOs (operating in the field of human rights, and mental health) were contacted. The initial request was forwarded by email to the personnel of each institution with data about the study, its purpose, and methods. Individuals who fulfilled the baseline socio-demographic characteristics were then recruited through the organizations and/or by Linear Snowball Sampling (LSS) across stakeholders. As an extra thing, online advertisements were posted on Bakeca (a popular Italian website). Potential candidates were made aware that the research would not affect their legal status, and that they could withdraw, at any time, without explanations. To protect privacy, names, and gender were altered and/or omitted.

### **Data Analysis**

In terms of procedures, interpretative phenomenological analysis (IPA) expected the creation of 2 levels of theme development: emergent themes (ET) and superordinate themes (ST). While ET were initial notes transformed into concise phrases listed in a reflexive diary (where the author looked for connections across them), ST were clusters of previous interpretations which captured more correctly the PTs' ideas. Of course, during the analysis certain items were dropped (e.g. lacking of evidences or without rich details). The outcome was a table of themes (results section) and a final argument that facilitated subsequent analyses (Smith & Osborn, 2004).

## **Results**

In being mentally ill, one might presume that hospitals can offer solace. Yet, contacts with TSO are notoriously problematic. And, it remains unclear to what extent it ameliorates health. Against this background, the PTs expressed feelings such as fury, and/or anger. As acknowledged by Rose, et al. (2017) their emotions are common across people exposed to at least one traumatic event such as being a witness/ victim of violence, or being the victim of abuses. But far worse than contempt were the major threats that TSO brought to Self-integrity. Moving into details, for **Male Key- Informants**, fear and/or confusion were frequent and linked to seclusion and/or the administration of sedatives. Most felt to be humiliated. Similarly, for **Female Key-**



**Informants**, conceptualizations of TSO included a sense of surprise, loneliness, and/or despair. As their memories showed, physicians and nurses faced criticism for having held them in an ER room and/or medicated them into a stupor. In most descriptions, what may have been a routine was interpreted as an assault.

#### **Strengths, and limitations**

The work could not provide (full) anonymity as the author knew those involved. Similarly, in the Snowball Sampling, existing study subjects, and institutions were aware of the PTs' identities. Nonetheless, the author maintained a high level of confidentiality. All PTs had the opportunity to choose a pseudonym before the QIs (and their biographical data were saved under these aliases). The qualitative nature of the endeavor rises a variety of issues: [1] It was hard for the author to recognize how far the concealment of biographic data had to go, given that the outcomes were presented to different audiences; [2] The PTs had different perspectives on anonymity, and confidentiality; [3] Whether or not anonymization was practical or unpractical (depending on its distinctiveness), desirable or less desirable (depending on its importance in providing the social context of the analysis that is being developed), there was always the risk of 'deductive disclosure'. Apropos, someone with analytical skills could have inferred the identity of the PTs, from quotations, speech mannerisms, and/or context (Kaiser, 2009).

#### **Comparison of findings with previous literature**

McLaughlin, Giacco, and Priebe (2016) attested that restrictive settings are associated with victims' disapproval. Lidz et al. (1995), and Kuosmanen, et al. (2007) reached the same conclusion. Zinkler (2006) asserted that the government should give more opportunities to patients to clarify their doubts and/or fears. Others academicians have been saying all along that the public is misinformed when it labels authorities as lenient. Kallert, Mezzich, and Monahan (2011) declared that non-consensual interventions are often too discretionary. For Kaltiala-Heino et al. (2000), compulsory care is fairly frequent, associated with SMI, and not determined by patient populations but by political ideologies. Iversen, Oyer & Sexton (2007) alerted us that legal-, perceived- and objective coercion reduces treatment compliance. This situation represents formidable challenges to policy makers. Especially when caseloads increase, services decline, and even patients who are motivated to improve their wellbeing have little opportunity to do so (Petrilia, 1995). Drawing after his fieldwork in a federal institution of over 7,000 inmates in Washington D.C (United States), Goffman (1918-2007) coined the term 'total institution' to describe Psychiatry (Davies, 1989).

#### **Discussion**

TSO rests in the subtle ethical fissure between patient's right to liberty, and physicians' duty to preserve life. Medical procedures under it are noticeable for being carried out in General Hospital Psychiatric Wards or in Mental Health Centers. Most PTs considered TSO a form of abuse, and not a component of a harm reduction service. To cite but a few, Silvia claimed that "*it demolishes trust, and relationship in mental health care, because nobody wants to be held hostage.*" The same frustration is present in Domenico who recalled that "*injected drugs are sometimes so powerful that they transform a man full of energy into a (moaning) shadow of his former Self.*" That is no small thing, and the same happened over and over. Across the discussions, stories of perceived mistreatments were common rather than being unusual. Complaints made by, or behalf of, clients indicated that "*to get defensive against doctors or nurses means to get in trouble*" (Gianni), and that "*to be to be called irrational is to be condemned to a life of horrors*" (Enrico). Being committed can generate despair (Marco), paralysis (Carla), and nightmares (Manuela). Many have been successful in rebuilding self-esteem. Others



were in the process. Nevertheless, for a minority, TSO left open scars. This is worrisome because all domains of trauma provide for depressive disorders, and anxiety. The PTs longed for the adoption of a person-centered, and recovery-oriented language. But what they were truly referring to was that power's apathy erodes adherence/compliance. From the discussions, 3 core ideas surfaced: [1] The 'welfare/paternalist argument' stating the Italian society tend to ensure the wellbeing of citizens who are incapacitated; [2] The 'protective argument' stressing that those who are dangerous to Self and others (e.g. suicide ideation) must be stopped. And [3] The 'treatment argument' accentuating that TSO is a legal instrument for the administration of treatment that, according to staff, patients need (Pelto-Piri et al. 2016).

### **Conclusion**

There is an ongoing debate in Italy as to the place of TSO in medical care. What is clear is that lack of resources in facilities have led psychiatric triage specialists to escalate the use of force toward individuals with chronic and/or acute psychoses. And, whilst formal coercion is regulated by national legislation, other practices that are often referred to as informal are less modulated. Poignantly, the QIs showed that the expansion of institutional power at expense of the capacity of individuals to act independently, corrodes trust in care. Like a ripple on a blank shore, the phenomenon also extends to levels of citizens' confidence in other public services. This is a potential recipe for disaster. And, unless practitioners alter their basic assumptions, by evolving attitudes on crucial questions, and support the dignity of persons, incidents are bound to happen.

### **Suggestions**

To improve the therapeutic relationship (TR) and reduce disability associated with Schizophrenia some advices are: [1] Identification of risk factors which make an individual more likely to be subjected to emotional reaction to psychotic symptoms; [2] Implementation of procedures built on psychometric characteristics; [3] Adoption of verbal and non-verbal de-escalation techniques; [4] Promotion of courses of Human Rights in academic curricula; [5] Strengthening, and correct enforcement of Mental Health Legislation (MHL); And, [6] Elimination of health disparities/ inequalities across Italian regions.

### **Competing Interest Statement**

The author declares that no competing interests exist

### **Ethical Statement**

The author received informed consent by all participants, and all (their) biographical data, including name(s), and gender(s), were modified. In addition, as zeroed in on by Schroter et al. (2006), aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the author, the anticipated benefits, the potential risks of the study and the discomfort it may entail, were made explicit before commencing the analysis.

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