# Philosophical Interventions with Psychiatric Patients and Institutions

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## Abstract

The objective of this interactive presentation is to present a case involving a year long philosophical intervention with Gina, a hospitalized pregnant psychiatric patient, and to show the philosophical issues and methods used in securing adequate treatment and a successful discharge for the patient. The case involved individual, group, and organizational philosophical practice and serves to suggest the kinds of theoretical and practical philosophical issues this challenging new area of philosophical practice may involve as well as the kind of expertise philosophical practitioners will have to develop to be effective in doing philosophical interventions.

## Introduction

There is always a dialectical relationship between philosophical theory and philosophical practice. In my recent work with psychiatric patients, however, I have concluded that practice must be the foundation for theoretical work in philosophical counseling for this population. Problems and enlightened theories will evolve out of sustained practice with severely ill patients in psychiatric hospitals and out-patient programs. While philosophical practitioners, including myself, have long recognized that many of the criticisms of current psychiatric practice by anti-psychiatry critics are legitimate, and offered additional criticisms of our own, philosophical practice has been slower to acknowledge or to emphasize that that there are some psychopathologies which require medical intervention

and some psychiatric patients who need periodic hospitalization and often prolonged medication (Raabe, 2000, Feary and Marinoff, 2014, Feary, 2017). As a consequence, the role of philosophical practice on the front lines of mental health care has yet to be developed. The ensuing discussion of philosophical intervention is intended as a step in that direction.

What is an "intervention" in the technical sense of the term, and what is the role of philosophy in an intervention? Usually interventions are a form of crisis counseling which involve meetings with psychiatric or substance abuse clients conducted by mental health professionals retained by families for the purpose of getting clients to seek treatment in drug rehabilitation programs or psychiatric hospitals. There is a vast literature written by mental health professionals about the topic of intervention and various psychological models; cognitive models are the closest approximations to philosophical counseling. However, I shall use the term "intervention" in a broader construal to refer to meetings between philosophical practitioners and psychiatric patients in crisis, their families, and professionals (hospital treatment teams, psychiatrists, addiction counselors, social workers, lawyers, police etc.) essential to insuring the best possible outcome for that patient.

Why should a philosopher take a leadership role in guiding a psychiatric patient's treatment ? First, philosophers are equipped to understand the meta-issues (conceptual , ethical, legal, and interdisciplinary) ) often involved in patient advocacy, to facilitate communication with requisite professionals on the patients' behalf, and to continue to assist patients and families before, during, and after discharge in securing informed continuity of care. Second mental health care in the United States and elsewhere is in a state of crisis. Philosophers are needed to look at the fundamental ethical and socio-political issues involved in improving the care of patients with mental illnesses and protecting their rights to autonomy and wellbeing while undergoing psychiatric treatment. Philosopher have skills of argumentation necessary for questions existing hospital protocols and practices. Third, and perhaps most important is a point emphasized by psychiatrist and philosophical practitioner David Brendel; we need a pragmatic medical ethic in the clinic. ( Brendel, 2006) Philosophers can assist psychiatrists in promoting

democracy in the clinic by inviting respectful dialogue and negotiation between psychiatric patients, their families and their treatment team. The following case of Gina will serve to illustrate these points.

**The Case of Gina-**

In the course of my philosophical practice, I began doing some philosophical counseling with psychiatric patients four or five years ago as well as group counseling work in institutions serving psychiatric patients. One of my clients was a 20 year old woman we will call Gina. Gina was dual diagnosed with addiction and severe Bi-Polar disorder and had been in two drug rehabilitation programs and already had five hospitalizations resulting from non-compliance. During her last two hospitalizations, she was diagnosed with Schizoidaffective Disorder. At the time I began working with her, she was seeing a psychiatrist, who was medicating her with Lithium and Lamictal, seeing an addiction coach once a week, and attending daily AA groups. She was employed and living independently. She had been stable, sober, and compliant for a period of over one year thus meeting requirements upon which, at that time, I insisted when beginning work with psychiatric patients outside of an institutional setting. Most of my work with Gina had been involved with decision making skills, identity issues, self respect, alternative paths to spirituality, finding meaning and hope in adversity, guilt, forgiveness and responsibility issues. Her parents paid for her counseling with me.

Early in 2017 her distraught father called to inform me that Gina had contacted her family for help in the middle of the night: despite being sober and compliant she felt she was becoming manic and needed to go to a hospital to have her medication adjusted. The parents has immediately rushed her to a local ER where she was voluntarily admitted to their behavioral health unit for observation. When the parents returned that afternoon, they were told that Gina had been taken off both Lithium and Lamictal and had been involuntarily committed to a local psychiatric facility. When the parents protested, they were informed that Gina had been involuntarily given a pregnancy test, and an ultrasound, and had been found to be about five weeks pregnant. Her medications (Lithium and Lamictal) on which she was stable when compliant had been withdrawn in conformity with

hospital protocols on the grounds that their use might result in birth defects. When Gina became hysterical in being denied the medication upon which she relied, and in learning of a pregnancy that was unwanted and unplanned, she begged for medication to terminate the pregnancy. The request was denied on the grounds that she was becoming psychotic and was no longer "competent" to make such a decision, and she was also refused the medication which had maintained her stability and would restore her competency. In sum, there was reason to believe that the result of seeking psychiatric help would be a nightmare for Gina. She would be enduring prolonged psychosis and continuing an unwanted pregnancy for nine months in a psychiatric facility.

**The Stages of Philosophical Intervention in Gina's Case**

Philosophical intervention in Gina's case required coordinating a multidisciplinary team, facilitating communication between its members, and developing arguments to advocate for Gina based upon consultations with them and research of my own. The team consisted of Gina's out-patient psychiatrist, her addictions coach (who was also a psychological/addictions interventionist and of invaluable assistance), her family. two attorneys, and consultation with forensic psychiatrists.

The intervention can be broken down into three stages over a ten month period. Stage One involved assembling and coordinating a team of relevant professionals, advocating for Gina in the hospital to which she has been originally committed, and then overturning her commitment in this hospital when it became clear that the so called "treatment plan" of the attending hospital psychiatrist was leading to rapid deterioration and very likely irreparable harm

The philosophical issues at this stage included: the concept of mental illness, the grounds and ethics of involuntary commitment, the rights of patients and their families to understand and refuse treatment, the rights of pregnant psychiatric patients versus hospital protocols, and various methods by which philosophical interventionists can protect the rights of psychiatric clients.

Stage Two involved effecting Gina's transfer to a state hospital and philosophical counseling and advocacy for her there. both to restore her medication and to assist her in terminating the pregnancy as she wished. The philosophical issues at this stage centered upon how philosophical practitioners can advocate for patients in a hospital setting, rights to abortion in a psychiatric context, and effective philosophical counseling techniques with patients in a hospital environment.

Stage Three involved advocacy for Gina after an unsuccessful discharge from the state hospital, securing alternative private arrangements and ultimately arranging a successful discharge with adequate intensive outpatient arrangements. The philosophical issues involved at this stage were the use of advance directives to protect the rights of clients, and the role of philosophical counseling in protecting the equal rights of clients to autonomy and wellbeing after an acute mental health crisis .

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