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Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care

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Abstract

Purpose—Few studies have focused on the experience of involuntary psychiatric hospitalization among youth, especially the impact of these experiences on engagement with mental health services post-discharge. In this study, we contribute to a deeper understanding of youth experiences of involuntary hospitalization (IH) and its subsequent impacts on trust, help-seeking, and engagement with clinicians.

Methods—The study utilized a grounded theory approach, conducting in-depth interviews with 40 youth and young adults (ages 16–27) who had experienced at least one prior involuntary hospitalization.

Results—Three quarters of the youth reported negative impacts of IH on trust, including unwillingness to disclose suicidal feelings or intentions. Selective non-disclosure of suicidal feelings was reported even in instances in which the participant continued to meet with providers following discharge. Factors identified as contributing to distrust included perceptions of inpatient treatment as more punitive than therapeutic, staff as more judgmental than empathetic, and hospitalization overall failing to meet therapeutic needs. Conversely, participants reporting more

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mixed experiences of hospitalization and simultaneously strong indirect benefits, including greater family support, diminished family judgement members and greater access to care.

Conclusion—Findings draw attention to the ways in which coercive experiences may impact youth pathways to and through care. Additional research is needed to understand the impact of these experiences across larger samples, and their influence on downstream outcomes including engagement and long-term wellbeing. Finally, these data may inform the development and testing of inpatient and post-discharge interventions designed to mitigate potential harm.

Keywords

Involuntary hospitalization; Youth and young adults; Suicide prevention: pathways to care; Treatment engagement

Introduction

In regions without easily accessible outpatient mental health services, crisis services—including emergency department visits, involuntary hospitalization and crisis-driven police contact or arrest—all too often become a default entrée into services [1–4]. While such intersections have been widely characterized in the youth pathways to care literature as “negative” [1, 5–7], detailed investigation of the longitudinal role and subjective impact of particular pathway to care experiences, especially those involving coercion, remains surprisingly scarce. In one of the few exceptions, a Norwegian follow-up study of young adults hospitalized voluntary or involuntarily for a first episode of psychosis did not find that initial admission status adversely affected subsequent psychopathology or medication adherence [8]. In contrast, a US-based study concerning the development of post-traumatic symptoms and disorder in response to either symptoms or treatment experiences associated with a first episode, found that 71% of the sample had experienced involuntary hospitalization (“forcibly being taken to the hospital”) among other negative initial treatment experiences; 47% of such experiences in turn met DSM-IV PTSD criterion for “perceived threat” and 63% for having induced “intense fear, helplessness or horror” [9, 10]. Overall, 66% of the study sample met criteria for post-traumatic stress disorder (PTSD) resulting from trauma associated with symptom onset, traumatic treatment experiences, or their combination.

Within the adult literature, a small body of research on patients’ retrospective assessment of prior involuntary hospitalizations suggests that some, but not all, former involuntary inpatients, at a subsequent time point, retrospectively assess their involuntary hospitalization as justified [11–13]. Studies of the impact of involuntary hospitalization on subsequent outcomes at follow-up have been more mixed; for example, a handful of studies have found no association between involuntary treatment or perceived coercion and subsequent treatment engagement [14–16], while others have linked involuntary hospitalization with decreased service satisfaction [17–20], diminished quality of life [21] self-efficacy [22–24] and negative influences on subsequent view of mental health systems [25]. Furthermore, it is well documented that risk for suicide peaks in the months following discharge from inpatient psychiatric care [for review see 24]. While this could be due to a selection effect, where individuals with the greatest risk are most likely to be hospitalized, there is some evidence

that iatrogenic harm contributes to post-discharge suicide risk [26–28]. A recent longitudinal study found that patients who reported perceived coercion during hospitalization admission were at greater likelihood of making a suicide attempt in the year following discharge, even after controlling for covariates including current suicidal ideation, engagement in services, and a diagnosis of depression [29, 30]. Although this evidence suggests post-discharge outcomes are influenced by inpatient experiences, empirical characterizations of perceived involuntary hospitalization experiences and its subsequent impact on post-discharge outcomes are currently lacking. Turning to the qualitative research, a recent meta-synthesis describes a heterogeneous mix of involuntary hospitalization experiences, varying by population, setting and context [31]. Across studies, some participants describe a sense of “sanctuary”, while others report fear, lost autonomy and perceived procedural injustice.

Various mechanisms for positive and/or negative impacts of involuntary hospitalization have been proposed. Instrumentally, hospitalization may lead to an initial diagnosis that ‘validates’ struggles that may have been downplayed or whose severity was previously unclear [32]. Furthermore, particularly where effective discharge interventions and referral pathways are in place, hospitalization may effectively link youth previously unable to access outpatient services with needed care [33, 34]. Simultaneously, loss of autonomy, perceived procedural injustice, and negative treatment experiences may lead to perceived ‘institutional betrayal’ and ‘sanctuary trauma’ [35–38] thereby undermining faith in the beneficence of psychiatric institutions [39]. Hospitalization may also trigger or reinforce stigma apprehension [40], diminish trust in providers [41], detrimentally impact self-worth and other aspects of emerging identity, and disrupt peer and school relationships [42].

Goals

Given major gaps in the literature concerning the impact of early involuntary treatment experiences and conflicting findings within the adult literature, we undertook an exploratory multi-stakeholder qualitative study with the primary guiding question of how initial involuntary hospitalizations impact youth and young adult treatment pathways following discharge.

Method

Design

A grounded theory (GT) informed design [43, 44] was utilized to enable in-depth exploration of young people’s experiences of involuntary hospitalization and the impact of these experiences once discharged back into the community. Adopting a constructivist approach within GT [43] we sought to understand the relationship between involuntary hospitalization and subsequent treatment as a “discovered reality” arising through the interaction between researchers, participants and their narratives. In contradistinction from what is sometimes referred to as “full” GT, our goal was not to develop fully fledged theory but rather a more preliminary conceptual understanding of IH impact on pathways to care. Our analysis, as discussed below, emerged from the ground up.

Ethics

Protocols were reviewed and approved by the first author's IRB. Participants 18 or older provided informed consent, and minors provided assent along with parental consent.

Sampling and participants

Our recruitment strategy was multi-pronged and included posting recruitment flyers at community colleges and universities, cafes frequented by young people, outpatient treatment centers and community hubs. In addition, electronic flyers were disseminated via regional youth listservs and social media (Twitter and Facebook). Ultimately, we conducted in depth interviews with 40 young people (aged 16–27) who had experienced at least one involuntary hospitalization.

Sampling was purposive, with the overarching goal of interviewing participants with diverse demographic profiles and experiences of involuntary hospitalization (IH). As trends emerged which indicated a need for counterbalancing, we recruited more selectively (e.g., proactively interviewing male participants and declining female participants once it became clear that disproportionately more women were volunteering). Data collection was closed when thematic saturation was reached—i.e., no major 'new' themes had been introduced across ten successive interviews among participants reporting both positive and negative impacts on post-discharge engagement. The interviews themselves were semi-structured; for each episode of involuntary hospitalization, they covered precipitants, initiation, transport and hospital experiences, and short and long-term impacts (see supplemental information).

Data collection and analysis

The first, second and fourth authors conducted interviews, along with an additional doctoral level research assistant. Following grounded theory approaches, the team utilized constant comparison throughout the active data collection period: viz ongoing evaluation of similarities and differences across interviews and interviewers, including presentations and discussion of preliminary conceptualizations during lab meetings. As salient themes and additional areas for further inquiry emerged, the research team augmented the interview protocol with additional prompts.

Once all interviews were transcribed, the first two authors independently engaged in line by line inductive coding of five transcripts. Initial codes were then iteratively discussed, refined and tested on additional transcripts. Additional research team members were consulted at key points on issues of interpretation and categorization. Once a final codebook was developed, formal reliability checks were conducted using 8 independently coded transcripts and yielding a Krippendorff's alpha of 0.88.

The relationships between these initial codes were then conceptualized through axial coding, or the process of mapping out relationships between categories and sub-categories identified through initial open coding. Specifically, aligning with Strauss and Corbin's [44] axial coding schematic, we sought to identify and inter-relate causal conditions, context, action/interaction strategies, and consequences.

Reflexivity

The broader research team (those involved in interviews as well as coding and interpretation) included researchers with diverse personal experience of involuntary hospitalization as initiators, inpatient providers and service users. These perspectives were discussed and explored throughout the project, with an emphasis on understanding how differences in individual experience might influence interpretation. In addition, the team reflected on ways in which research team members' broader work might have influenced participant narratives. For example, one participant described googling the PI's work prior to the interview and agreeing to the interview only, because, from her point of view, the PI's research seemed trustworthy and collaboratively produced.

Results

Sample

Our final sample consisted of 40 youth and young adults (aged 16–27). Full demographics are reported in Table 1. Over half our Y/YA 'experiencer' sample (55%) identified as a member of an ethnic/racial minority group.

Core phenomena: trust/distrust

As the analytic process progressed, the theme of (dis)trust following involuntary hospitalization emerged as our organizing phenomenon. Participants were categorized into two groups: those who reported negative impacts on trust following discharge and those who did not. Subsequent analytic efforts then focused on understanding drivers and consequences of these two overarching patterns. Figure 1 in supplemental information provides a visual depiction of our emergent conceptual framework.

In total, 70% (30/40) of participants described negative impacts on their ability or willingness to trust others—most frequently mental health providers, but in some cases extending to broader authority figures (parents, teachers) and peers. Both the intensity of distrust, where present, and degree of behavioral impact varied:

“...it made me not really want to open up to anybody because I would still go through the motions, but before, I would be a lot more open about it to people close to me and the psychologists. But afterwards, I didn't really want to talk about things anymore”.

“[Afterwards] I would always think about, I don't want to go back to [the hospital]. I don't want to ... I can't tell anyone I'm feeling this way because they're just going to send me back.”

Causal experience and interacting conditions

Contrasting experiences of involuntary hospitalization

Distrust group: dehumanization and punishment rather than care: Overall, the majority of participants in both groups described at least some negative experiences of involuntary hospitalization. Nevertheless, among those reporting distrust (30/40), negative experiences were nearly ubiquitous, often noticeably more intense and not infrequently described as

“traumatic” or “damaging”. The negative experiences of the distrust group were also more often described not only as unwarranted but explicitly “punitive”. Additional quotations illustrating the experiences of this group are located in Table 2.

With respect to perceptions of overall atmosphere, just over half (16/30) of the distrust group compared the facility they stayed in to a ‘jail,’ ‘prison’ or other carceral institution; almost half (14/30) reported feeling ‘terrified,’ ‘scared’ or ‘unsafe’, while confined and three quarters (23/30) described either the staff they interacted with or the overall environment as cold or unempathetic. Many (13/30) invoked the language of “dehumanization” (e.g., “they very much treated you like you were not a person in there. They very much undermined and belittled you”; “It felt dehumanizing... because they would not believe anything you said”). 13.3% (4/30) expressed concern that there had been no “meaningful” efforts to address the actual sources of their distress, and close to half (14/30) reported either no or very minimal (and inadequate) individual therapy or counseling.

Turning to narratives of more specific incidents of harm, one participant reported a sexual assault and two others sexual harassment by other inpatients; in all three cases, participants felt that staff took only minimal steps to ensure their safety and superficial de-briefing. Two participants noted that they were “threatened” with either a longer commitment period or sedation (e.g., “[staff were like] ‘Oh, if you don’t behave, we’re gonna sedate you’”) and four were secluded and/or restrained. An additional three participants described specific instances of negligence or maltreatment, in one case observed, i.e., staff forcing an elementary school aged child to eat food that she was allergic to (and who had repeatedly attempted to communicate this); another participant reported forced (and unwarranted) medical testing due to a medical records error.

Across these narratives, what we came to conceptualize as perceptions of moral judgement were common—for example the feeling of having been judged to be “lesser than,” “intellectually deficient” or “[like a] criminal” (see Table 2). Those participants describing these experiences often expressed anger about the fact that providers ostensibly tasked with supporting struggling youth instead blamed or belittled them. Almost half (43.3% (13/30)) reported “learning to lie” or “manipulate” staff to be discharged, calculations which seemed necessary in an environment in which social norms of fairness and mutual trust had seemingly been suspended. In at least some of these cases participants explicitly tied an internalized imperative to misrepresent their actual emotions to analogous post-discharge behavior (see Table 2 for examples). “Lying” within an inpatient setting, that is, set the stage for misrepresentation and intentional non-disclosure once participants returned to outpatient clinics.

Trust intact group: positive aspects of hospitalization and direct benefits: While only a few ‘trust intact’ participants described their experiences as positive overall, many more noted positive aspects of hospitalization that appeared to soften or counterbalance negative experiences. Examples included beneficial therapy groups or activities, “stand out” staff who left them feeling cared about and heard, and roommates or other youth with whom they bonded. See quotations in Table 3. A subset described explicit benefits in terms of improved mental health.

Distrust group: unmet expectations and unaddressed distress: Within the distrust group, negative experiences often seemed particularly impactful for participants who had expected the inpatient hospital environment to be very different; for example, 56.7% of the distrust group described their hospital stay as worse (or much worse) than they had expected versus only 20% (2/10) in the ‘trust intact’ group. In most cases the expectation was that inpatient hospitals would provide intensive therapy and/or psychosocial supports. Similarly, the majority of the distrust group (17/30), but only a few ‘trust intact’ participants felt they were either worse off after discharge or that their precipitating symptoms had gone unaddressed and were thus unchanged at discharge (Table 4).

Contrasting impacts and experiences following discharge

Intact trust group: indirect positive impacts: All ten of the intact trust participants described at least one significant “indirect” positive impact of hospitalization (compared to a minority of the distrust sub-group). Examples included participants’ parents or families taking their mental health challenges more seriously after discharge; experiencing less blame from family or friends; or ultimately receiving mental health services (including medications) as a result of their hospitalization that they felt were helpful. For six (of the ten), these ‘indirect’ positives included what was often framed as a kind of ‘wake-up call’ or ‘aha moment’ brought about by hospitalization, prompting participants to make needed changes in their lives, and/or take more responsibility for themselves. An additional subset described changes in perspective, generally involving the realization that their lives were better than many others’ (ie those with worse problems and more social disadvantage; see Table 5 for quotations).

Distrust group: post-discharge engagement with mental health services: Within our sample, distrust and engagement with services in the broader sense emerged as orthogonal, if sometimes overlapping, constructs. Among those reporting distrust, 8/30 reported minimal (short term) post-discharge use of mental health services followed by sustained disengagement, 2/30 avoided or disengaged from all mental health services from discharge on, 2/30 conveyed that they would potentially have been interested in post-discharge treatment but their parents would not allow or could not afford it; the remainder (16/30) reported some ongoing service use. Of these 16, seven began taking medications following their initial involuntary hospitalization, four were prescribed medications during involuntary hospitalization but decided against taking them (or any other psychiatric medications) once discharged, and 10 continued taking medications initiated prior to the hospitalization. With respect to therapy or counseling, 6/30 reported only negative experiences of therapy following discharge (which they then discontinued), 3/30 reported both negative and positive experiences, and 11/30 reported positive experiences (though for two these were short term).

Of the nine young people who reported both positive experiences of longer-term therapy and distrust, three reported eventually opening up about their fears of involuntary hospitalization with providers, and through reassurance, ultimately coming to believe they could safely disclose:

“Well, it took me a while to be able to be trusting of my therapist to be truthful about what goes through my mind about mental health, about the self-harm

ideation and suicide ideation and stuff because I was so afraid to get [involuntarily hospitalized] that I would hold back. I would literally, I would censor myself. [But] at one point, [my therapist] noticed that, and he said, ‘Why are you so against it?’ I ended up describing what happened, and he goes, ‘Well, I understand more now.’ He’s like, ‘Just so you know, not every experience is going to be like that.’”

“...it’s been the various counselors I’ve seen [who have explained that ideation alone should not lead to involuntary hospitalization]. They’ve all said the same thing which brought me comfort that they were consistent.”

An additional two participants felt that only certain classes of providers could not be trusted, in both cases linked the provider type who had initiated their involuntary hospitalization: for one this was primary care, for the other it was school-based counselors. Another three engaged with therapists, reporting positive experiences, while consistently refusing to bring up suicidal feelings out of fear of being sent back to involuntary hospitalization facilities, e.g.:

“I would always think about, I don’t want to go back to [inpatient facility]. I can’t tell anyone I’m feeling this way because they’re just going to send me back. I kind of knew if I had a plan that was kind of the red flag for the therapist, so I never said I had a plan even though I was hoarding pills for a good three years [all while in therapy]. I just remember always wanting to do it [suicide] but not saying anything.”

The last participant in this sub-group reported becoming more discerning:

“I’m a lot pickier about what I share in the beginning of meeting a new mental health provider. I don’t talk about this stuff right away [and] try to suss out what their personal takeaway is on hospitalization, how they think about trauma and triggers...if a provider doesn’t see me as a sound enough mind to make my own decisions, I’m not interested in seeing them long term.”

Among those reporting distrust who disengaged (or simply never ‘re-engaged’) after discharge, underlying distrust along with fear of a repeat involuntary hospitalization, was repeatedly referenced:

“...being [involuntarily hospitalized] that one time was enough to make me shut out all help from figures like therapists and school workers, my parents, for fear of going back to that place. I’ve had night-mares about it. So it really only caused me to shut in on myself further, and force out their help rather than look for it and accept it.”

Longer term consequences

Within our sample, only one participant reported making a serious suicide attempt following their initial involuntary hospitalization. However, many of the statements we heard were suggestive of the potential sequelae of distrust and associated decisions to not disclose or not seek help. Specifically, these consequences included unwillingness to seek help in the future even if suicidal:

“I definitely didn’t ever wanna get [involuntarily hospitalized] again. ...if I ever got to a point where I was suicidal again, I think I would be too scared to get help because the whole experience terrified me. And I always tell my parents, “No, that didn’t scare me. I’d be fine. I’d get help if I do it again.” But I don’t think I would. I don’t think I would, it was terrifying.”

And warning friends or peers not to seek help to avoid hospitalization:

“I tell my friends because I care about them, I’m like, ‘Look, if you’re depressed, go get mental help, but get it outside of school. Don’t ever go to a guidance counselor and tell them that much about you because [they can have you involuntarily hospitalized] and that’s gonna make you feel worse, going in [to these facilities] and being treated that way.’”

Discussion

Summary

Overall, the analytic work described in this study sought to deepen our understanding of the impacts of involuntary hospitalization on subsequent treatment engagement among youth, including how and why some young people may experience lasting negative effects on trust and others not. The pattern of experiences most common among those reporting distrust included more negative perceptions of hospitalization overall, frequently involving the sense that the hospital environment was more punitive than therapeutic, closer to a jail or prison than a place of healing, and that staff were judgmental rather than empathetic. Youth in this group rarely reported either direct or indirect benefits—many felt as depressed or more so at discharge relative to when they’d entered. For those with intact trust a different overall pattern emerged: most reported at least some positive aspects of hospitalization, the majority reported feeling at least somewhat better on discharge, and all described significant indirect benefits, including greater access to services and increased parental support as a consequence of IH.

With respect to post-discharge service patterns, distrust and unwillingness to disclose did not neatly map onto categorical disengagement: in many cases, selective unwillingness to disclose suicidal thoughts were reported even among participants who opted to use (or continue using) outpatient mental health services.

Implications

While a series of recent national reports and white papers have underscored the need for reductions in use of and reliance on crisis services, including involuntary hospitalization (IH), the fact remains that IH are a relatively common experience, and often figure in youth pathways to care, especially among those with significant mental health challenges [1, 4, 7, 9]. In Florida, where the study was based, 62,406 youth were involuntarily hospitalized during the 17/18 fiscal year [46]; a rate that has been increasing for at least the last decade, trends mirrored in other US States [47]. While our efforts recruited participants with experiences of involuntary hospitalization specifically, impacts and mechanisms explored here may well be present among the even larger numbers of youth who are ‘voluntarily’ hospitalized

[48]. Given the potential for negative impacts on help-seeking, disclosure, and potentially suicide, it is critical to continue to deepen knowledge of the ways in which early involuntary experiences impact youth and develop and test strategies to mitigate harm.

Mechanisms and process

With respect to theory, our findings are broadly consonant with the institutional betrayal [35, 36] and sanctuary trauma [36–38] literatures as well as research finding an inverse relationship between perceived procedural injustice in hospital admissions and therapeutic alliance [49, 50]. Within our sample, we nevertheless noted that the perception of hospital staff and policies as not just disrespectful or unfair but explicitly ‘punitive’ played an especially strong role in shaping participants’ experiences and their subsequent impact. Within our sample this experience of IH was often reinforced by police involvement and handcuffing, strip searches, elopement risk procedures and other practices mirroring arrest and/or incarceration. Furthermore, the age and developmental stage of a youth population raises questions not just about the point-in-time impact but also their influence on emerging understandings of ‘mental health’ and associated roles and systems. On this point, work within the legal socialization literature [51, 52] may have much to offer future studies: viz encouraging exploration of the ways in which early exposure to involuntary treatment laws and coercive experiences may “acculturate” youth to the mental health system through coercive legal intersections, in turn shaping their developing views, attitudes and beliefs in detrimental ways. The presence of perceived ‘blame’ also suggests potentially fruitful links to the literature on processes underlying the internalization of mental illness stigma [53].

Turning to the relationship between IH, engagement and disclosure, one of the more significant surprises was the extent to which youth did, at least nominally, continue to engage with providers after discharge, even in cases in which they felt unable to disclose suicidal feelings. Studies operationalizing post-discharge outcomes only in terms of (categorical) outpatient service utilization would thus miss this dimension of what might nevertheless be understood as a dimension of disengagement. Other participants in our sample engaged only with prescribers, in at least some cases specifically because they perceived the risk of inadvertently disclosing feelings to be lower than in therapy—a further differentiation of importance to developing a more comprehensive understanding of youth (dis)engagement with mental health services [4, 54–56].

The phenomenon of ‘indirect benefits’

Among members of the research team there were a variety of perspectives on the phenomenon of ‘indirect benefits.’ Indirect benefits were described in both the distrust and intact trust groups, though they were ubiquitous and occupied a more central place in the latter group. From a positive psychology perspective, these reports might be viewed as examples of early post-traumatic growth or ‘catalysts for positive life change’ [48]. Moreover, at least some participants appeared to suggest that no other event would have been of sufficient magnitude to bring about the changes in question—whether a transformation of parents’ attitudes toward their struggles or a more fundamental perspective shift on their part. Future research designed to further unpack these benefits would be helpful, including studies comparing alternative approaches to achieving change within the

same domains, including interventions designed to bring about more fundamental shifts in parental support or youth motivation for change [57–59].

Intervention development

With only five exceptions in our sample of 40, participants reported an absence of opportunities to “process” their experiences of involuntary hospitalization with therapists or other providers. For the five who did, these opportunities were perceived to be very impactful. These accounts suggest a potentially important role for post-discharge debriefing interventions or other ‘post-vention’ processing, possibly only requiring a single session [60–63]. In theory, such debriefing could be provided independently of other mental health services—for example, a third party or peer-operated service could provide one or more postvention session(s) regardless of service recipients’ decisions to otherwise engage with mental health services. Participant accounts also suggest that debriefing and processing should be consistently integrated into clinical practice. Finally, participant report regarding inpatient environments suggests a strong need for the development and evaluation of interventions designed to promote trauma-informed, and patient-centered practices in IH facilities [64–66], including efforts to more strongly differentiate hospitalization from incarceration.

Limitations/context

Participants in our sample ranged from those who clearly indicated affluence to those reporting significant socioeconomic disadvantage; for example, one participant was homeless and several others had grown up within the foster care system. Study findings nevertheless may not extend to more severely disadvantaged groups, including youth with long histories of involvement in the criminal justice system. Furthermore, all interviews were conducted in the state of Florida and while some participants also described involuntary hospitalizations in other states, the majority took place in a single region of the US. More participants were women than men, and the African American sub-group ($n = 4$) was small relative to the youth population in Florida. Bearing these limitations in mind, the work we described was designed to be exploratory, not confirmatory, and to generate hypotheses for future work aimed at a more comprehensive understanding of the role and impact of coercive practices in the context of initial pathways to care.

Conclusion

In spite of international efforts to reduce reliance on acute care, emergency services, including involuntary hospitalization, remain relatively common experiences for youth with a wide range of underlying mental health conditions [47]. Study findings underscore the potentially detrimental impact of involuntary hospitalization on subsequent provider trust and help-seeking and the importance of further research on the mechanisms identified here, as well as interventions aimed at promoting empathy and patient-centered values in inpatient settings. Opportunities for service users to process involuntary hospitalization experiences following discharge should be made available wherever possible.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Data availability

Due to methodology (in depth interviews) ethics permissions do not permit transcript sharing.

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Table 1

Youth/young adult demographics

Category	Frequency (percent) or mean
Sex	
Female	28/40 (70%)
Genderfluid or non-binary	1/40 (2.22%)
Race/ethnicity	
White	18/40 (45%)
African-American	4/40 (10%)
Asian-American	5/40 (12.5%)
Latinx	12/40 (30%)
Multiracial	1/40 (2.5%)
Neither parent completed college	11/40 (27.5%)
At least one parent with a graduate degree	12/40 (30%)
Age at time of interview	19.4 years
Age at time of initial involuntary hospitalization	16.2 years (range 11–23)
Time between initial involuntary hospitalization and interview	
1 month-1 year	27.5% (11/40)
1 year-3 years	27.5% (11/40)
4 years-6 years	30% (12/40)
More than 6 years	15% (6/40)
Involuntarily hospitalized two or more times	13/40 (28.9%)
First involuntary hospitalization in secondary school	20/40 (50%)
First involuntary hospitalization after high school	20/40 (50%)

Table 2

Distrust group: dehumanization and punishment rather than care

Theme	Example quotations
Analogies to prison or jail	"It was like a prison. You wake up at this time, they come in to wake you up, if you want to shower they have to be [there] monitoring. We would ask, "When are we going to do this? When are we going to do that?". It wasn't like [we were] talking to them, it was like they were just standing guard and just very cold."
Dehumanization	"After lunch, maybe, they'd take us outside [to] this little enclosure that was all fenced in. Felt like little animals on display there. After that, a few hours until dinner. All the time, you were just nothing. You'd sit there and watch the television like if you weren't insane before, you would go insane at this place."
Moral judgement	"...they didn't see us as people. It was just another patient coming in and out. The staff would kind of make jokes to one another, think they were above us because we were in the facility and they were in the staff"
Learning to lie	"[At the hospital] I just really noticed a lot of power trips... It's really easy to slip into a mindset of judgment when you're interacting with mentally ill people, because it's... it felt like they wanted that career not to help people, but to feel better than people" "The mindset you get into there, at least what I got into was like, 'Okay, I need to pretend I'm okay so that they'll let me out.' Because you aren't going to get better in that situation. You're just gonna pretend to be better, so they'll let you out, so you can go back to an easier life."
Learning to Lie' carrying over to post-discharge behavior	"[One of the other patients said] 'Hey, you need to stop crying,' and I was like, 'Why? I don't care. Why?' And one of them is like, 'Well, they won't let you out unless you show emotional stability,' and I was like, 'Oh my God. Okay.' "...the first thing I learned as soon as I was put into the hospital was that I couldn't actually talk about what was wrong. Because then I would be taken against my will somewhere, and my parents would have to pay for it... So as soon as I was told I couldn't leave, then I shut out even more. And I'd already been reluctant to hand out information, but at that point it was, 'I'm just going to say whatever I need to get out.' To anyone, to my parents, to therapists, whatever I need to do to make them think nothing is wrong." "Well...you learn really easily. You learn really easily. Unless you have some [condition] where you actually don't understand what it is that the person could be looking for from you, of course you know. Do you want to kill yourself today? 'No, I would never want to kill myself. I would never do that.' Are you depressed? 'No, I'm not depressed. Everything's great. Of course, I'm not going to ...' [If] you show your honesty, you get sent away. So from that point on, you're done [being honest]."

Table 3

Intact trust group: mixed or positive experiences and therapeutic benefit

Theme	Example quotations
Bonding with other patients (versus staff)	"I was nervous about the kids and then the kids ended up being the best part of the experience [whereas] I had expected the staff to be understanding and respectful and they were not either of those things"
Enjoyable groups or activities	"Every other day you'd do occupational therapy, we did art therapy. We did have some talking therapy, we did some sports stuff like ropes courses and stuff like that, which is always fun, so that was really cool."
Standout staff	"There was one [clinician]...I wish I remember his name, but he was...I really liked him. There was something about the way he carried himself, and the way he interacted with people. I felt like he... it was like a calming presence kind of thing."
Therapeutic benefit	"The guy who walked me [out] when my mom came to pick me up, he said to my mom, "It's like she's a completely different person." I think I really got the care that I needed."

Table 4

Distrust group: unmet expectations and unaddressed needs

Theme	Example quotations
Unmet expectations	<p>“My only experience with inpatient stuff was from movies, which was not accurate. I expected it to be more like [‘To the Bone’ on Netflix]. You were just kind of at a hotel, and you were allowed to do your own thing and...in the movie they had their phones. So I expected, I was like I’ll be able to have my computer and all this stuff. It shouldn’t be too bad. I won’t get behind in school. [But] It was not like the movie at all, obviously.”</p> <p>“I didn’t know what involuntary inpatient even was. What I thought something like that would be, would be more like a lot of counseling, a lot more help in that sense. But, it was less of help and more of like, ‘Oh, we’re just going to keep you for 72 [hours] ...’”</p>
Unaddressed needs	<p>“...that’s the thing, it makes you feel worse afterwards than you did before. I’m sitting here, I’m more depressed and stressed coming out of that, and freaked out, than I was going in before”</p> <p>“It was so unhelpful. There wasn’t any kind of psychological help really to it. It wasn’t like therapeutic in any way.”</p>

Table 5

Intact trust group: indirect benefits

Theme	Example quotations
Greater family support	<p>"It made me a lot closer to my family because it made me see how much they actually did care about how I was doing and I got a lot closer with my parents. I got a lot closer with my sister. So, in that sense, it was a benefit."</p> <p>"[it] definitely [affected] my relationship with my parents. It really opened up the conversation for what can we do, because I don't want to say they were ignoring it, but it was definitely hard for them to think about their child being in such distress. After...they were like, something clearly is not right in your life and we want to help you with that. That really...that was a big change in my relationship with my parents"</p>
Wake up call	<p>"I've become a much more like independent person, and I'm working towards being a lot more positive, because that was kind of like, just a big low period for me. Seeing what it was like inside the facility, and seeing some of the other patients and stuff, it kind of just made me want to get better because I don't want to go back to something like that."</p> <p>"The [involuntary hospitalization] was definitely a motivating factor to change within myself. Instead of railing against everything in my life that was staying the same. I just kind of wanted to do things for myself, and be able to say that I was dealing with it. It motivated me to not do the things I was doing to not handle things in the same way. To stop harming myself."</p>
Perspective taking	<p>"[Most other inpatients] were significantly younger than me. It made me realize how lucky I was in my situation because they were these 10-year-old kids that had abusive parents and things like that and it just made me more grateful for what I had and where I was coming from."</p> <p>"In retrospect, [it] did give me insight into - "okay, there's a lot of people here who have much worse lives than me."</p>