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Review Article

Coercion, trauma, and recovery: A critical analysis of mental health hospitalization services

Coerción, trauma, y recuperación: un análisis crítico de los servicios de hospitalización en salud mental

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ABSTRACT

Psychiatric hospitalization services are designed to provide care for individuals with severe mental health conditions. However, studies have identified challenges in their implementation, particularly those related to patients' lived experiences and their impact on recovery. Building on this, the objective of this article is to critically and substantively discuss how involuntary admissions, lack of information and participation, the use of restraint and isolation, as well as the physical and social environment, among other factors, may significantly hinder recovery, damage therapeutic relationships, and even generate traumatic experiences. Additionally, this paper briefly discusses innovative therapeutic models and initiatives while reflecting on the role of clinical psychologists in these hospital settings. Finally, it invites a broader discussion on the usefulness of the predominant model in hospital-based mental health care and suggests exploring and validating alternative approaches.

Keywords: Psychiatric hospital; Coercion; Physical restraint; Psychotherapy; Isolation.

RESUMEN

Los servicios de hospitalización psiquiátrica están diseñados para brindar atención a personas con trastornos mentales graves. No obstante, estudios han identificado desafíos en su implementación, especialmente los relacionados con las experiencias de los pacientes y su impacto en la recuperación. A partir de ello, el objetivo de este artículo es analizar de manera crítica y sustantiva cómo las admisiones involuntarias, la falta de información y de participación, el uso de la sujeción y el aislamiento, así como el entorno físico y social, entre otros factores, pueden obstaculizar significativamente la recuperación, deteriorar las relaciones terapéuticas e incluso generar experiencias traumáticas. Además, el texto examina brevemente modelos e iniciativas terapéuticas innovadoras y reflexiona sobre el papel de los psicólogos clínicos en estos entornos hospitalarios. Por último, invita a un debate más amplio sobre la utilidad del modelo predominante de atención en salud mental, basado en la hospitalización, y sugiere explorar y validar enfoques alternativos.

Palabras clave: hospital psiquiátrico; coerción; contención física; psicoterapia; aislamiento.

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INTRODUCTION

Despite international efforts to promote deinstitutionalization in mental health care[1] and although some countries have advanced toward more community-based, supportive, and human rights-respecting models,[2-5], psychiatric hospitalization remains a cornerstone for the care, rehabilitation, and treatment of individuals with severe mental health conditions.[1]

In Colombia, efforts remain insufficient, with mental health reform still awaiting development. While there have been legislative advancements (e.g., Law 1616 of 2013, National Mental Health Policy of 2018, Law 2460 of 2025), the practical reality may be bleak: the lack of community care centers is compounded by fragmented services and the persistence of psychiatric clinics that remain isolated from general hospitals.[6]

According to international statistics, in countries like England, 91,945 individuals were admitted to psychiatric clinics in 2023, representing 2.60% of all users who engaged with mental health services.[7] Similarly, data from Europe indicate that over 15.10% of users are readmitted shortly after discharge.[8] According to Buck et al.,[9] there is a readmission rate of over 18% for inpatient psychiatric facilities in the United States, which is over 25% higher than that of general hospitals. These authors expressed concerns about these statistics and indicated the need for improved inpatient treatment and positive strategies following the client's discharge.

In Latin America and the Caribbean, the outlook is equally challenging. A report by the Pan American Health Organization[1] found that over two-thirds of patients admitted to psychiatric hospitals (74%) have an average stay of one year, while 20% have a median stay of five years. In Colombia, according to the National Mental Health Observatory, 968,051 people were hospitalized in 2017 (the most recent data available), with 8,205 admitted due to severe mental health conditions such as schizophrenia, schizotypal disorder, and delusional disorders.[1]

Psychiatric hospitals represent complex environments where diverse individuals with numerous diagnoses, either voluntarily or involuntarily, are admitted. From a professional perspective, the goal is to provide care and clinical management of symptoms and disruptive behaviors while ensuring safety. Conversely, from the patient's perspective, hospitalization can signify an existential crisis, a disruption of life accompanied by a loss of identity and feelings of hopelessness, which negatively impact quality of life.[10,11]

These issues have spurred research,[10-18] some aimed at understanding what it means to be admitted to a psychiatric facility, the implications of voluntary or involuntary admission, the value of therapeutic relationships, experiences with coercive practices, and the physical and social environment, among other factors influencing recovery. Such studies have driven the creation of promising alternatives.[19,20]

This review critically examines contemporary models of psychiatric hospitalization, delineates their structural and ethical challenges, and analyzes their impact on mental health services. The review systematically synthesizes recent empirical work, primarily qualitative studies that illuminate service users' perspectives. Information regarding innovative alternatives now emerging in Europe and the United States is provided. Based on the review, inpatient hospitalization practices that prioritize person-centered therapy, human rights, and increased client involvement in their care are recommended.

ADMISSION

Admission to a psychiatric hospital may result from personal events causing significant stress,[18] often due to a lack of internal, interpersonal, or environmental resources.[18-21] For some, hospitalization may represent relief, an escape from problems, or a means of staying alive.[21,22] For others, it is a source of profound confusion and fear,[25,22-24] a restriction of freedom, and a disruption of their lives.[18,21,22]

A crucial aspect of hospitalization is whether it is voluntary or involuntary. Voluntary admissions are generally experienced positively by individuals, fostering therapeutic relationships and a collaborative attitude.[24] In contrast, involuntary admissions often stem from coercion,[17] heightening paranoia, distress, and feelings of powerlessness,[22] while exacerbating suffering.[21,25] Some users report a sense of rights violations[21] and traumatic experiences.[17,23,25] Compounding this issue is the lack of information about admission reasons, length of stay, treatment plans, and medication.[15-17,22-24]

Regarding the minimal or nonexistent participation in decision-making, it seems that once a psychiatric diagnosis is assigned by a professional, particularly one indicating severity, such as schizophrenia, the individual's personhood may be erased.[25] Opinions, needs, fears, expectations, subjective experiences, and life plans may be disregarded, with no consideration of the individual's capacity to make decisions. Individuals should not be forced into these facilities except in exceptional circumstances, such as when there is an imminent risk to themselves or others.[17,22,25] In such cases, transparent and collaborative discussions may help determine whether hospitalization is likely to benefit the individual or potentially exacerbate suffering. Importantly, decisions that rely exclusively on psychiatric authority risk framing distress as purely medical and treatment as necessarily pharmacological, an assumption that has been questioned in critical literature on neurobiological reductionism.[26]

DURING THE STAY

Once admitted, patients may face diverse situations and experience a range of emotions. Regarding infrastructure, psychiatric facilities, whether modern or outdated, public or private, are often perceived as unsafe and unfamiliar places,[23] experienced as emphasizing behavioral containment and confinement rather than therapeutic care. In some cases, the layout of the hospitals and the distribution of patients evoke the imagery of captivity.[15-17,23,25]

Regarding the social environment, establishing positive interpersonal relationships can foster a more favorable perception of hospitalization.[21,24] However, restrictions within the facility often hinder positive therapeutic relationships between patients and staff, heightening feelings of isolation.[16] Additionally, the diagnostic characteristics and concomitant issues of other patients (e.g., criminal backgrounds, history of sexual abuse, violent behavior) can be intimidating during admission and stay, perceived as risks to personal safety, complicating integration, and generating fear.[23-25] These factors can also contribute to the chaotic, noisy, and agitated atmosphere of some clinics and hospitals.[15]

Another important consideration is that children admitted to inpatient hospitals often struggle to form attachments to caregivers due to prior abuse or mistreatment. Sometimes, the relationship between hospital staff and admitted patients can be positive; children, in particular, may become close to staff and develop attachment. Once these children are discharged from the hospital, it could compound their struggles with abandonment and trust, possibly creating attachment disorders. Given this reality, it is pertinent to ask: Who can find peace under such unfavorable conditions? The need for a healing environment underscores the importance of developing a more open infrastructure, closer to the community, with access to natural and familiar environments that reduce the sense of isolation. Structuring spaces and dynamic interaction to account for individual needs and perceptions would also help create a safer environment, reducing anxiety and promoting social integration.

Regarding daily activities, routines may become monotonous over time, marked by passivity and neglect.[10,15,24] Some activities may be unappealing or even infantilizing, leading to boredom, loneliness, and demotivation.[25] In this context, individuals may benefit from remaining in their communities while receiving

clinical care. This approach would reduce coercion and isolation, ensuring a more favorable recovery context with personally meaningful spaces and activities shared with close, significant others.

Medication is another topic to be examined. Many times, it becomes the focal point of treatment due to the dominance of biological theories in mental health. Furthermore, patients are rarely involved in decision-making, a situation further complicated by limited information. While some patients view medication as necessary, others reject it due to its side effects on daily functioning.[22] Every patient has the right to participate in decisions about prescribed medications, including indications, side effects, dosages, effectiveness, and non-pharmacological alternatives. Notably, some patients comply with medication during hospitalization solely to expedite discharge, only to abandon their prescriptions afterward.[17,25]

In addition, the problem of overmedication and administration practices warrants attention. Clinicians sometimes prescribe medications to mask the side effects of other drugs. Even more troubling are instances of intimidation or deception to ensure medication intake, such as mixing pills into food.[25] The emphasis on medication and its involuntary use is deeply concerning,[22] with some arguing it has little to do with recovery.[21,25]

RELATIONSHIPS WITH THE THERAPEUTIC TEAM

One of the most sensitive and complex aspects of mental health hospitalization services is the social interactions between patients and care teams. These relationships may be crucial for recovery but can be adversely affected by factors such as involuntary admission or the manner in which medical staff treat patients.[23,25] Often, such admissions involve force and coercion,[17] heightening distress, confusion, and trauma.[15,17,23] These experiences foster negative attitudes toward psychiatrists and nursing staff, who are typically involved in the admission process.[25,27]

Trust is a cornerstone of these relationships, essential for expressing complex and difficult emotions.[16] However, building such trust with clinical staff is not always possible. Sometimes, a distant, cold attitude prevails, with little interest in patient needs. The lack of provider empathy may stem from workplace overload, staff shortages, systemic flaws, or even a lack of vocational commitment, shaped by paradigms, interpretive frameworks, and sociocultural and economic conditions.[16,21,24]

Patients commonly report several issues in their interactions with care teams during inpatient hospitalization. The most frequently cited concern is that patients experience staff who focus on their behavior rather than on their underlying emotions.[16] Patients also report care teams' emphasis on medication rather than the person.[22,23] Many also describe a lack of emotional support during critical incidents,[17] and feeling isolated.[15] Additionally, some patients perceive staff responses to their requests as dismissive or marked by annoyance,24 and express frustration with promises made by the care team that ultimately go unfulfilled.[22]

The heavy emphasis on diagnosis, symptoms, and medication may teach patients to manipulate clinicians' perceptions, claiming they no longer hear voices, sleep well, or adhere to medication, solely to secure discharge.[25] The lack of patient transparency is not an excuse for patients not being honest about their functioning. Still, dishonesty is evidence of the absence of genuine therapeutic alliances aimed at proper recovery.

Professionals must understand that no procedure can ever outweigh the person.[22] Poor communication and lack of contact intensify suffering,[23] whereas attentive, warm, and empathetic attitudes strengthen therapeutic bonds and reduce feelings of isolation.[22,23] Behind every diagnosis and symptom lies a person, and this person must remain the focus.[23,25] It cannot be forgotten that those who seek mental health services do so because they are suffering. The response cannot be abandonment or neglect, as occurs in some cases.[15-17,22,24]

COERCION AND TRAUMA

Among the most critical and sensitive topics in this article is the use of physical and/or chemical measures to control behavior. These procedures may be employed during emotional dysregulation or psychomotor agitation to prevent self-harm or harm to others. From the perspective of some hospital-based professionals, practices such as restraint and isolation are justified as last-resort interventions under established protocols and training. However, from the patients' viewpoint, these procedures can be profoundly harmful, to the point of being perceived as human rights violations.[1,23,25,27]

The following scenario illustrates this issue: A patient experiences emotional dysregulation and psychomotor agitation. Professionals may interpret this as a symptom exacerbation or relapse, an inherent reaction to the patient's "illness." However, from the patient's perspective, such behavior may be a legitimate response to being in an unwanted environment or a consequence of authoritarian attitudes and disregard for personal needs. In such cases, it is more valuable to focus on the patient's intentions, desires, and concerns, as well as the underlying motivations for their distress. Connecting to each highlights a critical issue: the type of help offered may not align with what some individuals truly want or need.

Standard restraint procedures include isolation, physical holds by staff (often involving struggles and joint locks), and devices such as straitjackets or straps. Resistance from patients is inevitable, making these measures more violent and emotionally damaging. Patients may sustain bruises, dislocations, suffocation, or muscle injuries, not to mention psychological trauma.[10,17,25,27] These practices also erode therapeutic relationships,[27] violate individual rights,[1,23] and reflect a failure to provide treatment rooted in dialogue and active listening.[25]

Another aspect to consider is that, if those who are being admitted into inpatient settings, regardless of age, are coming from abusive environments of physical control or restraint, and then experience similar restraining techniques within the hospital, it can be activating and cause patients to become volatile and emotionally dysregulated. Even though staff implement these strategies for safety, it is essential to know patients' histories and the techniques that could increase psychological harm.

Alarmingly, these are not rare incidents but may be routine techniques in many psychiatric clinics and hospitals. This situation has been associated in the literature with limitations in training and awareness, particularly in contexts where these methods are described as routine daily procedures. However, countries like the UK and Finland have banned or strictly regulated such practices.

Although careful and technical language has been employed, service users frequently describe these procedures as inhumane and degrading, particularly when experienced as coercive or traumatic. ¿What therapeutic value exists in restraining an individual so tightly that they experience a lack of control, possibly resulting in their breathing being restricted, or isolating them? In any other context, these acts would be unacceptable. Nevertheless, procedures utilized as therapeutic modalities may have an adverse effect, especially when those seeking help may be having situations that create trauma. People generally seek mental health services to alleviate suffering, rather than to experience coercive practices such as forced medication, isolation, or restraint. The severity of this issue is evident in cases where individuals exhibit post-traumatic stress symptoms post-discharge.[22,25]

What can be done by professionals?

1. Promote humane treatment: Eliminate coercion by recognizing its harm and having a commitment to respectful, dignified care. Those in all health care professions should adhere to the principle of non-harm.

2. Staff training and capacity: Professionals must adequately staff clinics with those health professionals trained in human rights, the *UN Convention Against Torture*, and emotional regulation.

3. Transparency and oversight: Until professionals eradicate coercion from the system and implement strict monitoring and auditing of restraint practices, problems may continue to occur. Transparency is vital, particularly in settings prone to abuse.[1]

RECOVERY

Given the above, it is relevant to ask whether psychiatric hospitalization services promote recovery. Can individuals under such conditions alleviate their suffering? Historically, individuals and professionals have recognized recovery as the absence of symptoms and dysfunction, a reductionist view borrowed from medical sciences and perpetuated in mental health care. However, few individuals achieve this ”recovery” level, which does not preclude meaningful healing.

Recovery must not be understood in such dehumanizing terms. It is a complex, individualized experience that transcends symptoms. It involves acknowledgment of mental health challenges, learning to live with them but not having them define a person, and pursuing a fulfilling life. These concepts necessitate a philosophical shift in how clients and professionals approach daily challenges, leading to greater self-perception and improved self-regard.[28] In this model, the focus is on the person, not merely their diagnosis or symptoms.

This person-centered conception of recovery starkly contrasts with the dominant model of psychiatric hospitalization. The following table conceptualizes these different approaches (Table 1):

Table 1. Models in psychiatric hospital care based on user experiences.

Disease-centered model	**Person-centered model**
Does not promote recovery.	Maintains connections with the external environment.
Focuses on monitoring, confinement, and control.	Prioritizes care and respect for the individual.
Prioritizes behavior over internal motives.	Values emotions and their meanings.
Emphasizes diagnosis and illness.	Emphasizes dialogue and listening.
Treats symptoms through medication.	Psychotherapy prevails over medication.
Relies on isolation.	Recovery transcends the presence/absence of symptoms; it is a personal process.
Uses coercive measures.	Encourages peers and community support; avoids coercion.

ALTERNATIVES TO PSYCHIATRIC HOSPITALIZATION

Drawing on the ideas presented, which collectively represent a serious, evidence-based critique of psychiatric hospitalization, it is pertinent to briefly discuss initiatives that have proven beneficial and respectful of human rights. These alternatives, emerging in developed countries through the deinstitutionalization movement and community-based care, are also informed by the negative experiences of thousands of service users. Internationally recognized approaches include the Hearing Voices Movement,[29] Open Dialogue,[20] the Soteria Project,[30] and Crisis Houses.[31]

The Hearing Voices Movement, for example, rejects the notion that auditory hallucinations are pathognomonic of illness. Instead, it frames these experiences as genuinely human, unusual yet deeply

personal, arising from an individual's life context and imbued with meaning. The issue lies not in hearing voices per se but in one's relationship with them. During sessions, voice-hearers and mental health professionals engage in open dialogue, exploring themes like voice content and coping strategies. Today, more than 180 such groups exist worldwide, with growing evidence of their effectiveness.[32-35]

Open Dialogue, developed by psychiatrist Jukka Aaltonen and psychologist Jaakko Seikkula in Finland for individuals with psychosis or severe crises, offers another compelling model. Within 24 hours of contact, a crisis team (typically comprising a psychologist, psychiatrist, and nurse) activates the individual's support network, including family, friends, neighbors, and employers. The initial focus is on improving family communication rather than challenging hallucinations or delusions. For Seikkula, Open Dialogue "cures" psychosis by reframing it as a response to extreme stress, not a disease. Remarkably, Western Lapland (Finland) has seen a 90% reduction in new schizophrenia cases, with 75% treated without antipsychotics.[20] While further research is needed, Open Dialogue has been integrated into several healthcare systems.[36]

Similarly, Crisis Houses, residential facilities led by professionals and non-resident users, have gained traction in the UK, US, Australia, and New Zealand. Inspired by the Soteria Project,[19] these minimally restrictive spaces provide crisis support to prevent conventional hospitalization. Interventions focus on problem-solving skills, empowering users to manage distressing situations. Crisis Resolution Teams complement this approach, reducing inpatient admissions and enabling community-based care with significant clinical impact.[37] Crisis Houses demonstrate comparable effectiveness to hospitalization but with higher user satisfaction.[38,39]

Collectively, these initiatives reject the medical model of mental "illness" and hospitalization as a default strategy. They oppose involuntary admissions, medication-centric approaches, coercion (physical/chemical restraint), isolation, and user exclusion from decision-making. Instead, they emphasize personal experiences, autonomy, and community integration. Psychotherapy, dialogue, and emotional expression replace forced treatments, fostering resilience and self-management.[40-42]

RECOMMENDATIONS FOR POLICY AND PRACTICE

It is time to incorporate urgent debates into the local context that have transformed mental health care elsewhere: deinstitutionalization (e.g., Italy's Basaglia Law), person-centered recovery (pioneered in New Zealand), alternatives to coercion (exemplified by Finland's Open Dialogue), and critiques of the biomedical hegemony (supported by researchers like Moncrieff and Whitaker). These are not abstract discussions, but practices proven to reduce suffering and promote autonomy.[1,26,29,443-48] From a rights-based and critical perspective, it is important to challenge the status quo, rethink the foundations of practices, and advocate for laws that may enable genuine transformation in mental health services.

This article will inspire students and professionals to explore reforms, principles, and approaches from other countries. Change can be driven by defending psychosocial frameworks rather than purely biological ones, disseminating alternatives, and developing new proposals. Achieving this requires political and legislative reforms, the integration of mental health services into healthcare systems, increased funding, community infrastructure, and staff training.[49,50]

CONCLUSIONS

This article examines psychiatric hospitalization, highlighting its structural tensions, therapeutic limitations, and challenges to the assumed benefits. Across literature, hospital-based psychiatric care emerges as a complex and heterogeneous practice, shaped by institutional practices that frequently prioritize risk management, containment, and biomedical intervention, while generating experiences of coercion, trauma,

and relational rupture for many service users. These findings do not suggest a uniform or consistent model of treatment across all hospitals; rather, they reveal persistent contradictions between the stated goals of care and the lived experiences reported in inpatient settings.

Practices involving the confinement of individuals in crisis, such as isolation, physical restraints, or the utilization of pharmacological interventions, have been widely criticized in the literature due to their potential to exacerbate suffering and undermine recovery processes. Evidence reviewed in this article highlights the complex relationship between coercive practices, experiences of harm, and recovery outcomes, underscoring the need for critical exploration of inpatient hospitalization practices and the institutional framework that contributes to possible negative outcomes.

At the same time, the review examined the emergence of alternative models and frameworks that challenge coercive paradigms and emphasize relational, community-based, and patient-rights-oriented approaches to mental health care. These approaches do not constitute a singular solution, but they offer important insights into how care practices might be reoriented toward autonomy, meaning-making, and social inclusion.

In this context, the role of psychology in mental health care, particularly within inpatient hospital settings, needs continued evaluation. From a psychosocial and rights-based perspective, the discipline is called upon to engage with the dominance of biomedical paradigms critically and to reaffirm its contribution to relational, contextual, and recovery-oriented approaches. Only by examining its methods, epistemologies, and the mental and emotional health benefits for those it serves can psychology advance equitable, ethical, and dignified care that honors human autonomy and freedom.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

AUTHOR CONTRIBUTIONS

HD participated in the conceptualization and design of the study, data curation, formal analysis, investigation, methodology development, writing the original draft, data visualization, general supervision, validation of results, critical review and editing, and final approval of the manuscript.
SA participated in conceptualization, data curation, formal analysis, methodology development, critical review, and manuscript editing, including revision and final correction of the English translation, as well as final approval of the manuscript.
YSC participated in conceptualization, data curation, formal analysis, methodology development, writing of the original draft, critical review, and final approval of the manuscript.
JGA participated in conceptualization, investigation, supervision, content validation, critical review, and final approval of the manuscript.
EA participated in conceptualization, academic supervision, data visualization, critical review, and final approval of the manuscript.

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