International Journal of Law and Psychiatry 49 (2016) 124–129

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

# The struggle for schizophrenia treatment: A case study☆

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ARTICLE INFO

*Article history:*
Received 17 August 2016
Accepted 18 August 2016
Available online 9 September 2016

*Keywords:*
Schizophrenia
Guardianship
Involuntary treatment
Expert witness

ABSTRACT

Individual of legal age with schizophrenia presenting anosognosia was abandoned, as a result of a court decision. Close family members were not allowed to provide medical follow-up, treatment, protection regarding his vulnerability, and preserve the dignity of their loved one. The issue was the court's prioritization of the autonomy of the individual over his mental health status. The purpose of this case study was to identify the pitfalls of a court case seeking medical follow-up and treatment for a family member with schizophrenia and anosognosia. The method was qualitative and the design was descriptive and instrumental, linking the law to the life experience resulting from the procedures for its implementation. This study examined the difference between clinical and medical–legal evaluation of the examinee. The application of the Therapeutic Jurisprudence principles to the high number of schizophrenia cases with anosognosia, the abandonment of the mentally ill, and family crisis call healthcare providers and the Judiciary for an improvement action of the process of guardianship.



## 1. Introduction

Schizophrenia is one of the top 10 causes of disability in developed countries worldwide (Schizophrenia Research Institute, 2013). In the United States of America, 1.1% of the population has schizophrenic disorders, according to the most recent epidemiological study of the disease (Norquist & Regier, 1996). About 50% of persons with the disease present anosognosia, the inability to recognize the disease in oneself (Baier, 2010). Individuals with this condition have a delusion of health and wish to keep the status quo (Van Putten, Crumpton, & Yale, 1976). They believe that the personality characteristics elicited by the signs and symptoms of the disease are an authentic part of whom they are. Schizophrenia can cause significant harm to a person's life (Birks, 2013).

Because the disease affects people in adolescence and early adulthood, it may be confused with the typical teen rebellion and remain unrecognized until its positive and negative symptoms become more apparent. This leads to serious legal considerations regarding those who present signs and symptoms of schizophrenia accompanied by anosognosia after entering the age of mental capacity. The purpose of this study was to explore a court case seeking involuntary psychiatric treatment for a 19-year-old individual presenting non-bizarre delusions and anosognosia. The present study sought to answer the following research question: What are the pitfalls of a court case seeking medical follow-up and treatment for a family member with schizophrenia accompanied by non-bizarre delusions and anosognosia? The setting of this case was a probate court in the state of Ohio, United States of America. The court case developed in 2015, after the individual's hospitalization, diagnosis, and treatment refusal. The court-case citation was omitted in this study for privacy. The Institutional Review Board approved the present study.

The method of choice was qualitative case study because the goal was to provide detailed information about the phenomenon. The design was descriptive and instrumental, linking the law to the life experience resulting from its implementation. The proposition was that close family members of individuals with schizophrenia and anosognosia are left without legal resources to permit them to provide medical follow-up, treatment, and protection regarding the vulnerability of their loved one in cases of lack of patient consent, despite legislation on involuntary outpatient treatment. In most cases, the lack of patient consent excludes the family from participation in the individual plan of care and treatment. Otherwise, the family could provide significant contribution to the plan, treatment compliance, psychiatric and psychological follow-up, and reduce the state burden.

The Common Law principle of autonomy led to the U.S. A. Supreme Court opinion that Justice Gray delivered in 1891, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient's consent commits an assault, for which he is liable in damages" (Union Pacific R. Co. v. Botsford, 1891). However, the issue in this case study was the Ohio court's prioritization of the individual's

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http://dx.doi.org/10.1016/j.ijlp.2016.08.005
0160-2527/

autonomy over the mental health status, in disregard for the person's inability to make medical decisions in reason of his lack of insight into his own illness.

My role in this study was emic; I lived the experience object of this case study. In addition, I was the instrument mediating the data. Further, the collection of the data was systematic, including documentation, direct observation, law, and case law. The data was analyzed through explanation building.

## 2. Medical decision on impaired capability

In schizophrenia, higher levels of negative symptoms may represent diminished understanding (Jeste, Depp, & Palmer, 2006) and correlate with decision-making incapability (Kovnick, Appelbaum, Hoge, & Leadbetter, 2003; Moser et al., 2002; Palmer, Dunn, Appelbaum, & Jeste, 2004; Stroup et al., 2005). Negative symptoms involve frontal lobe dysfunction and hypofrontality (Weinberger, Aloia, Goldberg, & Berman, 1994; Williams et al., 2013).

Among common symptoms in schizophrenia are delusions. Most persons have some strong beliefs but delusional ideations are beliefs so strong that it may become essential for persons with this symptom to conform to it and to have others understand and accept the belief. Delusions control the person. The person with a delusion may be able to argue for his belief for hours, be agitated, lose sleep over it, and may look unsettled when others do not understand the urgency and importance of the belief. The delusion can be about anything; it may seem like an ideology because of some rationale attached to it and the confidence that the individual expresses while trying to make it prevail. However, some of the claims are implausible, the timing of the argumentation may be unthoughtful, and the behavior inappropriate, disregarding the concerns of those they try to persuade. For the person suffering delusions, being wrong is not a possibility (Beck & Rector, 2005). Delusion is a positive symptom, significantly correlated with insight (Amador & Gorman, 1998; De Herta et al., 2009; Nieto et al., 2012). Through insight one detects distorted cognitive perceptions and has the ability to correct them (Joseph, Narayanaswamy, & Venkatasubramanian, 2015).

Insight allows the individual to differentiate personal identity from mental illness (Lincoln, Lullmann, & Rief, 2007; Hasson-Ohayon, Kravetz, & Meier, 2009). The disease may alter the individual's personality to one that is bold with built confidence, extroversion, and impulsiveness, which are very enjoyable characteristics to oneself. On the other hand, reduced insight in individuals with schizophrenia correlates with impairments of executive functions (Aleman, Agrawal, Morgan, & David, 2006; Kit Wa Chan et al., 2014; Osatuke, Ciesla, Kasckow, Zisook, & Mohamed, 2008; Rossell, Coakes, Shapleske, Woodruff, & David, 2003; Smith, Hull, Israel, & Willson, 2000). Persons developing this disorder may, suddenly, drop or fail college and have difficulty holding a job. Poor insight is a main factor leading to civil commitment (David, Buchanan, Reed, & Almeida, 1992; Kelly et al., 2004). Jeste et al.'s (2006) study results showed that 55 to 61% of individuals with schizophrenia presented low to partial insight, which confirmed the findings in Wong, Cheung, and Chen (2005), Palmer et al. (2004), Grisso, Appelbaum, and Hill-Fotouhi (1997); and Amador et al. (1994).

Persons with schizophrenia and anosognosia have absolute assurance that they are not sick. They may perceive individuals trying to help them recognize the disease and obtain treatment as controlling and despicable. Usually, those who try to help are close friends and family. An enormous psychological and emotional stress hit all those involved in the problem. On one side, the individual cannot understand why, suddenly, those who he believed to be dear, want him to go to a psychiatrist and psychologist to receive treatment for a disease he does not have. On the other side, family and friends, aware of the harm the disease is causing to the wellbeing of their loved one, feel the duty to arrange medical care for their loved one. At this point, it is common for the individual with schizophrenia and anosognosia to seek isolation from those friends and family members. Then, they may begin searching for people who accept their ideas and life style. One could say that this is a different person; the old one will not return. Currently available treatment will not bring the old person back. Treatment helps control symptoms. For example, treatment could lead to an increased ability to distinguish imagination from reality. As family members realize that their loved one, as they knew, does not exist anymore, a terrible shock happens; equivalent to the death of a loved one. The family is grieving and, at the same time, recurs to the legal system on a desperate effort to be able to protect the dignity and vulnerability of their loved one and arrange for healthcare. On the other hand, the person with the mental illness may feel betrayed and attacked by his own family. He is sure that he is not sick but his family insists in psychiatric treatment and medications. Both sides lose each other and, in result, they might suffer tremendously.

Insight makes possible the awareness of one's own health status, recognition of what is not normal, and the need for treatment. Lack of insight, denial of illness, and delusions lead to treatment refusal (Baier, 2010). Attempts to make patients aware of their condition have not helped (Lincoln et al., 2007). These patients have a delusion of health (Van Putten et al., 1976). If a person does not have insight enough to understand that he has a mental impairment or illness, he has not capability to make decisions regarding the medical and psychological treatments for the impairment or illness that he does not believe he has. The same way, the individual does not have capability to make treatment decisions, in cases of delusions involving the treatment. For example, the person has a strong belief that the medications are poisonous, could kill him, and so on. Medications have side effects. However, in the absence of delusion, one would communicate to the psychiatrist a specific intolerance to a medication. The psychiatrist would adjust the treatment, accordingly. Decisional capability for medical treatment and other daily living decisions involves three cognition elements, the comprehension of the nature of the information, understanding of its application to one's own condition, and the ability to process, critically, the information provided (Jeste et al., 2006). If the person does not understand that he is sick, he cannot apply the information to his own condition. The second element is missing. Therefore, this person does not have capability to give informed consent for medical treatment. In addition, poor insight leads to a deficit in appreciation of risks and benefits of a treatment or lack of it and to the impaired ability to compare it to alternative treatments (Jeste et al., 2006).

Insight is the best determinant of capacity for informed medical decisions in schizophrenia (Owen et al., 2008). The expert psychiatrist or psychologist must perform subjective and objective assessments of the respondent to determine the respondent's level of insight into his illness, inform the court on this person's capability or incapability to make medical decisions regarding his mental impairment or illness, and include the rationale for his opinion. Apart from the personality alteration, delusions, hallucinations, and diminished executive functions, other intellectual abilities might remain intact. Therefore, a full guardianship would not be justified. A legal decision on the capacity of a person must be in line with the court-expert opinion and have specificity in regard to the limitations imposed to the individual's legal capacity.

## 3. Theoretical framework

In 1987, Wexler introduced law as therapy at the National Institutes of Mental Health, during a law and psychology workshop (Wexler, 2008). That was the birth of the Therapeutic Jurisprudence. Therapeutic Jurisprudence involves the application of the law as a therapeutic agent (Wexler, 2011). It is interdisciplinary in nature, utilizing knowledge from sciences, such as psychiatry, criminology, anthropology, and psychology (Wexler, 2008). Therapeutic Jurisprudence is one of the most recognized law theories in the world (Perlin, 2014). It humanized the application of the law. The focus is in the application of the law with