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The Consumer Movement and Compulsory Treatment

A Professional Outlook

ABSTRACT: *Compulsory treatment is a controversial issue in psychiatry. In the last several decades consumer groups have repeatedly and clearly stood up against compulsory treatment and forced medication, although their positions include important diversities both in philosophical conceptualizations and practical consequences. This article reviews this issue through the eyes of professionals, highlighting aspects related to the consumer movement's radical wing and to the efforts toward negotiations of other groups. Issues arising from the debate between consumers and professionals are analyzed and strategies to overcome compulsory treatment are examined, with special reference to the psychiatric advance directives. The article stresses that compulsory treatment debate should be framed within the larger context of a public health approach and to the present state of mental health services. The article also considers the importance of the reflexive loop between what is offered by services and what is refused by consumers. Finally, the need to incorporate a variety of contributions outside a narrow medical model is outlined.*

The image of Pinel breaking the inmates' chains at Bicêtre in Paris is a landmark of the birth of psychiatry, even though historians recently showed that it was likely a manufactured myth [1]. According to all textbooks, modern psychiatry was born from this action, which freed the insane from restraint: Madness was getting out from the domain of generic segregation and getting into the science domain, converting the insane into a psychiatric patient. The gradual inclusion in the medical field, however, has not been able to clear away the issue of restraint, control, and power from this new science. Asylums soon became custodial institutions, and when the deinstitutionalization movement downsized and shut down the large mental hospitals, psychiatry had yet to come to terms with compulsory treatment.

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Can we therefore say that compulsory treatment represents the last chain to break to fulfill Pinel's promise? Is it possible at this time? Should we hope for it? These questions are certainly at the heart of a crucial debate.

Currently, as a result of social processes that view consumers as important actors on the stage, consumer organizations have progressively grown in relevance. In the field of mental health, some consumer groups, whose membership is mostly affected by depression, panic attacks, or anxiety disorders, consider their own suffering similar to physical illness and do not question the foundations of psychiatric knowledge. By contrast, others mainly affected by psychoses or serious mood and personality disorders do not accept the sick role and often reframe their condition by questioning psychiatric models. Such groups focus their interests on human rights, stigma, self-determination, or mental illness definition and are pursuing, with some exceptions, an unrelenting battle against compulsory treatment.

Professionals often resist the efforts of these groups, even though they know that compulsory treatment is the most hated among all psychiatric practices. Most professionals are also aware that in psychiatry, scientific evidences are often soft, mental disorders lack biological markers, and there is an interweaving between illness and human condition, clinical and nonclinical variables, ethical and scientific values, treatment and control, and medical and social explanations.

Since Pinel's days, psychiatry has changed and grown in knowledge and awareness. Now, in Western countries, multidimensional aspects of mental suffering, human rights, and values are recognized; moreover, strong family and users associations are empowered to stand up and speak out. Nonetheless, the core issues of compulsory treatment and professional power remain.

Antonin Artaud: Forerunner of Consumers' Perspectives and His Followers

A radical Italian on-line consumer group published the paper "Manuale di Autodifesa" (Self-Defense Manual) [2] on compulsory treatment. Within this document, a prominent position is allotted to an open letter from the French artist and writer Antonin Artaud [3] to the "Directors of Insane Asylums," dated 1925, whose main passages I quote:

> Sirs,
>
> The laws and the customs bestow on you the right to measure the soul. You exercise this sovereign and unquestionable jurisdiction according to your own judgment. Let us laugh at that. . . . Asylums, far from being true asylums, are fearful jails, where the inmates provide a source of free and useful manpower and where brutality is the rule, all of which you tolerate. An insane asylum, under cover of science and justice, is comparable to barracks, prison, or penal colony.
>
> We will not raise here the issue of arbitrary detention, to spare you the trouble of easy denials. We assert that a large number of your guests, crazy in every way according to the formal definition, are arbitrarily detained as well.

> We protest against any interference with the free development of a delusion. It is as legitimate, as logical as any other sequence of human ideas or acts. The repression of anti-social reactions is as chimerical as it is unacceptable in principle. All individual acts are anti-social. Mad people, above all, are individual victims of social dictatorship. In the name of that individuality which specifically belongs to man, we demand the liberation of these people convicted of sensibility. For we tell you no laws are powerful enough to lock up all people who think and act. Without stressing the perfectly inspired nature of the manifestations of certain mad persons, in so far as we are capable of appreciating them, we simply affirm their concept of reality is absolutely legitimate, as are all acts resulting from it.
>
> Try and remember that tomorrow morning during your rounds, when, without knowing their language, you will attempt to talk with these people over whom, you must admit, you have only one advantage, namely force. [2]

In this remarkable letter, Artaud clearly outlined 50 years ago the key issues of the radical wing of the modern consumer movement. He was one of the first persons with the experience of psychiatric treatment to use his intellectual authority to stand up and claim his rights against psychiatry's arrogance. It is worth noting that although Artaud suffered from mental and neurological problems for many years, he wrote his letter more than 10 years before his first commitment to a psychiatric hospital. He was, in some ways, foreseeing his future subjection to psychiatry's power.

In his letter [2], Artaud addressed the core problems around the compulsory treatment. First, he challenged the right of psychiatry to judge and to assess within a professional framework the human mind or, in the essence of Artaud's words, in absence of any biological illness marker. Second, he stressed that the distinction between mental illness and normality is groundless. Third, he pointed out the use of detention by psychiatry as an aspect of the conflict between individual freedom and social conformity. Finally, he specified that the issue is not the abuse of detention, but the detention itself that is always unjustified, irrespective of the mental state of the targeted person.

The Consumers Movements Today

The same indignation and the same opposition against compulsory treatment can be found on the MindFreedom International Web site (www.mindfreedom.org). MindFreedom is an important American consumer organization that has been able to challenge powerful psychiatry associations as well as drug companies, highlighting ambiguities and collusions among psychiatric practices, political issues, and economic interests. The Web site posts news, information, and personal stories of recovery and resilience in spite of psychiatric practices and periodically launches media campaigns in support of human rights and of alternatives to the mental health system against the biomedical hegemony. For example, in 2003 MindFreedom gained public attention by holding a hunger strike aimed at obtaining evidence from the American Psychiatric Association that supported the validity of

the diagnoses of schizophrenia and other major mental disorders as biologically based brain diseases.

MindFreedom and its director, David Oaks, place compulsory treatment center stage:

> When David Oaks hears someone suggest that compulsory drug treatment is the solution to mental illness, it horrifies him. Thirty years ago, while a student at Harvard, Oaks was diagnosed with schizophrenia and was locked up and forcibly injected with psychiatric drugs. The experience was so humiliating and frightening that when Oaks finally graduated, he dedicated himself as a human rights advocate, to ensure that others in the same situation would never be forced into medication. [4]

To this end, MindFreedom operates Project Landing Zone [5]:

> Forty-three USA states have laws allowing individuals to be court-ordered to take psychiatric drugs while living at homes. There is a loophole in the law that allows some of these individuals to leave their county or state and escape this forced outpatient drugging. However, successfully evading outpatient forced drugging takes more than a Greyhound ticket. Those escaping need a "landing zone" that can have enough services, support, advocacy and assistance that they can sustain themselves.
>
> The MindFreedom USA Committee's long-term goal: Locate two or three towns or cities in the USA where the movement is strong enough to become a "landing zone." We will assist in raising national support so that these communities can serve as sanctuaries for nonviolent individuals who are legally leaving over state lines to evade and escape coerced and forced outpatient psychiatric drugging. [5]

The tone we find here is the same we might find in any situation of serious discrimination and persecution when people attempt to escape tyranny. The term *psychiatric survivor* is not used by chance here. It refers, as in the expression *Holocaust survivor*, to an individual who has been unjustly imprisoned and even tortured. Not all consumer organizations share the same radical position opposing psychiatric practices; therefore, we must draw a distinction between groups that label themselves as consumers and as survivors. There are relevant differences between them regarding human rights, the nature of mental illness, attitudes toward professionals, and individual responsibility. These are all hot issues in the conflicting debates on which the consumers and survivors groups, on the issue of compulsory treatment, take different positions. Some believe that any compulsory treatment and detention is wrong, whereas others justify it under narrow conditions and strict criteria [6]. Overall, there is a wide agreement that use of force has negative consequences that overwhelm possible benefits and that its use should be reduced and limited to inpatient settings [6].

In recent years, however, many users and survivors groups have agreed on the importance of discussing the issue with mental health services and major institutions [7]. For example, the White House Conference on Mental Health was held

in the United States in 1999, chaired by Tipper Gore, wife of then-Vice President Al Gore. Following the conference, the National Association for Rights Protection and Advocacy released a statement:

> We consumers/survivors urge Mrs. Gore to take a leadership role in eliminating forced psychiatric treatment. Freedom is the fundamental and organizing principle of our country and yet it is still being denied to people with psychiatric disabilities. Recovery cannot occur in an environment of coercion. Therapeutic relationships cannot exist in an environment of coercion. A landmark research study, the Well Being Project administered by consumers/survivors found that 55 percent of consumers interviewed who had experienced forced treatment reported that fear of forced treatment caused them to reject treatment.
>
> We ask Mrs. Gore to stand with us now against the use of seclusion or restraint. The safety of consumers and professionals should be a paramount organizing principle underlying all system reform efforts and is the first real step towards the elimination of forced treatment. Consumers/survivors should not be held responsible for being non-compliant to non-existing or harmful services. If voluntary services of the nature that consumers/survivors wanted and needed were available and accessible, the concept of involuntary treatment would be obsolete.
>
> We consumers/survivors urge those at the White House Conference on Mental Health to share the vision of a healing-focused mental health service system that offers a wide menu of services which address the needs of the whole person in an environment of freedom, choice and equality. We ask Mrs. Gore to share this vision with us. Force is not the way to deal with people with psychiatric disabilities. It sabotages the potential of recovery for people with psychiatric disabilities. The consequence of forced treatment is that people avoid the very services they need to survive. Coercion frequently results in violence and abuse to people who are receiving services. Expansion of forced treatment will not stop noncompliance; damage left in the wake of forced treatment is the reason for noncompliance. Outpatient commitment is a false solution to a complex public policy issue, and it simply will not work. The truth is that many of the services currently available are not helpful to people; government efforts would be better spent on offering an improved array of services that actually promote healing and recovery. [8]

The Debate Between Consumers and Professionals

In 2003, the National Empowerment Center hosted a debate on involuntary treatment, with Judi Chamberlin and E. Fuller Torrey opposing each other on the topic: Should forced medication be a treatment option for patients with schizophrenia [9]? Torrey is a consistent supporter of the necessity of forced treatment and has voiced his opinions in such forums as the American Psychiatric Association's journal, *Psychiatric Services*, which every so often contains his articles and comments on issues related to involuntary treatment. He had always stressed the importance of forced treatment, claiming the disastrous consequence of no intervention: "The policies espoused by 'psychiatric survivors' have thus led to a large number of

no survivors. Political correctness currently focuses on the 'survivors.' Humane considerations suggest that our focus should be instead on the growing number of no survivors" [10, p. 143].

In this debate, Torrey [9] referred to a variety of reasons to claim the usefulness of compulsory treatment including scientific, humane, practical, and those related to the public protection. From a scientific point of view, he embraced a strong biological position and, from this standpoint, maintained that impairment of awareness is an inherent feature of major mental disorders. From there, he drew out likely social outcomes and consequences for the ill person such as homelessness and incarceration, which are directly connected to lack of treatment. He reported data from criminal statistics showing that 4.3 percent of all homicides are committed by individuals with history of mental illness and affirmed that the best prevention is treatment. Moreover, he asserted that practice demonstrates that involuntary treatment improves medication compliance and, therefore, reduces unfavorable outcomes.

Chamberlin [9], from her position as a legal and civil rights advocate, responded by posing two crucial questions in a framework of human rights: (a) Should doctors be permitted to force medication on unwilling patients as recipients, and (b) should psychiatrists be able to define some people as patients against their will? Chamberlin stressed that no medical tests can confirm the diagnosis of schizophrenia, which remains a clinical impression. She also challenged the idea that medications improve outcome, pointing to the growing evidence of negative consequences from their use. In response to the practical reasons indicated by Torrey, Chamberlin suggested that most people avoid voluntary treatment because they fear force interventions and she denounced the fact that people who refuse treatment are prescribed higher doses of medication. The reciprocal replies pursue the similar lines, going into some aspects but essentially not allowing any mediation nor providing opportunity to look at possible solutions. Rather Chamberlin ends her reply with words from English writer and theologian C.S. Lewis's "Humanitarian Theory of Punishment":

> Of all tyrannies a tyranny sincerely exercised for the good of its victims may be the most oppressive. It may be better to live under robber barons than under omnipotent, moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience. . . . To be "cured" against one's will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason. [9]

The first consideration that immediately arises after reading the debate is whether compulsory treatment should correspond to forced medication, which limits the debate and reduces the domain and practices of psychiatry to a narrow medical action. Moreover, the radicalization of the debate results in an oversimplification, cutting off contradictions, ambiguities, and context variables closely linked to compulsory

treatment that make it a very complex issue. As a consequence, understanding is undermined and possible innovative solutions are jeopardized.

The debate gives witness to the existence of two worlds very far apart and very unlikely to meet. The opposition between Torrey's medical model and Chamberlin's consumers/survivor model is, nonetheless, useful to highlight the interweaving between psychiatry and control and between individual and social requirements. Moreover, an important consideration hinted at is the issue of prevention, which is currently regarded as a milestone of medicine and as a future hope for psychiatry.

The consumer movement has very explicitly indicated that force should not be used for prevention of possible harmful behaviors. Chamberlin remarked that, even according to the American Psychiatric Association, psychiatrists have no special knowledge or skills with which to predict dangerous behavior. We also note that Torrey's opinions are not representative of the whole of mental health professionals, nor of psychiatrists, who have a variety of opinions about involuntary treatments. For example, L.R. Mosher resigned from the American Psychiatric Association in 1998, stating:

> These psychopharmacological limitations on our abilities to be complete physicians also limit our intellectual horizons. No longer do we seek to understand whole persons in their social contexts—rather we are there to realign our patients' neurotransmitters . . . We seem to have forgotten a basic principle—the need to be patient/client/consumer satisfaction oriented. [11]

Psychiatry, which in recent years has witnessed a dramatic biomedical drift, is inevitably moving toward reductionism, and must acknowledge the complexity of mental disorders. On the other hand, emphasis on individual will, refusal of treatment, and criticism and opposition toward psychiatry, when taken to extremes, open up a variety of contradictions not always taken into proper consideration by consumer representatives.

The social environment shapes the way in which compulsory treatment is framed. In other words, professionals' attitudes and cultures are part of social processes, and it is impossible to read any position without reading the context in which it is embedded. In some countries access to services and treatment is a privilege or exclusively a matter of social control, whereas in others a variety of treatment and rehabilitation opportunities exist. Moreover, countries have with a two-tiered system of mental health services, in which opportunities to exert choice and control over treatment vary significantly between the private and public sectors, resulting in different experiences of psychiatry oppression and in uneven empowerment across social classes [7]. Such differences imply different meanings and values in relation to compulsory treatment. Power and ethical aspects are intertwined, so at times professionals find themselves caught in a double bind and are forced to choose between duty to care and violation of individual will. The boundaries between respect for person's will and abandonment can be very thin, and we need to remember how lack of social protection coupled, with a culturally and economically deprived

environment, may push the balance toward neglect. We must also take into account issues of public health and its social mission, especially if we consider the adverse outcomes of vulnerable populations' abandonment, as reflected by the high rates of mortality in people with serious mental disorders [12].

A variety of aspects, which belong at the edge of compulsory treatment, have an important impact on it, as consumers' movement already pointed out [6]. The reflexive loop between what it is offered and what it is refused—what professionals are keen to give and what consumers accept or ask for—may change patterns around involuntary treatment. For example, the importance of recognizing the social nature of mental health problems, the role of trauma (especially in early life), and the benefits of psychological therapies, self-help groups, and peer support are all aspects valued by consumers.

We must also remember that psychiatry cannot be exclusively confined within a narrow and outdated biomedical model. We can refer to a variety of contributions in a biopsychosocial framework to enrich this debate and to stay closer to consumers' desires. Browsing various consumer Web sites, we find an astonishing number of papers on and by psychiatrists involved in the antipsychiatric movement and in community psychiatry as practiced in countries such as Italy. Early phases of the consumer movement in the United States have been deeply influenced by antipsychiatry, and for a period of time radical therapists and consumers have been partners in a renovation effort [7].

Mosher's [13] experience of Soteria House, for example, represents a kind of psychiatry that is in contiguity with consumers' experiences. The Soteria Project showed that a young, nonprofessional staff trained to listen, understand, and stand beside, could provide a therapeutic environment in which newly diagnosed schizophrenic patients were able to overcome a psychotic episode with minimal use of medications. The idea was that acute psychosis can often be treated with the help of meaningful relationships, rather than by drugs, and that such treatment would eventually lead to healthier outcomes [13]. The encouraging results coming from this experience were eventually overlooked later, which resulted in Mosher abandoning the American psychiatric establishment. Still, there are important lessons and suggestions from the Soteria experiences that cannot be dismissed by psychiatric culture.

For example, on the Web site dedicated to Mosher and the Soteria Project (www.moshersoteria.com), a guideline [14] is available for dealing with severe emotional crises, in which we find indications belonging, beyond any doubt, to the core of psychiatric knowledge and practice. These indications involve the assumption that when facing a crisis, it is important to remain in an environment as normal as possible, to maintain usual relationships, and to engage natural network resources in helping and providing support and understanding. In this guideline, we also find the awareness that each situation is unique and that most crises arise within the family and its historical context, requiring the need to acknowledge relational issues and life events related to the crisis onset.

Is There Any Space for Mediation?

One of the problems from a professional standpoint in mediating a resolution is finding a shared attribution of meaning to compulsory treatment, which requires finding a common ground to build a reciprocal and contractual recognition with consumers. Common ground implies a few common premises, a few common values, and the possibility to mediate around certain rules. First, we must take into account important differences between professionals' and consumers' points of view. Consumers' and professionals' perspectives involve different priorities that inevitably conflict with each other. For example, for clinicians, the priority is symptom relief or resolution whereas consumers indicate support for subjective experience and independent decision is more important. It is easy to understand how these differences could give rise to conflicts.

Second, professionals have a tricky bias to face. Issues such as subjective experience and attribution of meaning are traditionally seen in a psychological framework very much embedded in professional interpretation and expertise, but now consumers advocate the same topics as their own ground of empowerment and experience. A possible place to find a partnership could, instead, become a place of fight for power. As attribution of meaning to treatment is crucial, the possibility to find innovative solutions is partly related to this issue. In the upcoming years, this issue, which would reduce conflicts and create a more acceptable mutual frame of reference, will be the key test of whether a partnership between consumers and professionals is possible.

Recently, the recovery model has become increasingly important for professionals, researchers, and consumers; therefore, a number of services have revised clinical and rehabilitation issues from this perspective [15]. However, the recovery model, as outlined by many consumers, refers to a concept that is, at the same time, a process and an outcome, and it is rooted in individual values, interests, and goals that are sometimes at odds with the traditional psychiatric paradigms [16]. As indicated by a leader of the consumer movement, in any service rooted in recovery, it would be inconceivable that the service would see as one of its primary roles the use of force or even treatment by force as a means of ensuring compliance [17].

Consumers willing to implement a culture of recovery have outlined issues they consider crucial for mental health services. Personal resourcefulness, equality and partnership in services, diversity of models and treatment choices, and promotion of citizenship rights and social inclusion are the values identified as the core of a recovery model, based on autonomy and self-determination [6]. Some consumer groups have advocated the use of psychiatric advance directives as a strategy to pursue consumers' autonomy regarding involuntary treatment. As legal instruments, advance directives allow competent persons at risk of a psychiatric crisis, which could impair their decision capacity, to anticipate their will or to designate a proxy decision maker. Such directives are aimed at enhancing consumers' participation in

treatment decision and providing alternatives to coercion [18]. Interest in psychiatric advance directives among consumer advocacy groups is high, because these instruments seem to offer a positive alternative promoting consensus between patient and provider, by providing a way out from the dilemma of coercion versus neglect [19]. In fact, psychiatric advance directives have risen in last decade in the United States, Europe, Australia, and New Zealand. For example, 21 U.S. states have passed new legislation authorizing these instruments in some form. However, little is known about how psychiatric advance directives have been implemented, and there is some evidence of systemic barriers preventing their use, a lack of resources deployed to assist patients in preparing them, and a lack of acceptance by clinicians [19–20]. Nevertheless, the results from studies of informed deliberations by consumer-run services point out their relevance in mobilizing personal resources, reviewing past experiences, and assessing risks. The prospect of being treated as a responsible person in future interactions with the mental health system has been especially meaningful [20]. These results underline the importance of establishing a partnership with the mental health services and give clues of the worth of mediation between professionals' and consumers' views on compulsory treatment, as indicated by the Italian experience about psychiatric advance directives.

Italy, for a variety of reasons, does not have a strong tradition of consumer associations; nevertheless, the consumer movement is slowly growing. There are some radical groups that champion a clear opposition toward psychiatric services and a variety of self-help groups and small consumer organizations, born with psychiatric services support and working in partnership with them. In 1990, the Self-Help Group of Massa Carrara (a town in central Italy) received significant support from the European Network of (ex) Survivors of Psychiatry to develop a self-protection tool against compulsory treatment. The group decided to focus on psychiatric advance directives. With the involvement and approval of the local Department of Mental Health and the local government, the Self-Help Group of Massa Carrara set up a process whose outcome was the adoption of psychiatric advance directives as a policy by the Department of Mental Health. The initiative also had the formal approval of local consumers and professionals. This shared perspective allowed the growth of a mutual meaning in relation to the acute mental disorders and the ways to cope with them [21].

Elsewhere, consumer initiatives gave rise to other solutions, separated from psychiatric services but still officially recognized. For example, the Berlin Runaway House, which opened in 1996, is an anti-psychiatric residential service operating as a crisis center for survivors of psychiatry, funded through the German social welfare federal laws. The house is a shelter for people who strongly oppose psychiatry and want to go through a period of crisis without any diagnosis and drug treatment. They can stay in the house for a period of no more than six months. The working team is consists of 10 part-time and 2 full-time professionals. The qualifications to work in the house are mostly personal characteristics, such as attention, tolerance, sensibility, openness, personal experience, ability to manage conflicts and a clear

anti-psychiatric attitude. Staff academic background may vary but no psychiatry is a prerequisite. At least half of the staff are survivors, which is considered a crucial aspect because survivors have had the experience of mental suffering and psychiatric treatments and have been able to overcome it. Their presence in the house is invaluable for the residents because they offer, through their experiences, the opportunities to exchange stories of overcoming difficulties in a framework of possible shared meanings [22].

A certain number of places and consumer networks also exist that give a kind of semiprofessional support to patients who strongly oppose psychiatry, which possibly prevents compulsory treatment in some situations. However, in most cases (e.g., Berlin House and in the clubhouses), rules are in place, such as the prohibition of alcohol and substance use, that many consumers are not able to follow. Therefore, for a number of difficult patients, compulsory treatment remains a sometimes unavoidable option. Moreover, even in some consumer-run services, power hierarchies and abusive practices have been observed [7].

From a psychiatric standpoint, consumer-run alternative services, although outside mainstream mental health-care, should be viewed as a welcome opportunity. First, as previously noted, they could have an impact on access to treatment by allowing people not willing to accept psychiatric care to get help and possibly to avoid forced interventions. Second, they can give clues to understanding what mental health services can do to be more user friendly. We cannot separate consumers' refusal of treatment from what average psychiatric services offer. The consumers' refusal is only partly related to a radical ideological standpoint; to a large extent, it is a reaction against poor, inadequate, or even harmful interventions provided by mental health professionals. Low-quality care, especially if embedded in a narrow, stigmatizing medical model, is likely to trigger ideological answers.

Consumer groups point out a number of service shortcomings, such as lack of support offered to people to avoid crises, lack of alternative residential opportunities for people in crisis, misuse of hospitalization and drugs, authoritarian attitudes, and unwillingness to negotiation with service users to understand their needs and preferences.

Consumers stress the need for psychiatric services to reduce or eliminate the use of force, putting into place practical strategies such as crisis prevention, advance directives, mediation, and de-escalation. Moreover, they highlight the importance for mental health services to set up antidiscrimination practices, which could reduce community pressure to use force and favor advocacy groups that promote rights, inclusion, and participation for people with mental health problems [6].

Conclusions

Eighty years have elapsed since Artaud's [3] claim that the use of force is psychiatrists' only asset, but it seems that compulsory treatment is still an unresolved issue and that the lexicon between professionals and consumers is still often so differ-

ent that it does not allow a full or fruitful discussion. These issues pose pressing questions to psychiatry.

The presence of a consumer movement has changed the scenario and requires that the psychiatric world give accounts of its practices and theories. It is an important challenge for professionals. Is it worthwhile to take up the gauntlet? The reasons favoring this option come from ethical, political, scientific, and clinical standpoints. However, to carry out this task, professionals need to escape from the paradox posed by the dichotomy of compulsory treatment versus right to refuse it, which, removed from its context, is impossible to read.

In most fields of knowledge and social practice, we are cognizant that phenomena must be understood in an ecological systems perspective. Compulsory treatment is no exception. Thus, professionals are compelled to make an effort to connect all the issues related to compulsory treatment by analyzing the different loops involved. Specifically, we must be aware of what we offer in clinical, emotional, and social terms and what consumers' expectations and needs are. This awareness implies that psychiatry must listen in a new way and learn the language referred to by Artaud [3]. It is a challenging task, which involves giving back power to consumers, discussing conflicts, and accepting contradictions and paradoxes. On the other hand, we may also consider the value of improving the clinicians' professional and human competence and of reaching a greater capacity of understanding and integration.

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