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Psychiatric Hospitalization: Patients' Negative Experiences and Attitudes

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Abstract

Background: The negative experience of hospitalization in psychiatric wards is a common issue that can have destructive effects on treatment outcomes. Considering the significance of improving inpatient psychiatric care, this qualitative study was implemented to elucidate the patients' experience of hospitalization in a psychiatric hospital from September 2017 to February 2018**.**

Methods: The information was gathered using two approaches: focus groups, and in-depth individual interviews with hospitalized patients. Twenty-two patients, including 16 women and 6 men, participated in this research. Content analysis method was used for analyzing the data.

Results: Participants' negative experiences were categorized into three main categories: imprisonment, loneliness, and untrustworthy atmosphere. According to our study, the numerous restrictions and inflexible regulations of the ward, insufficient interaction with the psychiatrist and nurses, coercion, and insufficient physical facilities caused negative experiences.

Conclusion: It seems to be critical that the extent of care for each patient be individualized and free of humiliation.

Keywords: Focus groups, Hospitalization, Humans, Inpatients, Psychiatry

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Introduction

Considering the acuteness of the symptoms or the danger of harming others, many patients with psychiatric disorders need to be hospitalized. These patients need to be treated in a safe physical and emotional environment. Nevertheless, negative experiences of hospitalization in psychiatry wards are common. Such experiences can negatively affect the treatment. According to research, patients' satisfaction with psychiatric hospitalization is an important factor in determining the outcome of the treatment (1). Patients' satisfaction with psychiatric care has been associated with more positive consequences in the future such as fewer hospitalizations and symptoms after discharge (2-4). Being aware of the experiences of psychiatric inpatients can provide information concerning the quality of rendered services. Therefore, if the goal is to upgrade the quality of psychiatric services, having this information is beneficial. Nevertheless, there has been little research conducted in this regard in our country, Iran. The recent study has been carried out in one of the wards of Iran Mental Hospital in which, according to authorities, the implemented improvements have rendered better welfare and medical services to the patients as compared with those given in the other wards of the hospital. The difference in the experiences of the patients of this ward following the implementation of better services is interesting as it demonstrates the difference between the opinions of authorities and psychiatrists as opposed to those of the patients and recipients of the services. It seems that upgrading the services can increase patients' satisfaction. Therefore, this study was conducted to investigate different aspects of patients' experiences of hospitalization in Iran Mental Hospital. However, we decided to only report negative experiences since these are the issues that need to be addressed.

Materials and Methods

Design and sample

The conducted research was a qualitative study. The body of the research included patients hospitalized in the Mehr Ward of Iran Mental Hospital from September 2017 to February 2018. The Mehr Ward is designed for the hospitalization of non-psychotic and non-drug dependent patients in a crisis. Most of the patients hospitalized in this ward have multiple psychiatric disorders and most often axis II disorders are associated with axis I disorders. Psychological services in this ward are more prominent than in those of the rest of the hospital; the trained staff in this ward have more therapeutic interaction with the patients. There are two beds in each room and the ward offers better facilities than other wards do. Both men and women are hospitalized in the ward; a door in the middle of the corridor separates the spaces belonging to each gender. In each shift, there is one nurse for seven to eight patients. There is a psychiatric resident for every one or two patients who provides psychotherapeutic interventions. Non-pharmacological issues, as well as pharmacological treatments, are taken care of in the daily psychiatric visits.

Participants

The cases were selected from the Mehr Ward and the sampling was continued until saturation. Twenty-two patients, consisting of 16 women and 6 men participated in the study; they ranged from 19 years of age, the youngest, to 52, the oldest, and their average age was 29 years. All of the participants received medication.

Data collection

The data were collected by two systems: 1. Focus group, and 2. In-depth individual interviews. To this aim, the capability of the patients to participate in the study was approved by a psychiatrist who is a faculty member of an independent scientific board. Then the goal of the study, the duration of each session, and researchers' confidentiality obligation were explained to each participating patient. Finally, the participants gave their written consent.

Four focus group sessions were held during which sixteen participants expressed their experiences of hospitalization. The duration of each focus group session was approximately one hour. The sessions were held separately for female and male patients. In-depth individual interviews were held with six of the participating patients separately. Each focus group or individual interview started with an open question: *Please explain your experience of hospitalization in the Mehr Ward.* The session continued with more

questions regarding the patients' experiences of interaction with the staff, other patients, psychiatrists, and the quality of psychiatric services rendered in the ward. Some questions considering the patients' experiences of taking medication in the ward, the feeling of obligation, and safety (according to the interview manual) were also asked. If the patients talked about the issues not related to the question, the interviewer facilitated their expression. The duration of each individual interview was almost thirty to forty minutes. All of the interviews were recorded to be written down later for subsequent analysis.

Data analysis

The recorded interviews in the sessions were transcribed word by word. Content analysis was used for analyzing the data. The meaningful sentences associated with the subject of the research were coded. The achieved codes were compared and based on the similarities and differences, they were first categorized and then sub-categorized with the same concepts under each main category to formulate the pattern of the research. The process of holding the sessions, coding, categorizing, and sub-categorizing continued until no further conceptual code was found. Another interview session was held to reassure the data saturation. The achieved codes, categories, and sub-categories were again surveyed and modified by the authors until agreement upon the codes, conceptual categories, and sub-categories was attained.

Ethical considerations

This research was approved by the Ethics Committee of Iran University of Medical Sciences (Ethics code number: IR.IUMS.FMD.REC.1397.188).

Results

Table 1 represents the negative experiences of the patients in the research in three categories and sixteen sub-categories.

Hospital as prison

This category, with its seven sub-categories, describes the main atmosphere of the ward or the hospital focusing on the negative aspects and different reactions of the patients.

Feeling of Entrapment

In this sub-category, the limitations of the ward and hospital which are not responding to the patients' needs (such as outdoor time, meals, and sleep) and are in conflict with the patients' well-being are pointed out. Sometimes not having permission to use a mobile phone was annoying. In some cases, the problem was not having relationships with members of the opposite sex, and at other times patients criticized inflexible routines when taking medication and so forth.

"*I like it outside, not in here! This is like a prison!*"

Some of the patients criticized the obligatory treatments.

"I came here of my own free will, but they will not

Table 1. Conceptual categories and sub-categories

Category	Sub-categories
Hospital as Prison	- Feeling of entrapment - Horrifying environment - Disrespect in the hospital - Cry of objection - Hopeless reasoning
Experience of Loneliness	- Separation from the family - Not having anybody to talk to - The need for a psychiatrist and psychologist and not a resident - Stigma - Conflictual patient activation - Isolation
Untrustworthy Atmosphere	- Pessimism about the staff - Pessimism about patients - Distorted information

let me go when I want to. It's as if I'm a prisoner. For example, they can say: 'if you don't want to be here today, go and come back after two days, or if you can't tolerate the environment and you're suffocating, go home and come back four days later.' They keep you locked in. They want to treat you, but I won't get better this way."

Horrifying Environment

This sub-category points out a fearful, threatening, and unsafe environment from the patients' point of view and their different reactions to it.

"I tell them to install observation cameras so that we will be safe. That way when we sleep, we will have peace of mind that our mobile phone is being charged (and nobody will steal it)".

Some of the patients talked of being threatened to be 'fixed', even when there was no indication of anything being wrong with them:

"*Once somebody opened the door of the restroom. I argued with her and pushed her away a bit, and the nurse threatened to 'fix' me. I was upset because she had to ask me what happened, and if I was wrong, she could say so."*

Some of the patients complained about witnessing upsetting, horrifying events for other patients:

"That patient told the men who came to 'fix' him that he would cut his wrist if they didn't go, but he wouldn't really do it, he just threatened to do it. Before that, he hit and broke everything. I was stressed about what was going to happen now. Would he really do this or not?"

Disrespect in the Hospital

Some of the patients talked about times when they were disrespected and about the disconformity of the environment of the ward with their needs such as the low quality of the food, long food lines, insufficient amount of food, not having a separate room for smokers, the mousy smell of clothes, uncleanliness of the ward, the disgusting situation of restroom and bathroom services, inflexibility of the programs of the ward, insulting actions and such cases.

"They turn off the lights at half-past ten; they say we have to sleep. We don't feel like sleeping... but they say that we must sleep as if we are children!"

Some of the patients felt that limitations, might be necessary for some patients, were not beneficial for them:

"Some of the patients come in without knocking at the door; this makes the person uncomfortable (referring to the fact that restroom doors open outward to prevent suicide)".

Some of the patients justified the conditions to free themselves from suffering limitations to be able to tolerate those very limitations:

"When I tell them I have a headache and ask them to give me a tablet, they say that their headache is worse than mine. Of course, I think they are right. They shouldn't act in a way that we would like to stay here forever. The environment shouldn't be the way we like. We must help ourselves to get well as soon as possible to get out of here."

Cry of Objection

Some of the patients started to object, sometimes gently and sometimes violently:

"*I want to come here for a consultation whenever I want to. I don't want them to keep me here against my will. Yesterday I became nervous. I hit the bed and the other things just to make them let me go out, but they kept me in by force. I wanted to kill myself, I was so nervous."*

"I'm doing alright. I gotta go home. I will go insane in here"

Hopeless Reasoning

Some of the patients started to plead to find reasons for limitations:

"We are sick. I forget to wear a hair scarf maybe because of my mental condition. This disturbs me mentally. We are sick, we can't help it."

Experience of Loneliness

This category, with its 7 sub-categories, refers to a feeling of loneliness caused by different factors.

Separation from Family

Some of the patients talked about suffering separation from their families:

"Being away from the family? It hurts."

Not Having Anybody to Talk to

This sub-category points out the insufficiency of the

interaction between treatment staff and the patients, and the patients' expectations which are mostly focused on therapies. Furthermore, the phrase "talking one's heart out" was used to describe more need for consultation and talking than any other term. As if "talking one's heart out" and not psychotherapy was especially the main need of the patients participating in this study.

"I want somebody to listen to me, understand my problem and cure it. What do I want medication for? I took medication my whole life. Anyhow they (sometimes) come and sit with us, comfort us, and give us water to drink."

Some of the patients blamed the treatment staff by claiming they didn't listen to the patients:

"She criticizes me a lot. For example, she wants me to divorce my husband. She keeps criticizing. (While speaking about talking and sympathy, referring to one of the treatment staff members)."

The need for a Psychiatrist and Psychologist and not a Resident

This sub-category refers to the need for receiving treatment from the main psychiatrist and psychologist; sometimes visits by a resident are regarded as unequal to having a consultation.

"*It is so effective and important when the doctor, not the resident, personally visits us.*

Stigma

This sub- category refers to fear of public knowledge of hospitalization, and therefore, keeping it as secret and having no interaction with the outside world.

"One is unconsciously under pressure by the thought of the others outside who say one is hospitalized in a mental hospital. I do not like it. People do not have the right opinion about hospitalization in a mental hospital. This is great pressure on me. I think a lot about how to prevent people from finding out I'm in a mental hospital.

Some referred to the negative opinions of the staff regarding the patients:

"The cooks here think that we have a problem otherwise we wouldn't be here. So, whatever they give us, we are not supposed to say anything. We are not crazy; we just have some problems, so we had to come here."

Conflictual Patient Activation

This sub-category refers to cases in which the staff asked for the patients' help for different reasons (such as activating depressed patients, keeping patients busy, and so on); this caused mental conflicts for the patient. These conflicts could not be resolved and caused an increased feeling of loneliness.

"*One of the paramedic assistants gives us the bedsheet. We have to change them ourselves, and they say it's a part of therapy. We do not have a physical patient here. What do they do, if they do not change a sheet? We do not know how to tie; we are too nervous for that."*

Isolation

This sub-category refers to having no interaction with others and becoming lonely and isolated.

"Now we have two or three addiction cases who are restless or make so much noise that the staff must tie them down. In any case, there will be tension which causes everybody to be upset and feel sorry for them. Then just about everybody becomes isolated."

Untrustworthy Atmosphere

This category which consists of three sub-categories refers to an atmosphere in which nobody trusts anybody: patients do not trust the staff and the staff do not trust the patients.

Pessimism Towards the Staff

Some of the patients believed that the staff have a hostile motivation for controlling them.

"For instance, if I become intimate with you, they want to quickly separate us. I even think that they add camphor and such things to our food so that we have no feelings for men."

Pessimism Towards Patients

Some of the patients participating in the study described the staff as being pessimistic and distrustful of them:

"As I entered the hospital (the previous time, when I was hospitalized in another ward), I was still at the door when one of the staff told me, 'Hurry up, change your outfit. Let's go to the bathroom and take off your clothes. Let me see if there is any scar on your body.' I told her: 'I swear to God that I will tell you if there is

any.' She said: 'No! I have to see for myself.' I showed her... But here (in this ward) they asked my permission to see if there is a scar on my body."

Distorted Information

This sub-category refers to what has been told to the patients to persuade them to be hospitalized. Sometimes the staff and sometimes the family members of the patients told them such things:

My sister told me: 'if we go to the clinic, they will give you medication', but my doctor told me: 'if you are hospitalized, you will stay in the hospital for one or two weeks and then leave'. One week becomes thirty-seven/thirty-eight days here.

Discussion

Hospitalization is a difficult experience. Previous studies have shown that hospitalization in a locked psychiatry ward can lead to trauma (5). The participating patients in the study talked about their hopes and expectations that the hospital would be a safe and calm place in which they could get rid of life's difficulties, the blaming of the family, and loneliness. Establishing an acceptable interaction with a caring psychiatrist, efficient, attentive, and lenient nursing, respectful behavior of the staff, and suitable regulations of the ward (acceptable to the patients), helped the patients feel comfortable. There has been similar data in a recent study concerning patients' experiences of mental hospitalization entitled Effective *Factors in the Feeling of Safety*. To this concern, supportive and predictable services (the capability of mental and social services to meet the needs of the patients) empowered structured environment, interaction and acceptance of responsibilities, increase in the feeling of safety in the patients (6). The participating patients emphasized that caring and efficient psychiatrists as well as attentive and lenient nursing are effective in their recovery. This finding is in line with the results of the study conducted by Roche *et al* that the therapeutic relationship has a central role in psychiatric inpatients and is a powerful prognostic indicator for physicians (7). Nevertheless, some of the participants talked about some situations in which these expectations were not met. Although psychological and psychiatric services in Mehr are much better compared to other wards, some of the patients still complained about the lack of verbal communication with the psychiatrist and nurses and of its low quality; they even expressed their twenty-four-hour need for consultation and for talking their heart out. This finding is in line with the results of previous studies which emphasize the empathy and non-judgmental communication of the staff (8,9).

Inflexible rules, numerous limitations, disrespectful interaction, fear, insecurity, and receiving unwanted treatment were among the factors leading to negative experiences for the patients. Experiencing numerous limitations and receiving involuntary treatment caused the feeling of imprisonment in some of the participating patients, and hospitalization would be of no help to their recovery in these circumstances. These findings are in accordance with those of previous studies in which patients with very negative experiences of hospitalization complain about the limitation of their freedom, comparison of hospitals to prisons, and belief that hospitalization makes the person feel worse (10).

Although the patients agreed with the necessity of rules and certain limitations, they thought that the inflexibility of the staff in implementing these rules is inappropriate. From the patients' point of view, there were too many unnecessary limitations caused by pessimism which had negative effects on their comfort. The patients expected that the nurses and the medical staff implement limitations and check them with empathy only when necessary and not as a routine for all patients. Strict caring and limitations caused that some of the patients feel that the medical staff do not trust them or have hostile motivations and try to control them. It seems that there is a fine line between effective and professional care of the patients by implementing inappropriate and excessive limitations: even for trained staff this red line is difficult to determine, designating it is as complex as human mentality itself. Accordingly, the simplest (but not the best) solution would probably be to implement the utmost limitation with the aim of achieving the utmost safety in the ward. According to the report of Johansson *et al*, caring has complicated qualities from the patients' perspective, some care alleviates the suffering of the patients, though it causes stress for others. That is, care probably means the imposition of discipline from the patients' point of view so that

it affects the expected alleviation of suffering for the patient. Therefore, it is important to be careful about timing when control materializes in caring for patients (11). Although this strict and inflexible caring had a negative effect on the alleviation of mental suffering of patients, the continuation of this process is understandable from two aspects: first, the complexity and difficulty of the matter, and in some cases impracticality of the individualization of limitations for different patients, and second, the concern of the staff due to the legal consequences of decreasing the limitations and giving more autonomy to patients. This last can be a potential factor for increasing the possibility of self-harm, self-cutting, suicide and escaping from the ward. It seems as if responsibility and anxiety, caused by any reduction in limitations for psychiatric inpatients, are so high that they affect they patients' well-being, respectability and autonomy. This is so important and complicated that needs further study.

The participating patients in the research also talked about fear, worry and insecurity in the ward; they also worried about the theft of their properties and being attacked by other patients. They expected more implemented precautions in the ward so that they would feel secure in the hospital. Stenhouse *et al* also pointed out the fact that the nurses should be vigilant to the probability that patients might feel insecure and sensitive despite the absence of an apparent threat (12).

One of the factors that the participating patients in this study pinpointed with great discomfort is the experience of being trapped in a locked ward due to the breach by the psychiatrist or the family members. As involuntary hospitalization creates a difficult and demanding situation both for the psychiatrist and also for the patient, sometimes the psychiatrist or a family member presumes and states the duration of the hospitalization far shorter than necessary for the patient in order to ensure that the patient agrees to be hospitalized. In such cases, we meet patients who are hospitalized of their own will, but in fact, their long hospitalization is compulsory and against their own desire. These circumstances affect the process of treatment and the therapeutic relationship between the psychiatrist and the patient. In this respect, Katsakou *et al* maintain that respecting patients and allowing them to participate in decision-making concerning their treatment might reduce their feeling of being forced into something (13).

For some patients, especially those who were hospitalized for the first time, negative emotions were also caused by the stigma of being hospitalized in a mental hospital. They worried about their status in the family and among friends. They considered their situation as a patient hospitalized in a mental hospital as degrading, and blamed themselves for it. Besides, they related any inappropriate behavior of the staff to their own constrained and degraded situation. Lata *et al* stated that the hospital has an imposing environment in which the meaning of any behavior can be easily misunderstood. The result for patients hospitalized in such environments can be debilitating, depersonalizing, segregating, humiliating, and self-labeling, which doubtlessly has stressful effects which are antitherapeutic (14).

The recent reviewing studies present some important aspects and themes in the experience of psychiatric inpatients, such as collaborative and inclusive care or patient-centred care, high-quality and positive relationships, negative and aversive experiences of involuntary treatment, and a safe, healthy, and empowering social environment. It is also necessary that these aspects be considered to improve the hospitalization services, practical instructions, and future assessments of service quality (15,16). The results of this study are in concordance with the above-mentioned findings. Although the main aspects to improve the quality of psychiatric services are defined to a great degree and are approved in different studies, it seems that there are limited solutions and practical guidelines in this respect, or there are obstacles for their implementation. The absence of significant positive changes in patients' experiences in mental hospitalization, despite the reports of negative experiences, and recommendations and different precautions taken over many years is witness to this claim. In future research, it is necessary to attend in detail to each of the aspects which need improvement, to propose and implement practical solutions to improve the experiences of hospitalization in each aspect. Ultimately, these results need to be studied and evaluated.

Conclusion

It seems that rendering desirable services to psychiatric inpatients has not been attained yet. According to the findings of this research, numerous limitations, inflexible rules in the ward, insufficient interaction with the psychiatrist and nurses and involuntary treatment, as well as inadequate physical facilities in the ward caused negative experiences, that in their own way affect the treatment process of the patients. Nevertheless, the negative effects of the inadequate and inappropriate therapeutic relationship and numerous limitations in the ward were more prominent from the participating patients' point of view. As patients need different care according to their psychopathology, the staff should keep this fact in mind during the care of the patient. In other words, the degree of care for each patient must be individualized and implemented so that there is no excess or defect in this case.

Care for the patients must be free of disrespect and it is necessary to consider the basic ethical principles of considering the patients' autonomy, care, and benefit.

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Conflict of Interest

The authors report no conflict of interest.

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Data availability

The data that supports the findings of this study is available on request from the corresponding author. The data is not publicly available as it contains information that could compromise the privacy of the research participants.

References

1. Strauss JL, Zervakis JB, Stechuchak KM, Olsen MK, Swanson J, Swartz MS, et al. Adverse impact of coercive treatments on psychiatric inpatients' satisfaction with care. Community Ment Health J 2013 Aug;49(4):457-65.

2. Henderson C, Phelan M, Loftus L, Dall'Agnola R, Ruggeri M. Comparison of patient satisfaction with community-based vs. hospital psychiatric services. Acta Psychiatr Scand 1999 Mar;99(3):188-95.

3. Williams B, Wilkinson G. Patient satisfaction in mental health care: evaluating an evaluative method. Br J Psychiatry 1995 May;166(5):559-62.

4. Bleich SN, Özaltin E, Murray CJ. How does satisfaction with the health-care system relate to patient experience? Bull World Health Organ 2009 Apr;87(4):271-8.

5. Cohen LJ. Psychiatric hospitalization as an experience of trauma. Arch Psychiatr Nurs 1994 Apr;8(2):78-81.

6. Pelto-Piri V, Wallsten T, Hylén U, Nikban I, Kjellin L. Feeling safe or unsafe in psychiatric inpatient care, a hospital-based qualitative interview study with inpatients in Sweden. Int J Ment Health Syst 2019 Apr 8;13:23.

7. Roche E, Madigan K, Lyne JP, Feeney L, O'Donoghue B. The therapeutic relationship after psychiatric admission. J Nerv Ment Dis 2014 Mar;202(3):186-92.

8. Gilburt H, Rose D, Slade M. The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK. BMC Health Serv Res 2008 Apr 25;8:92.

9. Stewart D, Burrow H, Duckworth A, Dhillon J, Fife S, Kelly S, et al. Thematic analysis of psychiatric patients' perceptions of nursing staff. Int J Ment Health Nurs 2015 Feb;24(1):82-90.

10. Chevalier A, Ntala E, Fung C, Priebe S, Bird VJ. Exploring the initial experience of hospitalisation to an acute psychiatric ward. PLoS One 2018 Sep 4;13(9):e0203457.

11. Johansson IM, Skärsäter I, Danielson E. The meaning of care on a locked acute psychiatric ward: Patients' experiences. Nord J Psychiatry 2009 Nov;63(6):501-7.

12. Stenhouse RC. 'Safe enough in here?': patients' expectations and experiences of feeling safe in an acute psychiatric inpatient ward. J Clin Nurs 2013 Nov;22(21-22):3109-19.

13. Katsakou C, Marougka S, Garabette J, Rost F, Yeeles K, Priebe S. Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study. Psychiatry Res 2011 May 15;187(1-2):275-82.

14. Latha KS, Ravi Shankar BG. Hospital related stress among patients admitted to a psychiatric in-patient unit in India. Online J Health Allied Sci 2011 Apr 15;10(1).

15. Wood L, Alsawy S. Patient experiences of psychiatric inpatient care: a systematic review of qualitative evidence. Journal of Psychiatric Intensive Care 2016 Apr 1;12(1):35-43.

16. Staniszewska S, Mockford C, Chadburn G, Fenton SJ, Bhui K, Larkin M, et al. Experiences of in-patient mental health services: systematic review. Brit J Psychiatry 2019 Jun;214(6):329-38.