Exploring the experiences of people receiving psychiatric treatment-related soft or subtle coercion: A systematic review of qualitative research protocol

Introduction

Background to the review

One of the most contentious issues within psychiatry has been the administration of psychiatric treatment on people who have not wanted to be treated (Monahan, 2011), much of which has involved coercion. Coercive measures are routinely used in order to administer treatments to the extent that psychiatry is, according to Szasz (2007), “the theory and practice of coercion” (pxi). The extent of coercion is such that, in 2007, an historic World Psychiatric Association conference specifically to review coercive treatment in psychiatry took place (Kallert et al., 2007). This was to mark a global opportunity for world leading experts in this field to commence dialogue with psychiatric service user and survivor groups. Furthermore, it acknowledged the need for global scale recognition of the complexity and widespread use of coercion.

Coercion is commonly defined being “the act or process of persuading someone forcefully to do something that they do not want to do” (Dictionary, 2012). However, there is no single, uniformly agreed definition of coercion in clinical practice. Further, upon examination of the literature, it can be seen that within psychiatry coercion is seemingly defined by the way in which it is practiced rather than by the way in which it is understood. In general, though, coercion is used to exercise power to control another person, either by the threat of or the actual use of coercive measures (Arboleda-Florez, 2011). There are various terms used to describe coercion in the literature detailing different ways as to how this power is exercised. Arguably the broadest term is ‘treatment pressures’, which describes a hierarchy of coercive measures, ranging from persuasion through to leverage, to threats and to the use of legal jurisdiction (Szmukler and Appelbaum, 2008). Other terms commonly found in the literature to describe coercion include ‘involuntary admission’, ‘involuntary treatment’, ‘leverage’, ‘soft coercion’, ‘hard coercion’, and ‘subtle coercion’. This variation of terms, to some extent, relates to international cultural differences in the use of coercive measures and makes understanding the meaning of coercion difficult.

Broadly, coercion can be categorised into 3 themes:

1. Coercion as a result of legal or environmental constraints.

This type of coercion is encapsulated by the use of legal jurisdiction or the use of specific physical boundaries within an environment. For example, the Mental Health Act (Department of Health, 2007) is applied to ensure that service users maintain engagement with psychiatric services and receive treatment (see Canvin et al., 2014). Additionally, service users can perceive there to be a threat of the Mental Health Act being applied to administer treatment (see Carrick et
The physical environment of a psychiatric ward influences the perception of coercion (see Larsen and Terkelsen, 2014), such as the use of a seclusion room, which can apply pressure and firm boundaries to ensure people who are non-compliant with treatment or who exhibit behaviour perceived by healthcare practitioners to be unacceptable, receive treatment (see Kontio et al., 2012).

These types of coercion commonly fall under the term ‘involuntary admission’ or ‘involuntary ‘treatment’, which refers to the admission and treatment of a person under the use of legislation such as the Mental Health Act (see McGuinness et al., 2013, Katsakou et al., 2012, Hughes et al., 2009, Johansson and Lundman, 2002). Another term, ‘leverage’, refers to the way in which treatment adherence is influenced whereby, for example, unless a service user adheres to treatment then they would be unable to access subsidised housing or maintain control of their own finances (Canvin et al., 2013). This type of coercion typically includes compulsory treatment (see Ridley and Hunter, 2013) and Community Treatment Orders (see Canvin et al., 2014, Gibbs et al., 2004).

2. Coercion as a result of the use of physical power by a healthcare practitioner.

This type of coercion, commonly referred to as ‘hard coercion’, is defined by the use of physical restraint, whereby typically several healthcare practitioners simultaneously surround and lay hands on a person in order to exert physical control over them, often through forcibly positioning the person onto the ground or into a restrained position. Once in this position, often the person will then usually be forcibly administered an injection of a psychiatric drug. Examples of studies exploring hard coercion include the physical restraint and forced administration of medication (Meehan et al., 2000, Hoekstra et al., 2004, Kontio et al., 2012, Wynn, 2004) and the use of straight-jackets in a Dutch study (Carrick et al., 2004). This latter example demonstrates the cultural differences regarding the use of coercive measures (i.e. straight-jackets are no longer used in UK psychiatry).

3. Coercion as a result of the way in which a practitioner uses verbal persuasion.

This type of coercion is commonly referred to as ‘soft coercion’. Rather than the actual application of a coercive measure (hard coercion), soft coercion involves the perceived threat of punishment or perceived use of force (see Lloyd-Evans et al., 2010, Gilburt et al., 2010). This is closely aligned with the description of ‘subtle coercion’. In a UK study of 10 psychiatric nurses, (Lützén, 1998) reported subtle coercion to involve a number of processes and to include persuasion and encouragement, making decisions for service users, manipulation, and trading-off. Lützén conceptualized it as an interpersonal and dynamic interaction in which a person exerts their will upon another and, effectively, becomes a “type of weak paternalism” (p106).
These categories of coercion take place across both inpatient and community care. Within the literature, it is evident that hard coercion such as physical restraint exclusively occurs within inpatient environments, whereas leverage is predominantly used in the delivery of community-based care. Other forms of coercion within these categories can occur across both settings. Arguably, hard coercion implies the service user to have relatively little potential influence in the administration of treatment. Should treatment be refused, hard coercion would involve the use of physical force, legislative leverage or seclusion within a locked environment. Subtle or soft coercion is much less explicit and can involve a dynamic interaction between people, within a context of practitioners being expected to develop so-called helping or therapeutic relationships with people receiving treatment. For example, this can occur in the way in which a practitioner and a service user speak with one another in relation to treatment being administered. With regards to self-determination so that one can become empowered to take back one’s own life and recovery, as advocated by the survivor and consumer movement, it is important to understand not only the impact of coercion on this relationship but to understand this relationship from the perspective of people experiencing coercion-related treatment. This is important because, as commonly found in the coercion literature, service users report both a lack of understanding of reasons for coercive measures and to being persuaded into accepting treatment, often without full knowledge of what this might be or what the consequences might be (see Rose et al., 2005). It is this soft or subtle coercion that will be the focus for this review.

Constructing knowledge of psychiatric treatment and how it is perceived by those who receive it has been limited due to the exclusion from research of those receiving treatment. However, international demand from survivors of psychiatric treatment calls for a shift in the passive ‘patient role’ to instead become an active partner in treatment for mental (ill) health (Mezzich, 2011). As such, there has been increasing recognition in both the literature (see Larsen and Terkelsen, 2014) and UK policy (see NHS five year Forward View (NHS England 2014)) and Raising the Bar (Health Education England 2015)) of the importance of including the perspectives of those being treated in psychiatric services in the contribution of the evidence-base for treatment for mental (ill) health.

In terms of current knowledge of the use of coercion in psychiatric treatment, this too has been informed by research that has overwhelmingly edged out the voice of people who have received psychiatric treatment. It is evident that the terms used to describe coercion are defined, largely, from a professional perspective. For example, there are several studies acknowledging the marginalization of people who have received treatment in the construction of this knowledge (Landeweer et al., 2011, Jarrett et al., 2008, Hannigan and Cutcliffe, 2002, Olofsson and Norberg, 2001, Lützén, 1998). Despite this acknowledgement around the lack of service user involvement in the creation of an evidence base, current knowledge regarding coercion has become perceived to be the knowledge about coercion (Russo and Wallcraft, 2011). Within this context of excluding service user perspectives, coercion has become accepted as

Excluding perspectives of those who have experienced psychiatric treatment has, consequently, also led to knowledge acquisition based on outside perspectives rather than the perspectives of those subjected to psychiatric treatment. Thus, there is insufficient understanding of the human meaning(s) that underpin the lived experience of being coerced into accepting psychiatric treatment and the impact of this on the construction of therapeutic relationships. Critical of the research questions and methodologies examining coercion in psychiatry, Russo and Wallcraft (2011) argue that the quantitative methods used to investigate perceptions of coercion fail to sufficiently capture the experiences and meanings that coercion holds for people. Instead, they advocate for qualitative methodology to enable the researcher to get closer to the complexity of a person’s experiences and the impact this has on their lives. Consequently, there is a need to consider qualitative research studies to enable an in-depth exploration of the way coercion exists between people and the impact it has on therapeutic relationships. Further, this qualitative research must be considered in a context of all relevant qualitative research and contribute towards a cumulative knowledge. This is to say, all relevant qualitative research must be brought together in a systematic way and as a whole avoiding the biases associated with traditional literature reviews (Saini and Shlonsky, 2012).

Therefore, this will be a systematic review of qualitative research that will detail a transparent and rigorous approach to methods of searching, inclusion, quality criteria and synthesis to inform mental health policy and practice. There are several methods for conducting systematic reviews for qualitative literature (see Flemming, 2007). The method chosen for this systematic review is a thematic synthesis, which has evolved from other systematic review methods (i.e. thematic analysis, first used by Thomas et al. (2004)) and was developed by (Thomas and Harden, 2008). This method analyses and draws conclusions from a variety of themes from primary research and formulates a new interpretation, 'going beyond' the original findings. It is important to note, however, that the different methods for qualitative systematic reviews are debated and there are new ones still emerging (Saini and Shlonsky, 2012, Thomas and Harden, 2008). With this in mind, it is interesting that one approach to a thematic synthesis has been reported to include primary studies with different study designs (Thomas and Harden, 2008) whereas another clearly stipulates that a thematic synthesis should include only comparable study designs (Saini and Shlonsky, 2012). However, rather than restrict the number of studies for analysis, this thematic synthesis will be informed by Thomas and Harden’s method in order to identify and analyse themes from relevant primary qualitative research regardless of the study design.

**Review aim**

Through a systematic review of qualitative research, explore how people experience soft or subtle coercion in the context of psychiatric treatment and the effect of this on their interactions with practitioners.
Research objective

1. To identify peoples’ experiences of soft or subtle coercion during their admission/treatment in psychiatric services
2. To understand the effect of this coercion on their interactions with healthcare practitioners.

Methods and methodology

Inclusion criteria

This review will consider primary qualitative studies involving people who have experienced soft or subtle coercion during their admission/treatment in psychiatric services.

1. Studies reporting the lived experience of soft or subtle coercion during admission/treatment in psychiatric/mental health services.
2. Studies reporting the effect of this coercion on the interactions between people receiving treatment and practitioners.
3. Studies using qualitative research methods, including but not limited to, phenomenology, grounded theory and ethnography.
4. Mixed methods studies with inclusion of qualitative findings.
5. Participants aged over 18 years.
6. UK-only studies.

Exclusion criteria

1. Studies referring to predominantly hard coercion or leverage.

Literature search and selection

This qualitative synthesis will focus on interpretive explanation (rather than ‘prediction’ associated with quantitative approaches) and, consequently, the sample for the literature search will be purposive and underpinned by the principle aim of reaching conceptual saturation (Thomas and Harden, 2008). Using this approach it is deemed unnecessary for comprehensive searching to identify all literature on a subject, however detailed and systematic searches will be undertaken. The search strategy will be developed in conjunction with an information scientist and aims to find published and unpublished studies, comprising of 3 stages:

1. An initial limited search of CINAHL, MEDLINE and PsycINFO will be conducted followed by an analysis of text words contained in the title and abstract and index terms used to describe identified papers.
2. A further search using all identified keywords and index terms will be conducted across all included databases.
3. The reference list of all identified articles will be searched for additional studies. Studies published in English will be considered for inclusion and there will be no date restriction.
Search terms will be broadly categorized into 4 areas relating to (i) coercion, (ii) relationships, (iii) mental health, and (iv) qualitative research. Initial search terms will include ‘coercion’, ‘coercive measures’, ‘leverage’, ‘psychiatry’, ‘mental health’, ‘patient’, ‘client’, ‘service user’, ‘experience’, ‘lived experience’, ‘relationship’. Truncations and subject headings will be used where possible. Following stage 1, further search terms will be informed by the initial limited search. Published and unpublished literature in English and indexed in the following databases will be searched:

- CINAHL
- Embase
- Cochrane Library
- Medline
- PsycINFO
- OpenGrey
- Web of Science
- HMIC
- UKCRN Study Portfolio
- Social Care Online
- EThOS
- Dept of Health
- Networked digital library of theses and dissertations
- Proquest Dissertations and Theses Fulltext
- NHS Evidence Search: Health and Social Care

(PubReMiner will be accessed for further search terms)

**Appraisal**

Assessment of methodological quality

Qualitative papers meeting the inclusion criteria will be assessed for methodological quality prior to inclusion in the review in accordance with the Critical Appraisal Skills Programme (CASP) tool. In so doing, consideration will also be given to the 12 criteria Thomas & Harding (2008) recommend from previous research. This covers 3 main quality issues, namely:

1. Quality of reporting – study's aims, context, rationale, methods, findings
2. Strategies employed – reliability and validity of data collection tools, methods of analysis, validity of findings
3. Appropriateness of study methods.

Additionally, the quality of each study will be considered in terms of the context of the review objective rather than the context of the primary study in itself (Thomas and Harden, 2008).

**Synthesis of findings**

Data extraction

A data extraction form will be developed to allow different data from different studies to be recorded. This will include details such as methodology, methods, and data analysis.
As described by (Thomas and Harden, 2008), data will include text labelled as ‘results’ or ‘findings’ in the main report and also in the abstract. This data will be entered verbatim into ATLAS.ti for analysis.

Data synthesis
Thematic synthesis will involve 3 stages, as described by Thomas and Harden (2008).
1. Free line-by-line coding of primary study findings.
   In this stage each line of text, previously entered verbatim into ATLAS.ti from the primary studies (during the data extraction stage), will then be coded to capture the meaning and content of each sentence to produce ‘free’ codes. This will involve the ‘translation’ of concepts from one study to another, whereby each sentence (transferred into ATLAS.ti) from each study will be coded and, hence, new initial codes developed from the studies.
2. Free codes will then be organised into related areas to construct descriptive themes.
   The codes will then be grouped into a hierarchical tree structure in order to organise descriptive themes.
3. Finally, analytical themes will be developed.
   According to Thomas and Harden (2008), although up to this stage of the process the themes combine all the studies as a whole, the synthesis will have produced themes close to the original findings rather than address directly the original objective of the review. Therefore it will be necessary to ‘go beyond’ (Thomas and Harden, 2008) these primary study findings and develop additional concepts, understandings or hypotheses in order to answer the review objective/question. From an iterative, cyclical process of using the descriptive themes to answer the research question/objective there will emerge new analytical themes. This will continue until sufficiently abstract and new analytical themes explain all the initial descriptive themes.

Results
The final, analytical themes will be presented and discussed.
References

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