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A study to explore the level of subjective experience of coercion among individuals with psychiatric disorders

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Abstract

Background: The Coercion is a subjective inner experience of a particular intervention performed against a person's will, either through force or through threat of force. Ideally, no person should be coerced into treatment. Perceived coercion was found to be influenced by various socio-demographic, clinical and social factors.

Aims: To assess the subjective experience coercion among individuals with psychiatric disorders admitted at psychiatric hospitals.

Materials and Methods: The descriptive research design was adapted to assess the subjective experience of coercion of 100 patients with schizophrenia were selected from convenient sampling technique based inclusive criteria at state Government runs mental health institute, Karnataka, India and collected data using tools semi structured questionnaire to assess the perceived coercion and socio-demographic data sheet.

Results: In the assessment of perceived coercion reveals that, 34% of patients had mild perceived coercion and majority 66% of patients had moderate perceived coercion and none of the samples had severe perceived coercion. And also significant association was observed between perceived coercion and socio demographic variables, like place of residence of the patients, duration of anti psychotic treatments of patients and illiteracy levels of the patients at the level of $p<0.05$.

Conclusions: The study shows that the majority have moderate level subjective experience of coercion among patients with schizophrenia. It needs to address the caring strategies' to reduce the level of perceived coercion at mental health care settings.

Keywords: Perceived coercion, schizophrenia, subjective experience, mental health

Introduction

The WHO Global Burden of Disease study estimates that mental disorders are among the most burdensome in the world, and their burden will increase over the next few decades. The mental and behavioral disorders account for about 12% of the global burden of diseases. By 2020, it is likely to increase to 15% [1].

Schizophrenia is a severe form of mental illness affecting about 7 per thousand of adult population, mostly in the age group of 15 – 35 years. Schizophrenia affects about 24 million people worldwide and is a treatable disorder, treatment being more effective in its initial stages. More than 50% of persons with schizophrenia are not receiving appropriate care. 90% of people with untreated schizophrenia are developing countries [2].

The Coercion is a subjective inner experience of a particular intervention performed against a person's will, either through force or through threat of force. Ideally, no person should be coerced into treatment [3].

Use of coercive practice in mental health care has to balance between four different ethical issues representing interests, which are often controversial such as respect of the autonomy of patient, beneficence, non-maleficence and justice [3].

Perceived coercion has been studied in many of developed countries. Studies have shown that perceived coercion may be influenced by several socio demographic and clinical variables, such as higher age, being single, female sex and ethnicity [4].

In the Indian health context, society values medical and social paternalism than individual autonomy. The family structure like belonging to nuclear, extended or joint family plays an important role by treatment of mentally ill person. The head of family makes decision about treatment of beloved ones suffering from mental illness [5]. Majority members of family members are responsible of supporting the patients by providing economical and psychological support in addition to staying with them during

hospitalization. The Indian Mental Health Act 1987 under chapter iv Part II: No.19 also supports the family to admit the mentally ill person, who does not, or is unable to, express his/her willingness for admission as a voluntary patient. These are important protective factor for in India to treat person with mental illness. As such, absence of family support is expected to be a factor negatively associated course and outcome of mental illness [6, 7].

In short, perceived coercion was found to be influenced by various socio-demographic, clinical and social factors. It tended to improve during inpatient care and was predicted by the parallel changes in insight, symptom severity and global functioning [8].

In contrast, this issue has received relatively less research attention in developing countries. This is especially important in the background of the Mental health care bill-2013 of India that seeks for psychiatric treatment in least restrictive alternatives [9].

Perceived coercion in care is an issue of an particular importance in psychiatry, partly due to the growing use of interventions that intuitively increase the likelihood of this occurring [10]. As public policy drives an ever more community oriented psychiatric service, it is possible that the number of coercive actions undertaken to maintain patients in fewer hospitals beds will grow, potentially increasing perceived coercion particularly important for practicing psychiatrist [11, 12].

Coercion is a subjective response to a particular intervention and has been considered an unfortunate but necessary part of the care of people with psychiatric illness. Its ethical underpinnings, evidence base and clinical implications are not commonly considered in day to day care; however, this requires reconsideration as the potential for an increase in coercion stretches beyond the boundaries of the hospital into the community. Much of the research that has been undertaken highlights the prevalence of coercion, the 'grey zone' between compulsory interventions and the experience of patients and patient outcomes in the light of coercion. Policy makers need to consider the evidence for interventions that increase the experience of coercion in order to reduce its impact. Not only is there insufficient scientific evidence on the effects on various outcome parameters of coercive measures, the findings to data have been inconsistent. Although patients, family and staff all have different attitudes and perceptions of coercive measures, patients report very negative feelings, whether they have been restrained or secluded themselves or have seen it happening to others: "Being restrained was the most horrible experience I have had in my life….being restrained and not being able to defend yourself and then those injections, medication that makes you feel tired, that you want to sleep, but at the same time your restrained in such a way that you can't fall asleep….that's horrible." [13].

The issue of coercion as a potentially unwanted consequence of management is therefore becoming urgently important, both in terms of its impact on treatment and the need to understand the factors that influence it. This is true for intuitively coercive actions, such as detention, but also for management interventions that may not be considered coercive, such as informal admission. Despite this, the prevalence of this unwanted 'side – effects' is unclear [14, 15].

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Because of the above mentioned facts, researchers felt that there is a need to assess the subjective experience of coercion among individuals with psychiatric disorders.

Material & Methods

Research design

Descriptive research design was adopted in this study.

Setting of the study

The study was conducted in selected State Government mental health institute, India.

Population

Patients with Schizophrenia who were admitted at acute psychiatric wards and receiving routine care were selected as population for the study.

Sampling

The sampling technique adopted in this study is Non probability convenient sampling technique. Inclusion criteria, the study will include the patients admitted with Schizophrenia between the age group of 18 to 60 years. Patients who are not willing to participate in the study and with co-morbid psychiatric disorders, substance abuse, Mental retardation, a chronic physical and mental illness are excluded from the study. Beyond the inclusion criteria, eligibility for this study also required the patients' willingness to participate, written informed consent and ethical clearance approval was obtained from the Institute ethical clearance committee of study setting.

Sampling size

In the present study, sample size was 100 patients who met the inclusion criteria of the study. The sample size was calculated by considering the power of 80%, at 95% confidence limit with the level of significance at 0.05 level.

Tools: The tools were used in the present study are

Section 1: Socio-demographic data sheet

It includes in order establishing the representative nature of the sample, a range of background data was obtained. Participants provided information on age, gender, completed education in years, occupational status, family monthly income, current marital status, religion, type of family and area of residence. Various parameters included in clinical profile are age at onset of illness, duration of present illness, number of previous admissions, duration of treatment with antipsychotics, family history of psychiatric illness.

Section 2: Semi-structured Perceived coercion scale

Semi - structured Perceived coercion scale was developed by Guru S, Kumar CN, Suresh BM-coercion in Psychiatry, consists of 16 items. Each item was given with a score of zero for 'no' and 2 for 'yes', 1 for don't know. The

minimum score was zero and maximum score was 32. On the basis of scoring, the perceived coercion was classified as; No perceived coercion: 0, Mild perceived coercion: 1 – 10, Moderate perceived coercion: 11 – 20, Severe perceived coercion: 21-32.

Procedure for data collection

Data collection was initiated by after obtaining ethical clearance from institutional ethical committee. Subjects were selected based on inclusion and exclusion criteria. The purpose of the study was explained and obtained informed written consent from the participants and family members of the participants**.** The data was collected for five months from the inpatient department of state Goveronment mental health institute. Confidentiality was maintained during the data collection.

Data Analysis

After completion of the data collection, the data was coded and was analyzed in terms of the objectives of the study using descriptive and inferential statistics.

Results

Part I: Description of demographic characteristics of the patients using descriptive statistics

A) Socio demographic characteristics of subjects

Table 1: Frequency and percentage distribution of demographic characteristics, N=100

Characteristics	No. of participants	% of participants
Age in years		
20-29	38	38
30-39	27	27
40-49	19	19
50+	16	16
Gender		
Male	50	50
Females	50	50
Education		
Illiterates	35	35
Primary	16	16
Secondary	16	16
PUC +	33	33
Occupations		
Unemployed	15	15
House wife	8	8
Agriculture (Farmers)	28	28
Coolie	49	49
Religion		
Hindu	92	92
Muslims	8	8
Type of family		
Nuclear	93	93
Joint	7	7
Monthly income		
<=10,000	77	77
>=10,001	23	23
Marital status		
Married	29	29
Unmarried	71	71
Place of Residence		
Rural	91	91
Urban	9	9

The description of socio demographic characteristics of patients are, 38% of the samples were between 20-29 years of age, 27% were between 30-39 years of age, 19% were between 40-49 years of age and 16% of samples were 50 or above years of age respectively. 50% of the samples were males and 50% were females. 35% of the samples were illiterates, 16% of them studied up primary school, 16% of them up to secondary and 33% of the samples studied up to PUC and above. 49% of the samples were coolie workers, 28% of the samples were farmers, 8% were house wives and 15% were unemployed. 92% of the samples were Hindu's and 8% were Muslims. 93% of the samples were belongs to nuclear family and 7% were belongs to joint family. 77% of the samples family monthly income is <=10000 and 23% were having family monthly income is >= 10001. 71% of samples were married and 29% of the samples were unmarried. 91% of the samples were belongs to rural area and 09% of the samples were from urban area.

B) Description subjects based on clinical characteristics

Table 2: Frequency and percentage of subjects based on clinical characteristic.

Characteristics	No. of participants	% of participants
Age at onset of illness		
20-29	59	59
30-39	15	15
40+	26	26
Period of hospitalization		
1-5 days	44	44
6-10 days	48	48
11-15 days	8	8
Duration of present illness		
1-25 days	25	25
26-50 days	44	44
50+ days	31	31
Pre hospitalization		
No	66	66
Yes	34	34
Duration of anti-psychotic treatments		
No	38	38
1-2yrs	39	39
3yrs+	23	23
Family history of Mental illness		
N**o**	66	66
Yes	34	34

The distribution of samples based on clinical characteristics are, 59% of the samples age at onset of illness is between 20-29 years, 15% of the samples were between 30-39 years and 26% of the samples were 40 or above. 44% of the samples period present hospitalization is between 1-5 days, 48% of the samples is between 6-10 days and 8% of them between 11-15 days. 25% of the samples duration of present illness is between 1-25 days, 44% of the samples were between 26-50 days and 31% of the samples duration of present illness were above 50. 34% of the samples were previously hospitalized and 66% of the samples were not previously hospitalized**.** 38% of the samples were not having any duration of anti-psychotics treatments, 39% of the samples duration of anti-psychotic treatment is between 1-2 years and 23% of the samples were 3 years or above. 66% of the samples did not have any family history of

mental illness, where as 34% of the samples had family history of mental illness.

Part II: Assessment of perceived coercion among Patients with schizophrenia

Table 3: Frequency and percentage distribution based on perceived coercion among patient with schizophrenia, N=100

Perceived coercion levels	No of participants	% of participants
Mild Perceived coercion	34	34.00
Moderate perceived coercion	66	66.00
Total	100	100.00

The subjects shows the perceived coercion are, 66% of the samples had moderate perceived coercion and 34% of samples had mild perceived coercion and none of the samples had severely perceived coercion.

Part III: Association between socio demographic and clinical characteristics with perceived coercion levels.

The results findings shows the association between socio demographic characteristics with perceived coercion by Chi-square test, significant association found between rural area of patients with perceived coercion (χ^2 = 4.7030, p= 0.0300) at the levels of p<0.05. Duration of anti-psychotic treatment also found significant with perceived coercion (χ^2=8.3650, p=0.0150) at the level of p<0.05 and other socio-demographic factors are non significant with perceived coercion. Using one way ANOVA and unpaired t test, the study findings shows that significant association found between illiterates and perceived coercion (mean value = 12.00, SD= 2.11, t= 4.5094, p= 0.0053) at the levels of p value<0.05 and other socio-demographical factors are not found significant relationship with perceived coercion.

Discussion

The findings of the study had been discussed with reference to the aim of the study and with findings of other related literature / studies. The perceived coercion was assessed by using semi-structured tool and the data collected and analyzed using descriptive statistics. The assessment of perceived coercion reveals that 34% of samples had mild perceived coercion and 66% of samples had moderate perceived coercion and none of the samples had severely coerced.

The findings are in accordance with the earlier research examined the perceived coercion and also appraisal of the fairness and effectiveness of the treatment among schizophrenia patients. Results shows that perceived coercion was associated with experience with informal coercive treatment [16]. A descriptive study was conducted on involuntary admission and treatment experiences of persons with schizophrenia: implication for the Mental Health Care Bill-2016. It focuses on involuntary admission and treatment experiences may affect the attitude of patients toward subsequent treatment and further outcomes. Results shown that Perceived coercion in schizophrenia though common clinical phenomena, it is a dynamic state which reduces over course of treatment. At Discharge, majority reported that their admission was justified, even though they were admitted involuntarily. The study underlines the need for a standardized rule of conduct based coercive practice in psychiatry [17].

The earlier study regarding relevance statement Coercion within psychiatric/mental health care remains controversial, and repeated international calls have recommended a reduction of their use. This review indicates that greater attention to how patients perceive the use of coercive measures (before, during, and after incidents) needs to be considered in order to improve the evidence-based and clinical practice [18].

The study supports to the present study result, that is to assess how common the subjective experience of coercion is in psychiatric care and what affects its prevalence. The raw prevalence of perceived coercion ranged from 16 to 90%. A quarter of legally detained patients did not feel coerced into psychiatric care, whereas a quarter of voluntary in-patients reported coercion in care. Clinical implications: Coercion in psychiatric care remains highly prevalent but varies widely by study. Consistency in measurement is necessary to allow better comparison between studies [19].

The earlier study which was conducted at Indian setup supports to the present study results that coercive experiences are associated with several socio-demographic and clinical variables, especially with respect to perceived coercion and negative pressure [20].

The study results emphasized that perceived coercion is a significant problem in psychiatric settings and while other factors may be protective. One of the important aspects of current psychiatric practice includes improving rights for decision taking about treatment options by sharing, discussing, guiding and giving clear information to patients and their care givers through individual education, counseling, supplying information booklets, group therapy, etc. The important need of achieving this is by training nursing personnel in skilled communication for treat the patient with respect and how to reduce the subjective experience of perceived coercion of patients. The study results encourage the staff to focus, especially on at-risk groups. The essentiality of potentially reducing perceived coercion is advanced planning of nursing care for the possibility of future risk.

Conclusion

The profession of nursing is to be oriented and it must keep up with the advancing technology with the changing trends and issues during their practice. The findings of the study reveals that nurses need to understand the prevalence of perceived coercion among individuals with psychiatric disorders, while providing appropriate health care services. In the hospital or mental health care set up, nurse play an pivotal role in providing mental health services to mentally ill patients. As a part of mental health care, the nurses can teach the appropriate measures to reduce the perceived coercion among individuals with psychiatric disorders. The measures includes healthy living conditions, managing conflicts by self, relaxation techniques, developing satisfactory inter-personal relationships and enhanced coping strategies. The study result also recommends for preparing the guidelines at hospital levels to handle the patients with respect and appropriate ways to reduce coercion.

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