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Coercion in psychiatric care: Can paternalism justify coercion?

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Abstract

Background: It has long been debated whether coercion can be justified as paternalism in the field of mental health and it is still a continuing issue of controversy today.

Aims: This study analyses whether coercive intervention in mental health can be justified by the basic assumptions of paternalists: the assumption of incompetence, the assumption of dangerousness and the assumption of impairment.

Method: This study involved 248 patients: 158 (63.7%) were diagnosed with schizophrenia and 90 (36.3%) were diagnosed with mood disorder. In this study, experiences of coercion were divided into legal status, subjective (perceived coercion) and objective experiences (experienced coercion).

Results: The assumption of incompetence was justified in all three categories of coercion whereas the assumption of dangerousness was not justified in any. The assumption of impairment was not justified in legal status and perceived coercion, but provided a partial explanation to serve as a basis for justifying experienced coercive measures.

Conclusions: It can be noted that mental health experts who support paternalism without question must reconsider their previous methods. Above all, the reason why the assumption of dangerousness was not justified in any of the categories of coercion was because coercive intervention used to prevent harm to oneself and others must be very carefully carried out.

Keywords

paternalism, mental health service, coercion in psychiatric care, perceived coercion

Introduction

Coercive intervention in the area of mental health has gone through an immense period of philosophical and clinical debate but still remains as an unresolved and highly controversial issue. Although varying slightly, the mental health laws of numerous countries contradict themselves: while respecting the rights of mentally disabled individuals and designating recovery through self-realization as their highest goal, they restrict these individuals' civil liberties for reasons such as optimal treatment and prevention of harm to oneself and to others. The logic that justifies this contradiction is paternalism. Beauchamp and Childress (1994, p. 274) defined paternalism as 'the intentional overriding of a person's known preference or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose will was overridden.' This concept works around two principles: the principle of non-maleficence and the principle of beneficence. Thus, it suggests that coercion can be justifiable when used in an attempt to minimize harmful effects and maximize benefits.

Applying the principles of paternalism to the area of mental health, coercion has been justifiable with respect to therapeutic gains in those mentally disabled who are incompetent and dangerous with respect to deciding their own treatment and for the prevention of harm to both themselves and to others. As such, there are three premises on which coercion has been justified as paternalism in the field of mental health (Carpenter, 2006; Wynn, 2006). The first premise is incompetence. By nature, the mentally disabled

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lack the ability to agree upon treatment and are unable to choose what is beneficial for them. For the well-being of these incompetent individuals, their autonomy has been limited. Second has been the assumption of dangerousness. Because the mentally disabled are potentially dangerous, coercive treatment must be carried out for the sake of both the individual and the public. Third has been the premise of impairment. For mentally disabled individuals, realistic decision-making is difficult due to the impairment of psychosocial functions and symptoms of their mental disorder and because of this, coercive intervention has been necessary to provide them with optimal treatment.

There have been warnings about the danger of this assumption of paternalism. O'Brien and Golding (2003) claimed that in order for paternalism to be justified, coercion must be used to benefit the mentally disabled individual. However, preventing danger to others and increasing adaptation to treatment and thus making treatment easier, benefits the public and the therapist and not the individual, and therefore cannot be justifiable. Moreover, coercive treatment against an individual's will causes one to lose self-confidence as an able-minded human being and impairs therapeutic relationships, severely disrupting any voluntary search for help.

Also, there has been considerable refutation of the three assumptions of paternalism. First, regarding the assumption of incompetence, doubt has been raised as to whether mentally disabled individuals are truly incompetent and thus unable to decide their own interests. According to studies that have focused on the consenting abilities of the mentally disabled (Kitamura et al., 1998; Wirshing, Wirshing, Marder, Liberman, & Mintz, 1998), these individuals never showed lower levels of comprehension than other medical patients when equal information was given, and in cases of low comprehension levels, were shown to recover their ability when repeated training was given.

On the assumption of dangerousness, first, there has been no concrete evidence that the mentally disabled have a higher crime rate. Second, above all it has been difficult to accurately predict danger, and thus difficult to use coercion based on this potential danger. Third, focusing on the potential threat to others has not contributed to the beneficence of the mentally disabled individual and thus does not fit with the basic principles of paternalism (Carpenter, 2006).

On the assumptions of impairment, there has been criticism that the coercive intervention used to regulate symptoms has not brought as strong a clinical effect as predicted. Needless to say, there have been studies that have shown that coercive intervention lowers the possibility of readmission in the long term (Pribe et al., 2009) and enhances psychosocial functions (Gove & Fain, 1977), but on the contrary, there have also been studies that have shown that coercive intervention creates negative results (Bindman et al., 2005). According to these studies, coercive intervention deteriorates psychosocial functions, worsens symptoms of mental disorders, and results in the low use of community services. As previously indicated, it has long been debated whether coercion can be justified as paternalism in the field of mental health and in fact it continues to be a controversial issue today.

According to Korea's Mental Health Act, it is possible for a psychiatrist to decide on involuntary admission with only the consent of the primary caretaker if the patient does not have the competence to agree to hospitalization. The legal provision regarding the criteria of involuntary hospitalization is 'when the patient has symptoms serious enough to require hospitalization or when there is danger of the patient becoming a threat to him/herself or others' (article 24). However, there are no specific criteria to assess the individual's competence to consent, severity of the symptoms and the danger of becoming a threat to oneself and others, so considerable power is in the hands of the caretaker and psychiatrist. In Korea, 90.3% of hospitalized patients are involuntarily hospitalized (Ministry of Health and Welfare, 2007) because many caretakers and psychiatrists justify coercive hospitalization on the assumptions of dangerousness, incompetence and impairment. However, it has not yet been verified as to whether such coercive intervention can be justified as paternalism as practitioners have claimed. Therefore, this study analysed whether coercive intervention observed in Korea's field of mental health could be justified by the basic assumptions of paternalists: the assumptions of incompetence, dangerousness and impairment.

Methods

Participants

Participants were 248 adults (38.3% female, 61.3% male; mean age 38.58 years (±11.37) who had been hospitalized after diagnoses of schizophrenia and mood disorder. They were in hospital for four weeks. The average period of education was 11.91 years (±3.02). One hundred and fifty-eight (158) patients (63.7%) were diagnosed with schizophrenia and 90 (36.3%) with mood disorder.

Measures

Experiences of coercion were divided into legal status, subjective and experienced coercive measures. With respect to the legal status of the subjects, 40 subjects (16.1%) had been voluntarily hospitalized and 208 subjects (83.9%) involuntarily hospitalized. With regard to subjective experiences of coercion, which was perceived coercion (PC) by mentally disabled individuals, the five questions on the Perceived Coercion Scale (PCS) of the MacArthur Admission Experience Survey (MAES) were used, altered to fit the Korean culture. It asked whether hospitalization was according to one's own will, thoughts, choice, freedom

and influence, with answers on a four-point Likert scale (0 = never, 3 = always yes). The reliability of this scale, shown by Cronbach's α, was .811 in this study. In the experienced coercive measures (ECM), the participants were asked how often they had experienced threats, physical violence, restraint or forced medication on a four-point Likert scale. Cronbach's α was .746.

The legal status, dangerousness, symptoms of mental disorders and psychosocial functions of the subjects were evaluated by the psychiatrist in charge of each individual's treatment, and the consenting abilities of the subjects were evaluated personally by an evaluator trained in that area.

Consenting abilities were evaluated using the Korean Assessment Tool of Competence to Consent to Psychiatric Hospitalization (KATOC) developed by Seo, Kim and Rhee (2011). This tool assessed the mentally disabled individual's competence to consent to hospitalization by evaluating five sub-scales of the ability of understanding (five items), the ability of application (seven items), the ability of reasoning (six items) and the ability to express (three items). Each sub-scale had a relatively reliable Cronbach's α ranging from .70 to .87. The KATOC did not use the grand total score but provided cut-offs for the total score of each sub-scale to classify those capable of consent and those incapable. Thus, those who fell under even one of the following were considered incapable of consent: under 6.65 points for the ability of understanding; 3.81 for the ability to express; 10.5 for the ability of application; and 4.5 for the ability of reasoning. Evaluated in this way, 44% of the subjects were regarded competent and 56% incompetent.

With respect to dangerousness, the Overt Aggression Scale (OAS) by Hellings et al. (2005) was used. The OAS was divided into verbal aggression, which involved shouting or cursing, physical aggression against objects, which involved throwing or kicking objects, physical aggression against one's self, such as hitting one's head against a wall or hurting oneself, and physical aggression against others, which involved injuring or showing threatening behaviour towards others. Each sub-scale had four items, with 16 items in all. The Cronbach's α of each sub-scale was quite reliable, with .932 for verbal aggression, .850 for physical aggression against objects, .817 for physical aggression against one's self and .806 for physical aggression against others.

The Brief Psychiatric Rating Scale (BPRS) was used to assess the psychotic state of the subjects. Developed by Overall and Gorham (1962) to assess the relative seriousness of psychical disorder symptoms, it comprised 18 items with a seven-point scale (0 = none, 1 = very weak, 2 = weak, 3 = mediocre, 4 = slightly strong, 5 = strong, 6 = very strong). For scoring, the points for each item were added up, with totals ranging from 0 to 108. Cronbach's α was .844.

The Global Assessment of Functioning Scale (GAF) was used to assess the subjects' psychosocial functions. The GAF was used as Axis V for the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and was evaluated by a single score between 0 and 100. The evaluation criteria were presented by points of 10, and the therapist assessed the condition of each patient with detailed scores according to the given criteria.

Results

Incompetence

Legal status. To examine whether legal status could be justified as the incompetence out of the three basic assumptions of paternalism, the χ^2 test and F test were used. First, when examining the relationship between legal status and the competence to consent, the percentage of competent individuals (67.5%) was higher than the percentage of incompetent individuals (32.5%) in cases of voluntary hospitalization. However, with respect to involuntary hospitalization, there was a higher percentage of incompetent individuals (60.6%) than those competent to consent (39.4%) ($\chi^2 = 10.740$, $p = .001$). These results imply that legal status was based on a certain assumption of incompetence.

Perceived coercion (PC). The high PC and low PC groups were compared in incompetence. The groups were divided into two by the high/low 30% of their total PC score. The high PC group had a higher rate of individuals incompetent to consent (64.0%) and a lower rate of competent individuals (36.0%) than the low PC group ($\chi^2 = 9.540$, $p = .002$). This implied that the PC of mentally disabled individuals could be explained to some extent by the assumption of incompetence.

Experienced coercive measures (ECM). To examine the assumption of incompetence, groups with high and low ECM were compared. The groups were divided in two according to the high/low 30% of their total ECM scores, with 101 subjects in the low ECM group (average 2.10±1.11) and 74 subjects in the high group (average 6.87±4.79). The high ECM group had a higher rate of incompetent individuals (66.2%) and a lower rate of competent individuals (33.2%) than the low ECM group ($\chi^2 = 5.431$, $p = .02$). This signified that as with PC, ECM could be explained to some extent on the assumption of incompetence.

Dangerousness

Legal status. Table 1 provides dangerousness differences according to legal status. The sub-scales of dangerousness (verbal aggression, physical aggression against objects, physical aggression against one's self and physical aggression against others) did not show significant differences according to legal status. This signified that legal status was not justified on the assumption of dangerousness.

Perceived coercion (PC). The dangerousness assumption was compared between high PC groups and low PC groups. Consequently, all of scales showed no statistically significant differences as indicated in Table 1. This result

Table 1. Descriptive statistics, χ^2 and F value of legal status, PC and ECM according to the three assumptions

Assumptions	Scales	LS		χ^2/F	PC		χ^2/F	ECM		χ^2/F
		Voluntary	Involuntary		High	Low		High	Low	
Incompetence[a]	KATOC competence	27 (67.5)	82 (39.4)	10.740***	27 (36.0)	47 (61.0)	9.540**	25 (33.8)	52 (51.5)	5.431*
	incompetence	13 (32.5)	126 (60.6)		48 (64.0)	30 (39.0)		49 (66.2)	49 (48.5)	
Dangerousness[b]	verbal aggression	5.70 (10.37)	7.37 (10.48)	0.856	7.89 (10.66)	7.32 (11.23)	0.105	8.93 (11.51)	7.43 (11.05)	0.760
	physical aggression	4.68 (10.82)	3.60 (8.08)	0.522	3.33 (7.81)	4.22 (9.56)	0.392	4.19 (9.78)	4.20 (8.28)	0.000
	aggression against self	1.48 (5.27)	2.09 (7.69)	0.232	1.63 (6.22)	2.78 (9.08)	0.830	3.23 (9.44)	2.05 (7.74)	0.823
	aggression against others	3.48 (8.87)	2.99 (8.57)	0.108	2.37 (7.02)	2.83 (7.17)	0.158	2.96 (8.74)	3.50 (9.16)	0.157
Impairment[c]	BPRS	23.80 (13.33)	27.16 (14.73)	1.800	25.27 (15.54)	25.38 (13.90)	0.002	30.37 (15.34)	25.48 (13.51)	4.963*
	GAF	47.68 (14.56)	44.79 (12.49)	1.685	44.34 (13.06)	47.56 (11.98)	2.508	42.53 (12.76)	47.61 (12.67)	6.844**

a: frequency (%), χ^2test; b, c: M (SD), F test
BPRS: Brief Psychiatric Rating Scale; GAF: Global Assessment of Functioning Scale; LS: legal status; PC: perceived coercion; ECM: experienced coercive measures
*$p < .05$, ** $p < .01$, *** $p < .001$

demonstrates that PC was not justified based on the assumption of dangerousness.

Experienced coercive measures (ECM). The differences in dangerousness between the high ECM group and the low ECM group were not significant (Table 1). This implies that objective coercive measures were not justified on the assumption of dangerousness.

Impairment

Legal status. To examine the assumption of impairment, the psychotic symptoms and psychosocial function differences according to legal status were compared; no significant statistical differences were shown. This implied that as with the assumption of dangerousness, legal status was not justified on the assumption of severe impairment (Table 1).

Perceived coercion (PC). Impairment was compared between the high PC and low PC groups; all of scales showed no statistically significant differences (Table 1). This result demonstrates that PC was not justified based on the assumption of impairment.

Experienced coercive measures (ECM). Results of analysing the differences in BPRS and GAF between high and low ECM groups in order to examine the assumption of impairment showed statistically significant differences. This means that patients in the high ECM group had more serious psychotic symptoms and lower psychosocial functions. This signifies that unlike PC, ECM was justified on the assumption of impairment. Therefore, it could be said that measures such as forceful seclusion, coercion and medication during hospitalization were used to regulate those patients whose symptoms and functions had declined, rather than to regulate dangerousness. The important thing was that one could not but question the need for using human rights-abusive measures such as seclusion or coercion to regulate the symptoms of patients hospitalized in the protection ward.

In summary, the assumption of incompetence was justified in all three categories of coercion whereas the assumption of dangerousness was not justified in any. The assumption of impairment was not justified in legal status and PC, but provided a partial explanation to serve as a basis for justifying ECM (Table 2).

Discussion

The purpose of this study was to examine whether the coercion practised in the area of mental health could be justified on the assumption of incompetence, dangerousness and impairment, as paternalists claim.

Several important facts were found. First, the categories of coercion, legal status, PC and ECM showed mutually significant relevance with each other. Thus, when legal status was involuntary hospitalization, both PC and ECM were higher than in cases of voluntary hospitalization.

Table 2. Summary of the examination of three assumptions of paternalism

Coercions	Assumptions		
	Incompetence	Dangerousness	Impairment
LS	O	X	X
PC	O	X	X
ECM	O	X	O

O = support; X = fail
LS: legal status; PC: perceived coercion; ECM: experienced coercive measures

Also, both PC and ECM showed a meaningful correlation: the higher the PC, the higher the ECM. However, when cross-analysing the high/low PC and ECM groups with legal status in this study, we found that 26.7% of voluntarily hospitalized patients were in the high PC group and 22.2% were in the high ECM group, and in cases of involuntarily hospitalized patients, 45.1% were in the low PC group and 52.5% in the low ECM. These results may signify that Koreans' legal status could not be used as an effective tool to assess experiences of coercion. Therefore, it cannot be said that experiences of coercion in which legal status coincided with PC and ECM were measured just because involuntary hospitalization had higher PC and ECM than voluntary hospitalization.

Although legal status, PC and ECM have been correlated with each other, the reason why they have not been used to the same standards has been because each country has had different regulations regarding involuntary hospitalization and therefore many patients have not known their own legal status (Nicholson, Ekenstem, & Norwood, 1996). Even if patients are aware of their legal status, legal status excessively divides experiences of coercion into two and cannot explain the complicated causality in in the hospitalization and it cannot be used alone to assess experiences of coercion (Hoge et al., 1998). Therefore recently, many have recommended using PC as a tool to assess experiences of coercion. However, when assessing experiences of coercion exclusively with PC, there is the possibility of exaggeration, understatement or denial, and even when coercion is actually perceived, there is a danger of distorting the situation under normalized construction (Hoge et al., 1998). Consequently, Kaltiala-Heino, Laippala and Salokangas Raimo (1997) have recommended using legal status, PC and coercive experiences of therapeutic measures (ECM) holistically. As a result of using these three categories together in this study, it has been proven that although the three are interconnected, they cannot be used as the same concept.

Second, the assumption of incompetence assumes that people with mental disorders are not competent to decide treatment on their own and coercive treatment is called for (Pesscosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). The results of this study show that all three types of coercion are justified to a certain extent on the assumption of incompetence. However, it cannot be overlooked that 39.4% of involuntarily hospitalized patients, 36% of the high PC group and 33.8% of the high ECM group had the competence to consent. This means that more than a third of all patients experience various forms of coercion even though they possess the ability of consent. Thus, there is difficulty in claiming that coercion can be justified under the assumption of incompetence.

Judging from these results, it can be seen that a number of patients experience coercion during hospitalization without a critical evaluation of their competence to consent. Cairns and colleagues (2005) pointed out that most therapists have a tendency to justify coercive intervention while failing to understand and evaluate a patient's competence to consent on various levels and solely regarding a patient's refusal to treatment as incompetence. Kitamura and others (1998) reported that when comparing the consenting abilities of mentally disabled patients and other medical patients, the mentally disabled patients were assessed to be more incompetent; however, this was due to the unequal distribution of information to the mentally disable patients compared with other medical patients. Thus, therapists have concluded that mentally disabled patients are incompetent without providing patients with as much information as they would to other medical patients. Therefore, to justify coercion on the assumption of incompetence, there must be a premise of objective and a detailed examination of a patient's competence to consent.

Third, the assumption of dangerousness views coercive intervention as justifiable for the prevention of harm to oneself and to others. This plays as important a role in justifying coercion as the assumption of incompetence. Most of the public agree that coercive hospitalization should be permitted if the mentally disabled patient is dangerous, regardless of their diagnosis (Luchins, Cooper, Hanrahan, & Rasinski, 2004; Pesscosolido et al., 1999). The World Health Organization (1996, principle 16, p. 37) also stipulated that coercive hospitalization was possible in cases when 'there was a serious likelihood of immediate or imminent harm to that person or to other persons'. However, according to this study, the assumption of dangerousness was not justified in all three categories of coercion. Ultimately, opposed to the thoughts of the public, coercion was not justified clinically, even under the assumption of harm to oneself and others.

Several interpretations can be made from these results. The first may involve accepting the fact that dangerousness cannot be justified and concluding that the assumptions of the public and supporters of paternalism are wrong. Ultimately, this involves concluding that the various experienced coercion episodes during hospitalization are irrelevant to dangerousness. In this case, justifying coercion on

the assumption of dangerousness without evidence only increases the prejudice of the public (Carpenter, 2006) and seriously disrupts the recovery of the mentally disabled. Second, a point can be raised regarding the problem of selecting the subject group. The fact that the subjects agreed to and participated in the research signified that a certain amount of danger was regulated in this case. Therefore, there is a possibility that patients who could have experienced high levels of coercion due to dangerousness were excluded in the first place.

Wynn (2006) pointed out that there were several problems in using coercion on the basis of danger to oneself and others. First, the most serious problem was that dangerousness was difficult to predict accurately. In reality, the incidence of violence in mentally disabled patients has been low and the clinicians who predicted these incidents have been inefficient, thus based on this, coercion cannot be justified. Second, it is not even possible to use coercive measures against all patients that pose a threat to themselves and others; however, even if it were possible, the levels of coercion would become very high. This is not socially acceptable. Third, doubt is raised as to whether coercive measures can reduce violence in the long term. One cannot exclude the possibility that once coercive measures are used, patients feel a sense of frustration and anger, thus increasing the possibility of a more violent disposition.

Fourth, the assumption of impairment justifies the need for coercive intervention as a method to help the recovery of patients who cannot acknowledge the need of treatment due to their symptoms and impaired functions (Wynn, 2006). However, according to this research, legal status and PC were not justified on the assumption of impairment; only ECM. This does not mean that involuntarily hospitalized patients or patients that have experienced high PC have more severe symptoms or more impairment of functions than patients who have not.

In this study, the reason why only ECM was justified on the basis of impairment was because ECM has been thought to be a more serious type of coercion than legal status or PC. Constraint, violence and threat have been categories of coercion that continue to spark issues in the debate of human rights abuse. However, the important thing to note is that a serious type of coercion such as ECM cannot be explained by dangerousness but rather, is explained by symptoms and impairment of psychosocial functions. Symptoms and the impairment of psychosocial functions are the target problems of psychotherapy and to regulate these by the use of ECM, not therapy, can lead to serious problems and raise the possibility of infringing on human rights. According to Sørgaard (2004), ECM such as seclusion or forced medications have been the strongest factors for predicting PC and they explain 45% of it. Ultimately, ECM has a more negative effect on mentally disabled individuals than any other type of coercion, so its use must be very limited.

Studies that support paternalism claim that patients that were initially opposed to coercion, later after recovery, perceived coercive experiences as helpful (Beck & Golowka, 1988) and believed their forced hospitalization to have been justifiable (Pribe et al., 2009). On the other hand, studies that oppose paternalism claim that due to involuntary hospitalization or experiences of high PC, GAF decreases and BPRS increases as time passes (Bindman et al., 2005) and the subjective degree of symptom recovery also goes down (Bonsack & Borgeat, 2005). Furthermore, there have been other studies that suggest difficulties in seeing how experiences of coercion increase treatment adherence (Rain et al., 2003). Therefore, to effectively examine whether paternalism can be justified on the assumption of impairment, continued research is needed, as well as follow-up studies to examine the long-term effects.

Conclusion

Results indicated that all three types of coercion were justified under the assumption of incompetence. However, as we revealed that more than 30% of involuntarily hospitalized, high PC and high ECM patients had the competence to consent, there was some difficulty claiming that it could be justified under the assumption of incompetence. As for the assumption of dangerousness, it could not be justified based on any of the three categories of coercion. The assumption of impairment was not justified based on legal status and PC, but was justified with respect to ECM.

Based on these results, it can be noted that mental health experts who support paternalism without question must reconsider their previous methods. Moreover, these results can be used as a basis for stimulating more ethical practices in Korea, where the percentage of forced hospitalization is over 90% and is based on reasons such as preventing harm to one's self and others and optimal treatment. Above all, the reason why the assumption of dangerousness was not justified in any of the categories of coercion was because coercive intervention used to prevent harm to oneself and others must be very carefully carried out. Thus, its use must be limited; it must be used only in cases when there is a clear and objective prediction of the potential harm and any use must follow the principle of minimum use of force. Moreover, when the assumption of incompetence or impairment fails to justify any types of coercion, there must be strict regulations on which situations call for coercion, and also continued training must be given to experts who are in a position to decide on the need for coercive intervention.

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