**Mental health patients’ experiences of softer coercion and its effects on their interactions with practitioners: a qualitative evidence synthesis**

**Abstract**

**Aims:** To synthesize qualitative evidence of mental health patients’ treatment-related experiences of softer coercion and its effect on their interactions with practitioners.

**Background:** Coercion is controversial but global in mental healthcare. It ranges from softer to harder forms but less attention is given in the literature to softer coercion.

**Design:** Qualitative thematic synthesis examining patients’ experiences of softer coercion.

**Data Sources:** Electronic databases searched from inception to September 2015 and further updated January 2018.

**Review Methods:** Thematic synthesis of eleven UK/Irish articles, quality appraised using the Critical Appraisal Skills Programme tool.

**Results:** Three analytic themes were developed: Losing a sense of self, Less than therapeutic relationship, and Journey through treatment.

**Conclusion:** Softer coercion is experienced across mental healthcare within a context of broader coercion.

**Impact:**

**What problem did the study address?** Knowledge about coercion in mental healthcare is mostly informed by conventional quantitative methods focusing on harder coercion. This review synthesises qualitative research regarding softer coercion.

**What were the main findings?** Patients mostly report negative experiences related to coercion, largely influenced by how they experience interactions with practitioners.

**Where and on whom will the research have an impact?** Practitioners should prioritise positive relationships with patients to reduce negative experiences of coercion. Healthcare educators and providers must support practitioners understanding of power in relationships and development of therapeutic practice. More research from different populations within different health systems is needed to build the evidence base regarding softer coercion.

**Keywords:** Qualitative evidence synthesis, thematic synthesis, softer coercion, mental health, nursing

INTRODUCTION

Coercion is controversial in mental healthcare, with long-standing debate regarding its acceptability and justifiability of infringing upon a person’s rights. The World Psychiatric Association acknowledge coercion as an increasing international concern and evidence from international studies reveal international variation in the administration of coercion (Kallert, Monahan & Mezzich, 2007). Although commonly defined as *“the action or practice of persuading someone to do something by using force or threats”* ([English Oxford Dictionaries](#_ENREF_14)), there is no single, uniformly agreed definition in relation to clinical practice (Molodynski, Khazaal & Callard, 2016) . [Lidz et al. (1998)](#_ENREF_37) and Szmukler and Appelbaum ([2008](#_ENREF_60)) conceptualise coercion as ranging from harder types, such as legal measures, physical restraint and enforced medication, to softer types (see supplementary Table 1 for more detailed overview). Soft coercion is defined in mental health literature as a *perceived* threat of punishment or force (Gilburt et al., 2010; Lloyd-Evans et al., 2010). Similarly, subtle coercion is an interpersonal interaction wherein one person exerts his/ her will upon another and *infers* the potential to action a threat (Lützén, 1998). We use the term ‘softer’ coercion to capture the meaning of both soft and subtle coercion. We conducted a qualitative evidence synthesis to obtain an overview of existing evidence regarding experiences related to softer coercion.

**Background**

Practitioners (termed here as including mental health nurses and other clinicians in the mental health field) and patients report contrasting perspectives regarding coercion ([Hem, Gjerberg, Husum, & Pedersen, 2016](#_ENREF_22); [Hotzy & Jaeger, 2016](#_ENREF_24); [A. Molodynski, Rugkåsa, & Burns, 2010](#_ENREF_43); [Olofsson & Norberg, 2001](#_ENREF_47)). Some practitioners believe coercion can help patients avoid further deterioration and involuntary treatment ([Hotzy & Jaeger, 2016](#_ENREF_24)) but can also feel pressured into coercively activating patients towards discharge ([Femdal & Knutsen, 2017](#_ENREF_15)). But, whilst it is important for practitioners to feel able to justify their coercion ([Vuckovich & Artinian, 2005](#_ENREF_65)), they can underestimate how coercive they can become ([Hotzy & Jaeger, 2016](#_ENREF_24)).

Although patients report mixed experiences of coercion, these are often negative ([Care Quality Commission, 2015](#_ENREF_8); [The Commision on Acute Adult Psychiatric Care, 2015](#_ENREF_61)) and disproportionally affect larger numbers of people from Black and Minority Ethnic (BME) groups ([Bhui et al., 2003](#_ENREF_4); [Care Quality Commission, 2014](#_ENREF_7)). Some patients perceive coercion as being detrimental to their mental health and subsequently disengage or become increasingly non-compliant with treatment ([Hotzy & Jaeger, 2016](#_ENREF_24); [Jaeger et al., 2013](#_ENREF_26); [Swartz, Swanson, & Hannon, 2003](#_ENREF_56)). Patients can also perceive coercion as being traumatic ([Paksarian et al., 2014](#_ENREF_49)) or a form of punishment or to make things easier for staff ([Olofsson & Norberg, 2001](#_ENREF_47)).

However, patients also report contrasting perceptions about coercion, for example voluntary patients can feel coerced and involuntary patients may not feel coerced ([Kallert et al, 2011](#_ENREF_31)). Practitioners influence the experience of being coerced. For example, positive perceptions of coercion are associated with patients believing practitioners act in good faith, are beneficent, open and honest ([Bennett, Lidz, Monahan, Mulvey, & et al., 1993](#_ENREF_3)) when coercion is administered transparently and fairly ([Hotzy & Jaeger, 2016](#_ENREF_24)), in their best interests ([Lorem, Frafjord, Steffensen, & Wang, 2014](#_ENREF_39)) and through collaborative and trusting relationships with practitioners ([Thogersen, Morthorst, & Nordentoft, 2010](#_ENREF_62)).

International and cultural differences in the use of coercive measures influence the numerous terms found in the literature to define the type and frequency of coercion. This varies internationally, with the UK being more or less exclusive in the use of physical restraint, whereas other nations make more use of seclusion (Netherlands and Switzerland), mechanical restraint (Germany, Italy and Norway) and net beds (parts of Austria, Czech Republic and Slovakia) ([Steinert & Lepping, 2011](#_ENREF_55)). The significance of cultural context is emphasised when conceptualising coercion within a broad range of harder to softer types of pressure. Through conceptualising coercion in this way, softer coercion occurs in a context of harder coercion, i.e. verbal statements are more threatening when accompanied by physical force.

Despite service users reporting harrowing experiences related to coercion (e.g. [Hughes, Hayward, & Finlay, 2009](#_ENREF_25); [Paksarian et al., 2014](#_ENREF_49)), less attention is given in the literature to softer coercion. But, due to differences described above, *“the ‘heterogeneity of coercion’ remains poorly understood”* (Molodynski, Khazaal & Callard, 2016, p.1) and Szmukler ([2015](#_ENREF_59)) calls for a more precise understanding in order to advance thinking and research into coercive practice. This review, therefore, is context-specific to the UK and Ireland due to their similar legal and clinical practice frameworks regarding mental health and the subsequent influence on the range of coercion permitted on a similar population group.

Most mental healthcare in the UK has shifted to the community ([The Commision on Acute Adult Psychiatric Care, 2015](#_ENREF_61)) but is insufficiently resourced, contributing to patients’ increased disturbed behaviour during inpatient admissions ([Gilburt, 2015](#_ENREF_18)). Standard and alternative services predominantly provide medication as treatment ([Byford et al., 2010](#_ENREF_5); [Gilburt et al., 2010](#_ENREF_20); [Johnson et al., 2009](#_ENREF_28); [Johnson, Lloyd-Evans, Howard, Osborn, & Slade, 2010](#_ENREF_29); [Osborn et al., 2010](#_ENREF_48); [Slade et al., 2010](#_ENREF_54)). A different patient group tend to use alternative services: mostly female, from a BME group, less likely to be legally detained, more likely depressive rather than psychotic and exhibiting less disturbed behaviour ([Johnson, Lloyd-Evans, Morant, et al., 2010](#_ENREF_30)).

Conventional quantitative research methods insufficiently capture and under-represent lived experiences and meanings associated with being coerced ([Russo & Wallcraft, 2011](#_ENREF_51)) and mental health treatment ([Hannigan & Cutcliffe, 2002](#_ENREF_21); [Jarrett, Bowers, & Simpson, 2008](#_ENREF_27); [Landeweer, Abma, & Widdershoven, 2011](#_ENREF_35); [Lützén, 1998](#_ENREF_40); [Olofsson & Norberg, 2001](#_ENREF_47)). However, although interest in qualitative investigations of in-depth perspectives of receiving coercive treatment has recently increased, most knowledge derives from quantitative methods focusing on harder types of coercion.

This review brings together and examines qualitative research exploring mental health patients’ treatment-related experiences of softer coercion and its effect on their interactions with practitioners using thematic synthesis (Thomas and Harden, 2008). It details a transparent and rigorous approach to methods of searching, inclusion and quality criteria and synthesis with the aim of informing future mental health policy and practice. Reporting of the findings is informed by ENTREQ guidelines ([Tong, Flemming, McInnes, Oliver, & Craig, 2012](#_ENREF_64)).

THE REVIEW

**Aims**

The aim of this review was to explore mental health patients’ treatment-related experiences of softer coercion and its effect on their interactions with practitioners through a synthesis of qualitative research. There are 2 main objectives:

1. Identify patients’ experiences of soft/ subtle coercion during admission to, or in, treatment in mental health services.
2. Explore the perceived effect of this coercion on patient-practitioner interactions.

**Design**

The review was undertaken using a thematic synthesis, a design well suited to questions about perspectives and experiences of health-related issues ([Thomas & Harden, 2008](#_ENREF_63)) such as coercion. The method involves analysing and drawing conclusions from primary research and ‘going beyond’ the original findings to formulate a new interpretation ([Thomas & Harden, 2008](#_ENREF_63)).

**Search methods**

A searchable question was formulated using SPIDER search tool ([Cooke, Smith, & Booth, 2012](#_ENREF_12)) (see Figure 1). The initial search included combinations of the terms ‘coercion’, ‘coercive measures’, ‘psychiatry’, ‘mental health’, ‘patient’, ‘client’, ‘service user’, ‘experience’, ‘lived experience’, and ‘relationship’. Subject headings were used where possible. Following an iterative approach, ‘Treatment pressures’ ([Duncan, 2013](#_ENREF_13)) was also later included. Given the heterogeneity of coercion internationally, the subsequent influence of this on softer coercion and the need to identify studies situated within similar legal and clinical practice frameworks, searches were restricted to UK and Irish studies.

*Inclusion criteria*

Studies were included if they:

1. Reported treatment-related soft or subtle coercion experiences of patients in mental health services.
2. Reported the effect of treatment-related soft or subtle coercion on interactions between patients and practitioners.
3. Used qualitative research to obtain and analyse data.
4. Used mixed methods studies and reported separate qualitative findings.
5. Included participants aged over 18 years.
6. Were conducted in the UK or Republic of Ireland.

*Exclusion criteria*

1. Studies referring to predominantly harder types of coercion, e.g. physical restraint.

Searches were conducted in the following databases: CINAHL, Embase, Medline, PsycINFO, and the Web of Science. Grey literature was also searched: Health Management Information Consortium, UKCRN study Portfolio, Social Care Online, British Library Thesis Database (EThOS), Networked digital library of theses and dissertations, Proquest Dissertations and Theses (UK & Ireland), NHS Evidence, the Department of Health website, OpenGrey, and PubReMiner. No date restrictions were applied to the databases and the search was completed in September 2015. No further articles met the inclusion criteria during an updated search in January 2018 of the following databases: CINAHL, Embase, Medline, and PsycINFO.

**Search outcome**

Figure 2 illustrates 938 articles were initially identified. Duplications (n=96) were removed and titles and abstracts were screened for eligibility. Most (n=796) were not relevant and excluded. After reading the remaining full texts (n=46), 35 articles were excluded, resulting in a final 11 articles eligible for inclusion.

Four of the studies employed interviews ([Duncan, 2013](#_ENREF_13); [Hughes et al., 2009](#_ENREF_25); [Lloyd-Evans et al., 2010](#_ENREF_38); [Sweeney et al., 2014](#_ENREF_57)); two employed interviews and focus groups ([Gilburt, Rose, & Slade, 2008](#_ENREF_19); [Laugharne, Priebe, McCabe, Garland, & Clifford, 2012](#_ENREF_36)). Six studies employing interviews used applied Grounded Theory techniques ([Gault, 2009](#_ENREF_16); [Gault, Gallagher, & Chambers, 2013](#_ENREF_17); [Gilburt et al., 2008](#_ENREF_19); [Katsakou et al., 2011](#_ENREF_33); [Katsakou et al., 2012](#_ENREF_34); [Laugharne et al., 2012](#_ENREF_36)). Of these, [Sweeney et al. (2014)](#_ENREF_57) and [Katsakou et al. (2011)](#_ENREF_33) involved a qualitative arm of mixed methods studies. One study employed Interpretive Phenomenological Analysis ([McGuinness, Dowling, & Trimble, 2013](#_ENREF_41)). Finally, two of the articles ([Gilburt et al., 2008](#_ENREF_19); [Lloyd-Evans et al., 2010](#_ENREF_38)) were part of The Alternatives Study (TAS) and one article ([Sweeney et al., 2014](#_ENREF_57)) followed TAS investigation with the same authors.

**Quality appraisal**

Recent guidance by the Cochrane Qualitative and Implementation Methods Group recommends researchers assess methodological strengths and weaknesses ([Noyes et al., 2018](#_ENREF_45)). Each article was assessed independently by the first author (RA) for methodological quality in accordance with the Critical Appraisal Skills Programme ([CASP](#_ENREF_11)) checklist for qualitative research..

Although all articles documented ethical approval, seven lacked a detailed reflexive account of the researcher-participant relationship ([Gault, 2009](#_ENREF_16); [Gault et al., 2013](#_ENREF_17); [Hughes et al., 2009](#_ENREF_25); [Katsakou et al., 2011](#_ENREF_33); [Katsakou et al., 2012](#_ENREF_34); [Lloyd-Evans et al., 2010](#_ENREF_38); [McGuinness et al., 2013](#_ENREF_41)). However, four articles acknowledged power differentials in this relationship ([Duncan, 2013](#_ENREF_13); [Gilburt et al., 2008](#_ENREF_19); [Laugharne et al., 2012](#_ENREF_36); [Sweeney et al., 2014](#_ENREF_57)). Due to the overall methodological quality of articles, none were weighted or excluded based on the quality assessment

**Data abstraction and synthesis**

To aid organisation, data were extracted electronically from the results/appendices and entered into ATLAS.ti by the first author (RA). Data abstraction and thematic synthesis (RA, consensus with KF) was in accordance with the methodology described by [Thomas and Harden (2008)](#_ENREF_63), involving 3 stages:

1. Free line-by-line coding of primary studies.

Line-by-line coding of data was conducted in chronological order of articles. This captured meaning and content to develop initial ‘free’ codes ([Thomas & Harden, 2008](#_ENREF_63)). Through constant comparison, codes were inductively constructed from the first 4 articles, after which coding became increasingly deductive and data began to fit into existing codes.

1. Organising free codes to develop descriptive themes.

Codes were reviewed and organised into related areas of 48 descriptive codes within 8 descriptive themes, representing the primary data.

1. Development of analytical themes.

‘Going beyond’ this descriptive stage and developing analytical themes that address the review aim was achieved through a cyclical process of reviewing and re-reading the descriptive themes and codes in relation to the research question ([Thomas & Harden, 2008](#_ENREF_63)). Thus further distinctions were made between each theme to develop sufficiently broader abstract analytic themes that answered the research question (see supplementary table 2).

RESULTS

The 11 reviewed articles include 268 patients receiving involuntary (n=106) and voluntary (n=36) treatment or a combination of both (n=126). Demographic details are unclear for some articles but, generally, there were equal numbers of males and females, aged over 18 years, and most previously admitted to mental health services. Over half of participants were white British, mostly diagnosed with schizophrenia/psychosis or affective disorder/depression. Ten studies were in England, one in Ireland ([McGuinness et al., 2013](#_ENREF_41)). (See supplementary Table 3 for a summary of the articles).

Three analytic themes were produced (see Figure 3), broadly capturing patients’ treatment-related experiences of softer coercion and its effect on their interactions with practitioners. These demonstrate that patients attribute negative experiences during treatment not just to coercion but also to mental distress. But during treatment, relationships with practitioners significantly influence their perceptions of coercion. Additionally, how patients attribute mental health distress and how they engage in treatment influence their transition through treatment. That is, some patients perceived treatment as coercive but others did not, despite similar treatment contexts, subsequently influencing their response to coercion.

Patients’ experiences are situated within the broader treatment environment across mental health services, which are predominantly aligned with a conventional biological model of healthcare and reliance on medication. Patients mostly reported this as negatively coercive, especially traditional inpatient wards: *“the whole environment was very very threatening”* ([Lloyd-Evans et al., 2010](#_ENREF_38)) or felt *“like a prison”* ([Gilburt et al., 2008](#_ENREF_19)). Consequently, many patients reportedly experienced inpatient wards as *“like being inside a pressure cooker”* ([Sweeney et al., 2014](#_ENREF_57)), where practitioners are seen as *“prison guards”* ([Sweeney et al., 2014](#_ENREF_57)) and where patients *“feel like you know, a sort of criminal who’s sort of violated their rules…”* ([Duncan, 2013](#_ENREF_13)).

The analytic themes are discussed below. Unless stated otherwise, quotations refer to traditional inpatient settings.

1. *Losing a sense of self*

This first theme broadly concerns whether patients attribute treatment-related experiences to either their mental health or to coercive treatment.

Some people lose opportunities in life due to their mental health problems, which can change their sense of identity: *“I was at work I had a life before this. I was all right, I was going to university”* ([Gault, 2009](#_ENREF_16)); *“I used to be someone, went to college, had a job, now I’m just a patient”* ([Gault et al., 2013](#_ENREF_17)). But, once admitted to mental health services, patients report contrasting perceptions about treatment. For example, some recognise their own vulnerability due to mental health problems: *“I was a danger to myself…I was telling people to pick up their litter and you can’t do that here, I was…taking risks”* ([Katsakou et al., 2012](#_ENREF_34)); some perceived their mental health rather than coercive treatment to be problematic: *“My illness has affected me, but I wouldn’t say being sectioned has affected me”* ([Hughes et al., 2009](#_ENREF_25)), to the extent that some believe that patients can be *“too ill to engage [with practitioners]”* ([Lloyd-Evans et al., 2010](#_ENREF_38)). These examples illustrate that, for some patients, personal circumstances rather coercion is reportedly problematic.

However, most patients attribute negative experiences to coercion, e.g. feeling like *“an underclass because you don’t have the rights that anyone else in the society has”* ([Duncan, 2013](#_ENREF_13)) or being reminded of previous trauma as a result of being physically restrained: *“That took me back to my childhood…my childhood abuse”* ([Hughes et al., 2009](#_ENREF_25)).

1. *Less than therapeutic relationship*

Once admitted to mental health services, patients’ treatment-related experiences are significantly influenced by their relationships with practitioners. This is the largest analytic theme and includes four sub-themes (Brokerage of responsibility, Lack of genuine choice, Less than equal, and Importance of feeling connected). It encapsulates the notion of a ‘Brokerage of responsibility’ as of central importance in terms of coercive treatment experiences, which consists of a dynamic shift of responsibility between practitioners and patients. This is influenced by the extent of patients’ genuine choice of treatment, perceived equality between patients and practitioners, and the quality of engagement between patients and practitioners as an underpinning foundation for success.

*(2a) Brokerage of responsibility*

The notion of responsibility between practitioners and patients can be complex and constantly shift but it centres on ensuring patients comply with treatment. Patients report both positive and negative experiences in relation to either self-determination or having their responsibility taken from them by practitioners.

Some patients acknowledge practitioners’ professional responsibilities: *“I think a lot of the fear [for] consultants is that if somebody does kill themselves they are accountable, they haven’t done their job”* ([Gilburt et al., 2008](#_ENREF_19)). Some also retrospectively acknowledge benefits from coercive treatment: *“I certainly would have been a serious problem at work….so I’m glad [involuntary admission] happened”* ([Katsakou et al., 2012](#_ENREF_34)).

Patients’ ownership of responsibilities is typically demonstrated by their adherence to prescribed treatment: “*I have the ultimate responsibility for my actions. Who has responsibility over my medication and whether I take it or not? I do”* ([Laugharne et al., 2012](#_ENREF_36)). But, the impact of mental health (as identified in ‘Losing a sense of self’) can also affect patients’ level of responsibility: *“I think when you’re very ill [practitioners] have to take decisions”* ([Laugharne et al., 2012](#_ENREF_36)); *“Sometimes when I feel very lost I want to be told what to do…at some level I want to be told no, you can’t go out…because I can’t make that decision myself…”* ([Sweeney et al., 2014](#_ENREF_57)). Failure to take such ‘responsible’ action can lead to practitioners taking responsibility to ensure treatment compliance: *“I thought…what can I do to protest?…I stripped off naked and I started parading…around the ward naked. And of course they didn’t like it…they restrained me…took me to my bedroom and they injected me”* ([Duncan, 2013](#_ENREF_13)).

*(2b) Lack of genuine choice*

Patients reported their treatment as one revolving around medication, administered through a combination of softer coercion such as threats and harder forms such as physical restraint. Sometimes patients perceived they had no real genuine treatment choice: *“They say if I don’t take the tablet they were going to inject me”* ([Lloyd-Evans et al., 2010](#_ENREF_38)); *“I refused to take an injection…I became involuntary’* ([McGuinness et al., 2013](#_ENREF_41)).

Given such limited choice, for some patients treatment aimed to *“drug you up”* ([Gault, 2009](#_ENREF_16)) or *“control or manage* [patients]*”* ([Gault, 2009](#_ENREF_16)). In a context in which harder coercion can be administered,threats can be sufficient to coerce patients into accepting treatment: “*in my experience a lot of coercion actually goes on without the mental health act…just through the fact that the mental health act could be brought in…I’ve been… told that if I didn’t comply…I would be sectioned on numerous occasions”* ([Gilburt et al., 2008](#_ENREF_19)). Consequently, many patients believe they are left without any real choice: “*I did feel coerced…it certainly didn't feel like I had a choice”* ([Katsakou et al., 2011](#_ENREF_33)).

*(2c) Less than equal*

Whereas the sub-theme ‘Brokerage of responsibility’ captures some positive experiences related to relationships and coercion, by contrast ‘Less than equal’ represents more negative experiences. For example, some patients find relating with practitioners difficult: *“you come to see the staff as being sort of the prison guards…you can’t really have a relationship with people you see as holding you captive”* ([Sweeney et al., 2014](#_ENREF_57)).

Examples across all clinical settings illustrate patients perceiving treatment as dehumanizing: *“[practitioners see]* *only the illness, not the person*” ([Gault et al., 2013](#_ENREF_17)) or *“[I’m] just another black woman with schizophrenia”* ([Gault, 2009](#_ENREF_16)) or *“part of a slave underclass”* ([Duncan, 2013](#_ENREF_13)). Some perceived practitioners as being aggressive and abusive and reciprocated: “*treat me like an animal, then I’ll act like an animal”* ([Hughes et al., 2009](#_ENREF_25)). The following example illustrates how harder coercion contributes to perceived power of softer coercion and the subsequent power imbalance in practitioner-patient relationships: *“*T*hey took me back to the room, they put me face down on the bed, actually holding my face into the cushions, so that I couldn’t breathe. I was ﬁghting and ﬁghting. And they were saying, um, go on, pull her trousers down and stick it in her arse. I thought they were raping me”* ([Hughes et al., 2009](#_ENREF_25)).

*(2d) Importance of feeling connected*

Patients described the importance of personal qualities in practitioners, e.g. practitioners should be *“caring and understanding”* ([Sweeney et al., 2014](#_ENREF_57)) and “*understand…accept and…treat [patients] with dignity…as if I was my normal”* ([Katsakou et al., 2011](#_ENREF_33)). It is also important for patients *“to feel connected as a person, rather than simply a patient”* ([Duncan, 2013](#_ENREF_13)).

However, some patients perceived they lacked a connection practitioners, e.g. *“they have their own agenda about what I ought to do rather than let me talk about my problems…I can’t get them to listen to me”* ([Gilburt et al., 2008](#_ENREF_19)), *“when I got here nobody actually listened to me*” ([McGuinness et al., 2013](#_ENREF_41)) or *“there’s a whole team there and they don’t listen to you, they TELL you…it just made me feel like I wasn’t human…”* ([Katsakou et al., 2011](#_ENREF_33)).

It was evident across the reviewed papers that developing a trusting relationship is an important element of feeling connected with practitioners: “*my consultant was brilliant...because he really got that I couldn’t trust him and he really…worked to rebuild that”* ([Duncan, 2013](#_ENREF_13)).But trust must be earned: *“If someone does what they say they’re going to do then you are more likely to trust them… I have to earn people’s trust, so they have to earn mine”* ([Laugharne et al., 2012](#_ENREF_36)). Unfortunately, though, trust was lacking in some patient-practitioner relationships, e.g. *“I resent them for not trusting in me after they know me”* ([Sweeney et al., 2014](#_ENREF_57)).

1. *Journey through the system*

The final analytic theme captures patients’ perceptions about their transition through treatment. It represents two sub-themes of contrasting experiences: ‘Accepting illness-based explanations’ and ‘Playing the game’.

*(3a) Accepting illness-based explanations*

This sub-theme concerns patients’ acceptance of conventional treatment, informed predominantly by a biological understanding of mental health. Although ‘Lack of genuine choice’ captures negative experiences, some patients believe treatment can lead to a positive outcome: *“I suppose in the end what made me well was the tablet form, the medication”* ([Gilburt et al., 2008](#_ENREF_19)); *“without the medication I wouldn’t have become well again”* ([Hughes et al., 2009](#_ENREF_25)).

For any personal conflict regarding limited conventional treatment, some patients were able to reconcile this: *“I don’t like this curfew of not being able to control my meds…. But when I weigh it up it’s worth it….”* ([Duncan, 2013](#_ENREF_13)). Even where coercion is recognised, it could be accepted: *“even though it’s coercion when it actually happens….if you….anticipate it….it just feels, even if not at the time, afterwards certainly, because a lot of it’s…dealing with the aftermath…and it’s a much better process dealing with [it] when you actually…condoned the whole thing yourself”* ([Duncan, 2013](#_ENREF_13)).

Such acceptance enabled patients to put their faith in practitioners: *“[practitioners] have got most power over my life. I don’t make many decisions because I’m frightened of making the wrong one”* ([Laugharne et al., 2012](#_ENREF_36)); *“I’m not worried about choice on medication. I know what the doctor prescribes is going to be the right thing”* ([Laugharne et al., 2012](#_ENREF_36)). However, patients were aware that resisting would lead to practitioners threatening or persuading them: *“if I stopped my medication, I’d be sectioned within 24 hours, I guarantee”* ([Gault, 2009](#_ENREF_16)); *“I refused to take* [tablets] *at first…and then they came round with their heavies to try and inject me and then I stuck out my hand and took* [the tablets]*”* ([McGuinness et al., 2013](#_ENREF_41)). This again suggests that softer coercion is understood within a range of softer to harder coercion.

*(3b) Playing the game*

In contrast to accepting conventional treatment, ‘playing the game’ represents patients’ deceiving practitioners regarding treatment compliance, e.g. *“I’d just pretend I took it* *[medication]”* ([Gault, 2009](#_ENREF_16)). Patients described using different approaches simply to exit mental health treatment: “*being a good patient leads to getting my freedom back”* ([Gault, 2009](#_ENREF_16)); “*I manipulated my way out of the section. I didn’t talk about the things that were hounding me, I sort of avoided subjects that were extreme”* ([Gault et al., 2013](#_ENREF_17)).

Some patients pretended to comply in order to deceive practitioners: *“It makes you feel like you have to convey a certain impression to [practitioners] in order to win your freedom…To get out you have to play the game”* ([Sweeney et al., 2014](#_ENREF_57)). Similarly, others become *“an exemplary patient”* ([Hughes et al., 2009](#_ENREF_25)) or approached treatment *“like playing chess”* ([Sweeney et al., 2014](#_ENREF_57)) or simply complied: *“the only way to get out is to cooperate…in order to get out…”* ([Duncan, 2013](#_ENREF_13)).

DISCUSSION

This review synthesised qualitative evidence of mental health patients’ treatment-related experiences of softer coercion and its effect on their interactions with practitioners. These experiences occur within a healthcare environment, situated in a UK or Irish context, in which patients reportedly receive treatment against a backdrop of coercion, represented by three analytic themes (illustrated in Figure 4).

It is evident here that coercion is a complex phenomenon about which patients report contrasting experiences. This complexity is recognised in philosophical and sociological theories of coercion. Broadly, coercion is conceptualised to fall within structural and agency perspectives. From a structural perspective, coercion is theorised to occur within social, political, economic and cultural contexts of society ([Ball, 1978](#_ENREF_2)), i.e. a UK/Irish treatment environment. This supports findings in this review and the literature. Not only is coercion a global problem in mental healthcare (Kallert, Monahan & Mezzich, 2007), it is so widespread that mental health services have become *“the theory and practice of coercion”* ([Szasz, 2007, p.xi](#_ENREF_58)) casting a *“coercive shadow”* (Szmukler, 2015, p.259) wherein patients fear treatment refusal leads to involuntarily administration. In the UK, inpatient wards are regularly found to include a coercive culture ([Care Quality Commission, 2013](#_ENREF_6), [2014](#_ENREF_7), [2015](#_ENREF_8), [2016](#_ENREF_9), [2017](#_ENREF_10)).

By contrast, an agency perspective focuses on coercive interactions within relationships ([Ball, 1978](#_ENREF_2)), i.e. between patients and practitioners. Most empirical literature regarding coercion concerns an agency perspective. Findings from this review suggest that relationships with practitioners play a key role in patients’ experiences of coercion. The importance of therapeutic relationships is at the heart of professional codes of conduct (e.g. [Nursing & Midwifery Council, 2015](#_ENREF_46); [Royal College of Psychiatrist, 2014](#_ENREF_50)) and UK national policy (e.g. [NHS England, 2014](#_ENREF_44); [Seale, 2016](#_ENREF_52)), particularly in terms of practitioners’ sensitivity to inherent power dynamics and fostering supported and shared decision-making. The ‘Less than therapeutic relationship’ theme supports wider literature in which patients’ perceptions of coercion are seemingly influenced more by practitioner-patient interactions than by coercion *per se* ([Hem, Molewijk, & Pedersen, 2014](#_ENREF_23); [Sibitz et al., 2011](#_ENREF_53)).

But these findings also suggest that patients’ self-determination, or lack of autonomy through practitioners’ actions, do not necessarily determine perceived coercion. Patients also report a lack of equality in these relationships and a lack of genuine treatment choice. Further, patients report many examples in which important qualities they expect of practitioners are lacking. Collectively, this challenges the notion of positive therapeutic relationships and highlights the importance for practitioners’ reflexivity when working alongside patients.

It is also evident that softer coercion takes meaning within a range of coercion in which practitioners ensure treatment compliance (Szmukler & Appelbaum, 2008; Lidz et al., 1998). In order to determine how coercion plays out within these relationships, commentators have focused broadly on either an ‘enforcement approach’ in which the *coercer issues* threats and/or direct force; or a ‘pressure approach’ in which coercion is determined by whether or not the *coercee subjectively* *perceives* they are threatened ([Anderson, 2010](#_ENREF_1)). Harder coercion, such as legal detainment or enforced medication, is relatively easy to determine. But softer coercion, such as determining whether or not a verbal interaction is threatening, is less clear. According to a ‘pressure approach’, softer coercion is determined by patients’ *believing* power behind the threat, i.e. that practitioners will enforce harder coercion if necessary. Patients’ beliefs about the credibility of potential threats might explain some contrasting reports of perceived coercion. Further, the eventual outcome (i.e. recovery or deterioration) may subsequently influence whether or not treatment-related experiences are retrospectively perceived as beneficial (and not coercive) or threatening (and therefore coercive).

These findings are bound to the context of the review aims and UK/Irish-centric perspective, which focuses on a limited population reporting context-specific experiences. A further limitation is only one author (RA) completed extraction of references, coding and analysis. Therefore, relevant literature may have been inadvertently excluded and other reviewers may conclude a different interpretation of the findings. Caution must also be noted regarding the construction of the analytic themes. In their critique of theoretical coding in Grounded Theory, [Wasserman, Clair, and Wilson (2009)](#_ENREF_66) argue that the clear technique of data-specific levels of coding (i.e. line-by-line) becomes ambiguous when coding at conceptual and theoretical levels. Similarly in this review, although synthesising the data was in accordance with methods described by [Thomas and Harden (2008)](#_ENREF_63), there is a lack of explicit guidance when moving from data-specific descriptive level to abstract analytic themes.

CONCLUSION

This review contributes to the current evidence base regarding the mixed but predominantly negative impact of coercion on patients receiving mental healthcare. They also indicate that power associated with softer coercion is influenced by patients’ belief that practitioners will administer harder coercion if necessary. As such, patients’ experiences of softer coercion manifests within relationships with practitioners. It is therefore important for practitioners’ education to include an understanding of how the broader healthcare environment in which treatment occurs might impact upon their role of providing treatment and the impact of this on potential for coercion in caring relationships.

This review identified a gap in knowledge regarding the impact of coercion on specific types of mental health problems, e.g. voice hearing, depression or anxiety. Future research is needed to investigate why coercion affects people differently, the processes involved, the role of diagnosis, and how coercion is defined in mental healthcare and by whom. It is also important to replicate a context-specific evidence synthesis from different populations within other health systems to compare findings and build upon the evidence base regarding softer coercion.

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