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The Effects of Perceived Coercion on Group Attendance, Participation in Groups, and Leaving Against Medical Advice in an Inpatient Psychiatric Facility

Joseph DiCondina

Philadelphia College of Osteopathic Medicine, josephdic@pcom.edu

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Philadelphia College of Osteopathic Medicine

Department of Psychology

The Effects of Perceived Coercion on Group Attendance, Participation in Groups, and
Leaving Against Medical Advice in an Inpatient Psychiatric Facility

Joseph DiCondina, MS, LPC

Submitted in Partial Fulfillment of the Requirements for the Degree of

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DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by Joseph DiCondina on the 16th day of March, 2016, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality

Committee Members' Signatures:

Barbara A Golden, PsyD, ABPP, Chairperson

Robert A DiTomasso, PhD, ABPP

George Collins, PsyD

Robert A DiTomasso, PhD, ABPP, Chair, Department of Psychology

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Abstract

Perceived coercion is a prevalent, presenting problem for patients in psychiatrically-based facilities, yet how a client's perception of coercion and its impact on his or her treatment in an inpatient psychiatric facility has not been fully understood. The aim of this study was to examine the effect of perceived coercion on those entering an inpatient psychiatric facility and how this impacted their rate of group therapy attendance, participation levels while in group therapy, and whether they left chose to leave the inpatient psychiatric facility against medical advice. A review of current literature, including an overview of the MacArthur studies, is included. This study used original data, collected from adults, aged 18-years and older, who have been discharged from an inpatient psychiatric facility within the last 3-months. Participants completed an online survey, via Survey Monkey, which included the Admission Experience Survey: Short form (AES-15), demographic information, and questions regarding their inpatient psychiatric admissions. The findings can be used to assist those employed in an inpatient psychiatric facility as well as in crisis residential centers in becoming more aware of the impact one's coercion level can have on their treatment. Potential explanations, limitations, and implications are explored as well.

Keywords: admission experience survey: short form, perceived coercion, inpatient psychiatric hospitalization

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PERCEIVED COERCION AND ITS EFFECT ON ONE'S TREATMENT

Chapter 1: Introduction

Statement of the Problem

Each year approximately 7.6 million people are admitted to inpatient psychiatric facilities across the United States (McGann & Hanrahan, 2010). Those individuals in need of inpatient psychiatric services can receive treatment either voluntarily or involuntarily. Coercion has been used to influence individuals into obtaining inpatient psychiatric treatment (Lidz et al., 1995). The legal definition of coercion consists of two dimensions, subjective and objective (Iversen, Hoyer, Sexton, & Gronli, 2002). Objective coercion is defined as the actual deprivation of liberty, the use of seclusion, restraint and forced medications; subjective coercion refers to the patient's experience of making decisions under duress (Iversen, et. al., 2002). Coercion, and its use in treatment of individuals with mental illnesses, has been a controversial issue in the field of psychiatry and mental health law in the United States (Cascardi & Poythress, 1997; Lidz et al., 1995; Hiday, Swartz, Swanson, & Wagner, 1997). Many mental health professionals believe coercion is necessary because it allows a patient to receive psychiatric treatment for his or her mental instability (Geller, 1991). Others within the field believe that coercion can cause the patient to distrust family members, friends, and/or clinicians, as well as cause him or her to withdraw from and avoid treatment (Campbell & Schraiber, 1989; Kjellin, Andersson, Candefjord, Palmstierna, & Wallsten, 1997; Swartz, Swanson, & Monahan, 2003). Specifically, the use of coercion can create friction between the patient and treatment team, resulting in an inadequate therapeutic alliance and poor treatment outcomes (Group for the Advancement of Psychiatry, 1994).

There are two forms of coercion, legal and extra-legal. Legal coercion is derived from English common law that assigns the government the responsibility to intervene on behalf of citizens who cannot act in their own best interests (Testa & West, 2010). Instances of legal coercion involve individuals who are involuntarily or civilly committed to inpatient psychiatric care. The criterion required for an individual to be civilly committed is regulated by state law (Testa & West, 2010). In general, this occurs when an individual displays imminent danger to him or herself, to others or is deemed incapable of self-care. (Kaltiala-Heino, Laippala, & Salokangas, 1997). These individuals are thought to lack the capacity, insight, or judgment to recognize that their behaviors and/or current symptomologies require stabilization and, as a result, are coerced into receiving treatment (Kaltiala-Heino et al., 1997).

Extra-legal coercion, an informal form of coercion, urges an individual to obtain appropriate treatment voluntarily (Hoge et al., 1998). The use of informal coercion can occur when there is no legal basis for making someone comply with a regime in a hospital or in the community. In these situations medical staff or others involved in an individual's treatment may lead the client to believe that if does not do as asked, he or she will be mandated to conform (Hoge et al., 1998). Although those voluntarily seeking treatment do so freely from a legal perspective, some may be inadvertently or purposefully coerced by family members, friends, or clinicians. In addition to formal forms of coercion (i.e. threat and force), subtle forms of coercion (i.e. interpersonal pressure and persuasion) have been used to compel individuals to enter treatment voluntarily. Mental health clinicians, staff members, public defenders, and family

members have used informal means of coercion to assist in the voluntary admission process (Hiday et al., 1997). It has been suggested that those formally coerced into seeking treatment may be less likely to attend treatment, participate in treatment, and may request to leave against medical advice (AMA) (Cascardi & Poythress, 1997; Gardner et al., 1993). Furthermore, they may be less inclined to seek inpatient psychiatric treatment in the future because of concern over being coerced again (Cascardi & Poythress, 1997).

Different forms of pressure, both positive and negative, have been used to compel individuals to enter treatment. Positive pressure, a form of coercive behavior, instills in the patient the idea or thought that he or she is being treated fairly and with respect (Lidz et al., 1995). Positive pressures are used to show someone that he or she would benefit from treatment. Examples of positive pressures include persuasion (talking to the patient without threats of hospitalization) and inducements (someone offering or promising something in return for the patient admitting him or herself to the hospital) (Lidz et al., 1995). Negative pressures are the threats and force that are applied throughout one's admission to a hospital (Iversen, et al., 2002). Negative pressures are designed to influence patients into a hospital admission or threaten them with consequences if they choose to refuse treatment. These individuals often feel that their opinions regarding their hospitalization are unwanted. Examples of negative pressures range from legal to extra-legal coercion and can include threats of civil commitment, deception, physical restraint, and threats of withholding resources (i.e., living situation, employment, and finances); (Gilboy & Schmidt, 1971; Rogers, 1993; Decker, 1981; Lewis, Goetz, Schoefeld, Gordon, & Griffin, 1984).

Negative pressures, as well as positive pressures, can directly affect an individual's level of perceived coercion when entering treatment (Lidz et al, 1995). Negative pressures resulted in higher levels of perceived coercion, but positive pressures were associated with lower levels of perceived coercion. (Lidz et al, 1995). Those who perceived that they were negatively pressured into entering treatment were less likely to adhere to treatment recommendations because they lacked autonomy in their decision making process (Slovic & Monahan, 1995) or because their acute mental health symptoms did not allow them to reflect on their current behaviors.

In order to decrease levels of perceived coercion, procedural justice has been endorsed to decrease such perceptions (Lidz et al., 1995). Procedural justice, defined as how the individuals felt they were treated in terms of voice, interaction, validation, and respect, has been negatively correlated with the perception of perceived coercion (Lidz et al., 1995). Having the ability to speak about their situation, be validated during the admissions process, and recognize that the admissions staff is acting in good faith and without bias can positively influence individuals' experiences and decrease their levels of perceived coercion (Hiday et al., 1997; Bennett et al, 1993; Hoge et al., 2001; Cascardi & Poythress, 1997; Hoge et al., 1993; Monahan et al., 1995).

Examining the relationship between perceived coercion at admission and an individual's participation in group therapy, involvement in group therapy, and whether or not the individual wanted to leave the hospital, AMA, are important areas that need to be investigated because this area lacks research (Cascardi & Poythress, 1997; Gardner et al., 1993). Each of these components can adversely affect a client's treatment in an inpatient psychiatric facility. The MacArthur Admission Experience Scale (AES-15), which

utilizes the MacArthur Perceived Coercion Scale (MPSC), has been helpful in identifying an individual's perception of perceived coercion at admission (Iversen, et al., 2002).

Obtaining this information would allow crisis residential centers (CRC) to understand the role and impact that perceived coercion can have on treatment. It also would allow CRC staff members to address perceived coercion at admission, in order to increase a patient's adherence to treatment during his or her inpatient psychiatric stay.

Purpose of the Study

The purpose of the study is to investigate the level of impact that perceived coercion can have on patients committed voluntarily and those committed involuntarily to an inpatient psychiatric facility. The factors that will be examined include a client's participation in group therapy, group attendance, and desire to leave, AMA. In order to identify whether or not one believes that he or she has been coerced into treatment, the MacArthur Admission Experience Scale (AES-15), which measures level of perceived coercion, will be administered. Information, including group therapy attendance, participation in groups, and whether or not the individual left, AMA, will be investigated to determine whether perceived coercion impacts these factors during one's hospitalization. This study will provide insight for crisis center admission staff in regard to the creation of an intake process designed to decrease perceived coercion in hopes of fostering increased treatment attendance, increased participation, and decreasing the likelihood of leaving, AMA.

Chapter 2: Perceived Coercion

Studies of Coercion

The impact of perceived coercion on those entering inpatient psychiatric treatments has been discussed in much detail. This discussion began in the 1960s and 1970s with the civil liberties revolution, which opened the fierce debate on individuals being committed to inpatient psychiatric units (Greer, O'Regan, & Traverso, 1996). Many policy makers, legal professionals, and mental health professionals have debated whether or not the use of coercion is effective in one's treatment. Many have argued that the patient has a moral right to make an autonomous decision to enter treatment and to be treated with dignity and respect (Monahan et al., 1995). Others have stated that without judicious coercion patients will not receive the necessary care that they require (Appelbaum, 1985).

In order to understand the impact of perceived coercion one must understand what coercion is and how it can affect one's treatment. Coercion is not necessarily limited only to the pressure to enter an inpatient psychiatric treatment facility; rather, it has been described as a wide range of actions taken without consent of an individual (Blanch & Parish, 1993). Others believe that coercion falls on a continuum, including friendly persuasion, interpersonal pressure, control of resources through the use of force, and verbal persuasion (Diamond, 1996). Friendly persuasion and interpersonal pressure are types of informal coercion; however, control of resources through the use of leverage and force are forms of formal coercion. The use of verbal persuasion by mental health professionals, who have the ability to commit someone involuntarily, lies in a gray area between both formal and informal coercion.

On the other hand, others have rejected any standard definition of coercion and believe that coercion should be evaluated dimensionally and assessed in multiple psychological domains. They have found that coercion could not be positive in its use in treatment (Marlowe et al., 1996). Another study explained that a situation that exploits a client, and which includes a few unwanted choices, is coercive (Bonnie & Monahan, 2005). The one commonality among the various operational definitions of coercion is the patient's belief that he or she is not free to refuse the choices provided within his or her treatment (Monahan et al., 1995).

Much of the research on this topic has stated that coercion, in specific situations, has led to better outcomes for those entering inpatient psychiatric facilities, in contrast to those not coerced into entering treatment; specifically, it would decrease the likelihood that those who were coerced would be in danger of hurting themselves or others (Kjellin & Wallsten, 2010). Others have insisted that coercion has led to an increase in treatment adherence and better quality of life (Christy, Boothroyd, Petrilla, & Poythress, 2003; Swanson, Swartz, Elbogen, Wagner, & Burns, 2003; Swartz, Swanson, & Monahan, 2003). Some researchers believe that individuals coerced into treatment will not engage in treatment, not seek treatment in the future, and/or feel deprived of their rights (Swartz et al., 2003). Although many studies assume that patients experience coercion negatively (Hiday et al., 1997, Lidz et al., 1995; Swartz et al., 2003), the results of Hiday et al.'s (1997) study demonstrated that a psychiatric hospitalization can allow a patient to feel validated, have a voice, and avoid the perception of force even when they were not given the initial choice to enter treatment. Hiday's study did not imply that coercion was not existent, but rather that clients experienced coercion in a positive light. These authors

demonstrated that coercion can be effective in the treatment of clients in an inpatient psychiatric facility if used properly by mental health professionals. In order to provide effective treatment, one must understand how coercion is perceived in the admissions process and why it is perceived either positively or negatively.

Factors of Perceived Coercion

The usage of coercion in the treatment of individuals with mental illness has been controversial in the field of psychiatry and mental health law. Coercion is a multifaceted construct comprised of and associated with pressure, procedural justice, culture, and family involvement. Each of these factors can influence the client to enter treatment either voluntarily or involuntarily.

Pressures. Pressure is defined as the actions used by others to influence a client to enter treatment in a hospital setting (Lidz et al., 1995). Pressures, which can be broken down into two forms, positive pressures and negative pressures, can compel individuals to enter treatment. (Lidz et al., 1995).

Positive pressures. Positive pressure instills in patients the belief that they are being treated fairly and with respect and it demonstrates to clients that they would profit from receiving treatment (Lidz et al., 1995). Examples of positive pressures include inducements and persuasion (Lidz et al., 1995). An inducement is defined as the act of offering or promising to clients by a family member, friend, mental health professional, etc., something the clients perceive as valuable if they admit themselves into a hospital setting (Lidz et al., 1995). Persuasion is described as a way of speaking or talking to clients about admitting themselves to an inpatient psychiatric facility without the use of threat (Lidz et al., 1995). Inducement and persuasion make up the subcategory of positive

pressures, which were considered informal forms of coercion within Lidz's study (Lidz et al., 1995).

Verbal persuasion. Verbal persuasion was found to be the most common form of coercion used with clients entering an inpatient psychiatric facility (Lidz, Mulvey, Arnold, Bennett, & Kirsch, 1993; Nicholson, Ekenstam, & Norwood, 1996). The use of verbal persuasion can often lead to verbal threats, however, as seen in Gilboy and Schmidt (1971); many of those voluntarily admitted to an inpatient psychiatric facility had been coerced by mental health staff members prior to entering treatment. Many of the individuals who declined to enter voluntarily were threatened with involuntarily commitment. Replications of this study demonstrated similar results (Lewis et al., 1984). The staff's ability or inability to commit the patient against his or her will for treatment affected the way that the patient experienced persuasion (Lidz et al., 1993). Patients who admitted themselves voluntarily but were threatened with commitment if they did not sign themselves into treatment reported higher levels of coercion during their hospitalization (Rogers, 1993). The higher levels of coercion were associated with the patient being more likely to reject treatment in the future, as well as having a more negative view of psychiatric services (Rogers, 1993). On the other hand, many patients who admitted themselves voluntarily and were not threatened with commitment found their treatment helpful; they were accepting of their psychiatric diagnosis, and were less likely to report receiving unwanted treatment, when compared with those involuntarily forced into treatment (Rogers, 1993). Another study found that the most frequent barrier that prevented those from seeking treatment was the fear that they would be committed to treatment against their will (Swartz, Swanson, & Hannon, 2003). The fear of being

committed against one's will can deter someone from receiving the treatment that he or she may desperately require.

Negative pressures. Negative pressures are the threats and force that are applied throughout one's hospitalization. Negative pressures are intended to influence a patient into a hospital admission; they can be used prior to admission to threaten patients with consequences if they choose to refuse treatment (Iversen, et al., 2002). Both threats and force are considered formal forms of coercion within Lidz's study (Lidz et al., 1995). Threats are defined in the study as intimidating someone to enter treatment as well as using leverage (i.e. not allowing him or her to speak with family, removal of money, inability to return to his or her house) to force a patient into entering treatment prior to admission (Lidz et al., 1995). Force was described as the use of actual physical force to place an individual in an inpatient psychiatric facility (Lidz et al., 1995).

Each of these pressures can produce unwarranted effects, for example causing these individuals to feel that their opinions regarding their hospitalization are unwelcomed. Negative and positive pressures can affect clients' perceptions of whether or not they are being coerced. Providing the clients with the ability to express themselves during the admissions process, validating their opinions and views during the process, and utilizing positive pressures as opposed to negative pressures when entering treatment, can significantly impact how the persons will perceive their inpatient psychiatric treatment. Clients who experienced more negative pressures than positive pressures upon entering treatment felt more coerced (Lidz et al., 1995). This demonstrated that the patient's perception of coercion is related to the form of coercion, legal vs. extra-legal, rather than the absence or presence of the coercive behavior. The client's feelings of

being coerced during the admissions process were related to his or her experiences of positive pressure as well as his or her level of perceived procedural justice, which is used to distinguish how positive and negative pressures affect those experiencing coercion (Lidz et al., 1995). This would allow clinicians to lower or minimize levels of perceived coercion in the admissions process by paying closer attention to procedural justice matters. It also reveals that the form of coercion can drastically impact the client's satisfaction with treatment, which could affect adherence to treatment, including attending group therapy, participating in group therapy, and whether or not he or she chooses to leave AMA. This demonstrates the importance of having a perceived coercive measure that identifies one's level of perceived coercion as well as procedural justice matters. Although the act of having the client admitted is still coercive, having mental health professionals understand this concept can change how the act was perceived and also allow the client to be more satisfied with the treatment provided.

Procedural justice. Procedural justice was identified as the second factor observed in Lidz et al.'s (1995) study. Procedural justice examined whether or not the patients believed that they were being listened to, were being validated, whether or not they were treated respectfully and fairly, or whether or not their views were ignored (Lidz et al., 1995). Each of these factors, including their legal admission status, was associated with perceived coercion during the admissions process (Lidz et al., 1995). Having the ability to state one's case and be included in the decision making process was found to be central to the client's subjective experience of coercion (Hoge et al., 1993; Bennett et al., 1993). Lidz et al. (1995) found that even those admitted involuntarily for treatment felt

that if they were treated with respect, concern, and fairness, they would then partially accept the need for treatment.

Clients perceived that procedural justice was satisfied when they felt that they were able to express their views, believed that their views were considered during the clinical decision making process, and felt that they were treated with dignity, respect, politeness and concern during the admissions process (Lidz et al., 1995; Lind, Kafner, & Earley, 1990; Cascardi & Poythress, 1997). It is plausible that procedural justice may lead to greater receptivity to being treated in an inpatient psychiatric unit and a greater likelihood that those admitted involuntarily would be willing to sign in voluntarily (Cascardi & Poythress, 1997). If given the opportunity to change their legal status, one would suspect that cognitive dissonance theory would suggest that those able to receive treatment voluntarily would reframe their admissions experience in a more positive light (Cascardi & Poythress, 1997). Not only would it change their treatment adherence while in an inpatient psychiatric facility, but it also could increase compliance rates post-treatment; it would also encourage less resistance to entering treatment at a later time. Individuals would be more receptive to the treatment provided. A review of 18 outcome studies showed that most of the individuals admitted voluntarily/involuntarily to an inpatient psychiatric facility exhibited clinical improvement, and this study also retrospectively demonstrated that between 33% and 81% found their inpatient psychiatric admission as necessary and their treatment helpful (Katsakou & Priebe, 2006).

The MacArthur Network on Mental Health also highlighted the importance of perceived procedural justice as it examined client's perceptions of coercion (Bennett et al., 1993; Gardner et al., 1993; Hoge et al., 1997; Lidz et al., 1995; Monahan et al., 1995).

This research found an association between patient's coercion levels at admission to an inpatient psychiatric facility and perception of procedural justice (Lidz et al. 1995). The research conducted by MacArthur Foundation demonstrated that an individual can feel not coerced even when in a coercive situation, as seen in a civil commitment hearing. Feeling not coerced was contingent upon the client having a voice, feeling validated, and being provided with respect and dignity (Lidz et al., 1995). These individuals recognized that they were coerced into treatment when not provided a voice, validation, respect, and dignity. Those who were provided procedural justice felt less coerced than those who were not granted procedural justice. This demonstrated that it is the nature, not the presence, of coercion that impacts the perception of being coerced (Hiday et al., 1997; Lidz et al., 1995). Those who believe that entering treatment was their own choice and who felt less coerced were more likely to benefit from treatment and be more personally invested in the treatment provided (Wexler & Winick, 1991).

Process control vs. outcomes control. A patient's view of whether or not the admissions' process was fair defines perceived procedural justice. When determining whether or not the admissions process was rational, the client can explore whether or not others (i.e. mental health professionals) have considered the client's views and identified the motives of those involved in the intake process (Hiday et al., 1997). Providing the client with the chance to speak (voice) and having others attend to this (validation) could influence the patient's perception of the outcome of entering treatment even though it may not be the outcome he or she would have desired (Hiday et al., 1997). This has been called "process control" and has been found to be essential in one's perception of fairness (Thibaut & Walker, 1975). "Process control", which identifies the manner in which

arguments are made and information is presented, varies from “outcome control”, which is identified as the one who has the control in making a final decision in resolving a disagreement. The highest levels of perceived procedural fairness and highest levels of satisfaction were found with patients having process control and a third party having outcome control. In this study the third party was a judge, making the ruling for the involuntary commitment hearing (Thibaut & Walker, 1975).

Therapeutic jurisprudence. Legal professionals have addressed coercion through therapeutic jurisprudence in civil commitments. The client's behavior that is coercive can directly impact his or her perception of the court hearing as well. The perception of having free will can provide psychological benefits, and therefore autonomy should be safeguarded (Wexler, 1993; Winick, 1992). Attorneys advocate for patients, providing them a voice, and allowing the client to feel heard during the process, regardless of the commitment outcome. Clients were more satisfied with an outcome of their civil commitment if they felt as though the process was fair (Stone, 2002). If the clients felt the hearing was unwarranted and unnecessary, they felt that they were treated disrespectfully, without dignity, and they felt that they were not seen as equal members of society (Stone, 2002). Because many clients feel as though the civil commitment hearing is unwarranted, clients may begin to feel worthless and lose their dignity (Greer, O'Regan, & Traverso, 1996). As a result, this could worsen their mental state and decrease their motivation to stay active in their treatment (Winick, 1992).

In order to better understand the impact that the civil commitment procedure can have on a client's therapeutic progression, research was conducted with individuals actively involved in the process (Greer et al., 1996). The study demonstrated that the

outcomes of their treatment during the hospitalization were affected by their perceptions of procedural due process at their commitment hearing. It was also found that the patients' perceptions of the treating clinician were negative during most civil commitment hearings but their lawyers, hospital lawyers, and judges were viewed with mixed results (Greer et al., 1996). Of the eight people that participated in the study only one trusted their treating clinician but the other clients felt embarrassed, frustrated, and angry at the treating clinician (Greer et al., 1996). The clients' views varied between the legal professionals and treating doctors; this depended on whether or not they were treated with respect and dignity by the legal professionals involved in their cases. Regardless of the conclusion of the court hearing, clients believed that being treated with respect and dignity was important (Greer et al., 1996) and each was central to the patients' perceptions of fairness (Tyler, 1992).

Lacking control to make a decision: helplessness and reactance. Research has focused on individuals who perceive themselves as lacking the ability to make their own decisions. The absence of perceived control can cause reactance and/ or helplessness, both psychological reactions (Brehm & Brehm, 1981; Seligman, 1975). Helplessness is a mental state in which an individual is forced to endure an aversive stimulus, which is painful and/or unpleasant, and in which one is unable to avoid encounters with the stimuli even if the stimulus is avoidable or escapable because it has been learned that one is unable to control the situation (Seligman, 1975). Helplessness has been associated with increased depression and anxiety (Seligman, 1975). Reactance is a motivational reaction to other individuals, rules, or regulations that threaten to destroy specific behavioral freedoms. This occurs when an individual feels that someone or something has taken

away his or her choices and has provided only limited alternatives (Brehm & Brehm, 1981). Reactance can cause anger towards the source of the restricted freedom, at attempts to restore the restricted freedom, yet become more attracted to the forbidden option (Brehm & Brehm, 1981). Workman and Brehm (1975) conducted a study on loss of control and on each of these psychological reactions. Those participants that had minimal experience with loss of control (more likely to be in control in the present) were more likely to produce reactance when they were they presented, experimentally, with a loss of control situation but those with experiences in lacking control (those admitted to inpatient psychiatric facilities on multiple occasions) felt helpless. This study supported McKenna, Simpson, and Coverdale's (2003) findings that identified the fact that clients who lack autonomy are likely not to notice or be less likely to notice when their autonomy is taken away. This demonstrated that personal control is adaptive.

Decision control vs. informational control. Strategies that affect the consequences associated with lacking control and freedom include "decision control" and "information control" (Monahan et al., 1995). "Decision control" provides the client with the power/ ability to make a decision that would often be made by others (Monahan et al., 1995). In a nursing home setting, those provided with "decision control" were more active and engaged when compared with those that lacked "decision control". One year later the individuals with "decision control" demonstrated more psychological and physical stability than those that lacked "decision control" (Rodin, 1986). "Information control" provides the client with a sense of control after obtaining or being given information about a stressful event (Monahan et al., 1995). Being provided information about the sensations that they will experience and procedures that they may experience

has allowed those individuals to adjust much easier to a stressful event (Monahan et al., 1995). This demonstrated that, although a client may not be actively involved in the event, he or she can adjust to the event if provided with an understanding of the event or situation. This further supported the idea that a client's level of autonomy and dignity affects how an event was perceived, but it can also affect how he or she viewed his or her treatment, including its effectiveness in an inpatient psychiatric facility.

Process exclusion. Also important in the evaluation of process fairness, are decision makers acting in good faith and without bias (Tyler, 1990). When a client has perceived that friends, family, and clinicians are acting without bias and in good faith, the client was more inclined to believe that the hospital admission process was justified (Bennett et al., 1993) and was less likely to perceive that coercion had taken place (Hoge et al., 1993; Monahan et al., 1995). A study conducted by Hiday et al. (1997) found that approximately two-fifths of the study participants reported little or no negative pressure as well as little or no process exclusion during the admissions process. Even if involuntarily admitted, a client could still feel as though he or she had a voice and was validated, avoiding the use of force even when not given a choice, during this process. The challenge that has remained is attempting to provide all patients the ability to express their opinions, desires, rights, and dignity during the admissions process.

Culture. Culture, the third and final factor of importance in Lidz et al.'s (1995) study, also was used to distinguish how positive and negative pressures affect those experiencing coercion. Culture was defined within the study as individuals from different demographic and/or cultural groups (i.e. race, gender, and demographic area). People that were from different cultures, as evident with gender, have experienced the admissions

process for an inpatient psychiatric hospitalization and being committed to mental health treatment differently. An example of this was evident, with theories of gender, which hypothesized that women are more likely to experience commitment to an inpatient psychiatric facility primarily as a threat to their interpersonal relationships but men may see it as a threat to their autonomy (Tannen, 1990). This hypothesis is similar to cultural differences that may be present in different geographical areas, as evident with different administrative and legal procedures and guidelines for hospitalization. This may be related to feelings of perceived coercion among people in different areas who suffer from mental illness (Riecher-Rössler, & Rössler, 1993). In fact, a study demonstrated that coercion was more common outside the USA, with patients subjected to legal detention (Newton-Howes, & Stanley, 2012). The EUNOMIA project, a study analyzing existing variations in coercive psychiatric treatment in 12 European countries, explored this concept and believed that it is possibly a result of cultural factors, including patients' expectations, legislation, and psychiatric practice (Kallert et al., 2005). Because coercion can vary individually, procedural justice and culture can help us understand how informal and formal coercion can impact a patient's perception of the admissions process and also the effect that this can have in group therapy attendance, group therapy participation, and risk for leaving, AMA.

Involvement of family members, friends, and other mental health

professionals. A patient's perception of coercion can vary based on legal status, culture, pressures, and procedural justice, but the perception of coercion can also vary between other members involved in the admissions process (Hiday, Swartz, Swanson, & Wagner, 1997). Family members, clients, and mental health professionals were interviewed to

decipher and determine whether or not their perceptions of coercion varied, based on their roles during the admissions process (Hoge et al., 1993; Bennett et al., 1993).

Hoge and colleagues (1993) found that clients commonly believed that there were alternative routes to treating their mental illness rather than being admitted to an inpatient psychiatric facility, although the clients could not identify such alternatives. Family members, on the other hand, felt that hospitalization was the only option to help treat the client's mental illness. Family members and mental health professionals believed that hospitalization was necessary to treat the client's mental instability, but clients often disagreed with the need to be hospitalized (Hoge et al., 1993). Family members felt that they were pressuring the clients to enter treatment although the clients did not feel pressured by these family members. It was hypothesized that clients were willing to understand and forgive family members if coerced by them to enter treatment (Hoge et al., 1993). This hypothesis relates to the "Thank- you theory" originally proposed by Stone (1975). The "Thank- you theory" stated that the retrospective acknowledgement of one needing to be involuntarily committed for treatment weakens the level of perceived coercion recalled by the client over time. The use of physical force or threats, which was witnessed by a third party, was not interpreted as coercive by the patients over time (Bennett et al., 1993).

In conclusion, procedural justice, legal status, and negative pressures were shown to have the greatest effect on perceived coercion for family members, mental health staff, and patients, although the level of perceived procedural justice provided at admission did vary between and among each of the three groups. Patients felt that they were not given a "voice", believed that "no one listened", found their experience to be inadequate, and

therefore felt more coerced. This occurred despite family members' and clinicians' perceptions that the patient was given the maximal opportunity to discuss their issues and needs (Hoge et al., 1998).

Hoge's Study. At times, clients lack the capacity to discuss their issues and needs due to an impairment that impedes their ability to voice their concerns. "Many psychiatric patients are cognitively disordered at the time of admission and may have impaired ability to perceive coercive interactions, to understand the significance of events, or to recall interactions in an undistorted fashion" (Hoge et al., 1997, p. 180). In order to avoid this issue, Hoge et al. (1998) included patients, family members, and clinicians to identify whether or not patients have fully understood the perceived circumstances that led to their admission, distinguishing whether or not they understood the actions that led to their treatment. This study examined two questions: "How do family and clinicians' perceptions of coercion compare with the perceptions of patients?" and "Are the determinants of family and clinicians' perceptions of coercion the same as the determinants of patients' perceptions of coercion?" (Hoge et al., 1998, p. 133). A clinician's or family members' recollection of the admission process may vary from the patient's view because each can present different types of information. A patient's perception of the admissions process may be skewed due to increased stress. This could also include lack of coping mechanisms, cognitive disturbances, and personal suffering, all of which could directly affect the perception of coercion (Hoge et al., 1998).

The degree of perceived coercion can also vary based on the client's moral "right" to engage in the action (Wertheimer, 1993). Although the patient, family member(s), or clinician may perceive the event the same way, their views of whether or not coercion

took place can vary based on the morality of the action (Hoge et al., 1998). This was evident in Blanch & Parish's (1993) study that demonstrated the need to validate and respect the concerns of the patient (procedural justice) during the admissions process because each is morally important, although family members and clinicians were not sensitive to such concerns. Also, patients, family members, and clinicians may agree on the level of perceived coercion in the admissions process but may have obtained this information from various routes (Wertheimer, 1993; Monahan et al., 1995; Bennett et al., 1993). The results of Hoge et al.'s (1998) study demonstrated that family members of those involuntarily committed had experienced less coercion and negative pressures (threats and force) when compared with the views of the patients and clinicians. Last, patients felt that they received less procedural justice during the admissions process when compared with the views of clinicians and family members. Clients did not feel that they were given the ability to voice their concerns and preferences, and did not feel they were treated fairly (Hoge et al., 1998). The family members' and clinicians' accounts of procedural justice may have been magnified due to their internal views of the patients requiring treatment (Lidz et al., 1997). This indicates that the perception of coercion varies between and among family members, clinicians, and patients.

Chapter 3: Forms of Coercion

There has been much debate over the use of coercion in mental health treatment because it can impact a client's moral right to his or her decision-making autonomy as well as to his or her individual dignity (Blanch & Parrish, 1993). This depends on the form of coercion used. There are two forms of coercion: legal and extra-legal coercion. Legal coercion mandates a client, involuntarily, to enter treatment. It has been used by mental health professionals, police officers, case managers, and family and friends to initiate treatment. Legal coercion is often initiated by these individuals because the clients may be a danger to themselves or others, or lack insight into the severity of their current symptomology. Extra-legal coercion often compels a client to enter treatment voluntarily. The client chooses to enter treatment although the client may have been persuaded to enter by family, friends, or mental health professionals. Each form of coercion has been utilized in mental health treatment and has benefits and consequences.

Legal Coercion

History. During the era of institutionalization (19th to 20th century), society's view in the United States felt that individuals who were mentally ill lacked the capacity to make decisions and required stabilization via hospitalization. At that time, all admissions to psychiatric hospitals were involuntary. Individuals had to display the need for psychiatric treatment and were recommended for such services when necessary (Testa & West, 2010). State commitment standards were based on the doctrine of *parens patriae*, meaning "parent of the country". During the 20th century, states decided to change civil commitment laws and develop legal protections for clients to ensure their rights to liberty when considered for inpatient psychiatric treatment. This included the

client being able to stand trial and have the representation of an attorney prior to the involuntary admission (Anfang & Appelbaum, 2006). Rather than medical professionals making the commitment decision, judges and magistrates were the only ones able to make the decision (Anfang & Appelbaum, 2006). Due to long waits with the pre-commitment trials the National Institute of Mental Health (NIMH) published the "Draft Act Governing Hospitalization of the Mentally Ill" (U.S. Public Health Service, 1952), which allowed psychiatrists once again to have the decision-making ability to commit someone involuntarily (Anfang & Appelbaum, 2006).

With the establishment of deinstitutionalization in 1955 and the civil rights movement in 1964, the standards for civil commitment were modified. In 1964 it was mandated that a person must have a mental health diagnosis prior to being committed against his or her will, and was considered an imminent danger to him or herself or to others, or was unable to provide for his or her basic personal needs for food, clothing, or shelter (Anfang & Appelbaum, 2006). It has been interpreted that danger to oneself refers to suicide, danger to others refers to homicide, and imminent danger refers to the act occurring in the near future (Testa & West, 2010). Delaware has not adopted this model. The law in Delaware states that a person can be committed if he or she is unable to make responsible choices about being hospitalized. Iowa requires that an individual is likely to cause severe emotional injury either to himself, herself or others (Anfang & Appelbaum, 2006). These standards were developed to protect psychiatric patients when they were psychiatrically unstable and are still applied when necessary.

Supporting legal coercion. It has been argued that the use of legal coercion has resulted in some clients feeling less suffering, pain, and embarrassment (Parrish, 1993).

Without external intervention, those that lack reasoning, judgment, capacity to recognize reality, and the ability to provide for their own basic life needs would be at great harm (Culver & Gert, 1982). It has also been suggested that the use of legal coercion has allowed such individuals to attend to their current symptomology and begin to address their issues in a safe and structured setting. Also, when individuals are in an acute psychotic, manic, depressed or delusional state, they may not recognize the impact that it may be having on their family members. The individuals may not be able to identify the amount of concern and anguish that their behaviors may have caused their loved ones. Legal coercion can assist the client in obtaining treatment, in hopes of reducing acute and distressing symptoms, and helping to initiate recovery. It also can be used to prevent the clients from maintaining a "sick" role, while also promoting personal growth, having the ability to confront their issues, and develop coping skills to compensate for such issues (Appelbaum, 1985).

Family members, friends, and mental health professionals working with those with mental disorders are often faced with the difficult decision to involuntarily commit an individual for treatment. Each of these parties may be concerned about the client's psychological well-being, as well as others' well-being and also those individuals with whom the client may frequently come into contact. Legal coercion has often been utilized by these individuals because the client and family may require personal safety. According to Cahn (1982), deinstitutionalization has decreased the length of hospitalization stays and those with severe mental health disorders may likely still display threatening and frightful behavior. Families are often exposed to such violent behaviors and violent threats (Wexler, 1993). Family members and friends often feel the need to hospitalize the

clients against their will in order to obtain physical security in response to violent threats or behavior (Williams, Thornby, & Sandlin, 1989). At other times, family members, friends, and mental health professionals may view legal coercion as the only route to resolve the client's problematic behavior. When a client refuses treatment and the client's behavior continues, legal coercion may be the only viable option to initiate treatment (Parrish, 1993). Mental health professionals and family members may permit the use of legal coercion because it allows an individual to be treated and prevents an outcome that could be far worse than if he or she did not obtain the forced treatment.

Opposing legal coercion. Although there are persuasive arguments for the use of legal coercion, there are also arguments opposed to its use. It could result in the loss of the clients' decision-making powers; it may also expose him or her to harmful institutional environments, and to potentially ineffective treatment (Parrish, 1993). Those legally coerced into treatment may be at risk of losing their civil rights. According to the Fourteenth Amendment, "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws" (2015, November 25). Retrieved from <https://www.loc.gov/rr/program/bib/ourdocs/14thamendment.html>. This process has been compromised for those entering treatment involuntarily because they lack the ability to provide informed consent. It has been argued that some individuals with serious mental illnesses are incompetent to make treatment decisions for their best interest

(Blanch & Parrish, 1990). According to Monahan and Shah (1989), jurisdictions require that an individual be mentally disordered, which is a statutory criteria for treatment. The vague description of “mentally disordered” has not been defined properly and varies among states. In addition, specific states do not specify those diagnoses that qualify as mentally disordered (Monahan & Shah, 1989; Culver, 1991). Often, individuals are legally coerced into treatment by mental health professionals who may have met with them only briefly before determining their need for treatment, against their will (Blanch & Parrish, 1990).

Individuals are often legally coerced into entering treatment for paternalistic reasons, providing them a safe and therapeutic setting in which they can regain their mental stability (Blanch & Parrish, 1990). It would allow the client to be socially monitored by staff and be subjected to interventions and standard treatment protocols. This form of treatment has not been accepted universally. Individuals often report more harm than good because they may have been left with emotional damage due to their loss of control, apathy, and feelings of dehumanization during their involuntary admission (Blanch & Parrish, 1990). Humiliation, the negative emotional reaction that occurs in victims experiencing force of authority, has been felt by those entering inpatient psychiatric treatment and has been magnified for those forced into treatment (Svindseth, Dahl, & Hatling, 2007). As a result, this can deter individuals from seeking mental health treatment in the future. Campbell & Schraiber (1989) found that 47% of former clients avoided mental health treatment due to their negative experiences when involuntarily committed.

Family members and friends can also disagree with the use of legal coercion when the client enters treatment. Family and friends can often be placed in a difficult predicament when making the decision to involuntarily commit a loved one. If they choose not to commit a loved one, the person could continue to harm himself or herself, yet if they choose to commit the individual it could sever the relationship that they previously had (Parrish, 1993). It can destroy the intra-familial trust and positive relationships that may have been created between the individual and his or her family member(s) and/or friend(s), resulting in a broken relationship (Urban Affairs Center, 1991).

Parens patriae and police power. Mental health professionals, as well as state governments, struggle with the difficult decision to admit a client involuntarily. The state government has developed two legal principles and each has acted as a guide for mental health professionals who struggle with having to admit a client that is refusing to seek services. The two principles consist of *parens patriae* and police power (Testa & West, 2010). *Parens patriae* indicates that it is the responsibility of the government to intervene when a citizen is unable to act in his or her best interest (Testa & West, 2010). As a result of *parens patriae*, individuals who receive treatment are able to make better judgments after treatment because they experience fewer acute symptoms (Testa & West, 2010). This has been evident for those that are severely depressed because they may identify a situation as being much worse than it actually is, may feel increasingly hopeless, have a lack of clarity and as a result may be more inclined to make rash decisions, such as suicide. Police power reinforces the concept that it is up to the state to protect all interests of its people (Testa & West, 2010) and the responsibility to protect

and oversee all people living within its state. This has allowed the state to develop statutes to protect society at large even though it may impinge on the rights and liberties of certain individuals (Testa & West, 2010). This view varies among mental health professionals because many are primarily concerned with the client's being a danger to himself or herself or to others, as opposed to the rights of all individuals residing in that state.

Extra-legal coercion

State law differentiates involuntary vs. voluntary commitment although coerced hospitalization or treatment can occur in the absence of legal involuntary status. Extra-legal coercion has been used by many mental health professionals to ensure treatment and protection for clients, believing that clients will have better results if willing to participate in their treatment (Hiday, 1996). At times, mental health professionals, family, and friends have the ability to discuss the benefits of treatment openly, which would allow the client to enter treatment voluntarily. Mental health professionals often provide clients with reasons to accept treatment or they may utilize persuasion as a tactic to encourage the client to enter treatment voluntarily rather than threatening the client (Lidz et al., 1993). The threat of civil commitment, removing one's valued resources, and deception have been used to entice a client to enter treatment voluntarily (Decker, 1981; Gilboy & Schmidt, 1971; Lewis et al., 1984; Rogers, 1993). If a client is unwilling to accept treatment voluntarily, the threat of involuntary commitment has been used to convince the client to sign in willingly (Gilboy & Schmidt, 1971).

Studies examining the effects of coercion on patients' attitudes towards hospitalization or treatment compliance have typically associated coercion with legal

coercion (Beck & Golowka, 1988). This was not necessarily correct for the following reasons: many individuals may not have been aware of their legal status (Monahan et al., 1995); one's legal status did not always comport with one's subjective experience of the admissions process. Also, many of those that entered treatment involuntarily were not coerced, yet many of those voluntarily admitted felt coerced (Rogers, 1993). Generally speaking, clients have shared a moral code about how they would like to be treated during their admissions process. This moral code consists of being included in the decision-making process, others being concerned about their well-being during the admissions process, and others acting in good faith (Hoge et al., 1993). If each of these criteria is met the client is more likely to state that he or she felt less coerced and is more obliged to voluntarily admit themselves for treatment. When mental health professionals who are able to discuss the benefits of treatment and treat the patient with concern, respect, validation, voice, fairness, and lack of deception, can increase the effectiveness of extra-legal coercion during the admissions process (Gardner et al., 1993). These variables can increase the clients' empowerment, allowing them to take control of their lives and improve their quality of life (Nelson, Ochocka, Janzen, & Trainor, 2006). An increase in empowerment can result in gains in self-confidence, social support, and self-esteem (Nelson et al., 2006). These characteristics can be achieved after addressing their psychiatric issues during treatment and continuing with outpatient psychiatric treatment (Strack & Schulenberg, 2009). Numerous scholars now argue that empowerment and self-determination are necessary at all stages of treatment, not just when symptoms remit, as evident with the recovery-oriented model applied in mental health settings. Instilling hope, optimism, and self-determination for clients with serious mental illnesses can help

them in achieving their recovery goals while receiving treatment as inpatients or as outpatients (Corrigan et al., 2012; Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009; Hungerford & Fox, 2014).

Studies examining legal vs. extra-legal coercion

Many of the earlier studies that were cited focused on coercion, examining the relationship between legal status and one's experience of coercion (Hiday, 1992; Lidz et al., 1995; Monahan et al., 1995). Early studies on coercion assumed that being involuntarily committed was synonymous with coercion (Lidz et al., 1995; Monahan et al., 1995). It was hypothesized that those admitted voluntarily would be less likely to perceive coercion, when compared with those admitted involuntarily (Monahan et al., 1995; Iversen et al., 2002; Cascardi & Poythress, 1997; Hiday et al., 1997; Hoge et al., 1998; Lidz et al., 1995). Research has indicated that 10%-29% of those admitted voluntarily experienced the admissions process to an inpatient psychiatric facility as coercive (Swartz, Wagner, Swanson, Hiday, & Burns, 2002; Monahan et al., 1995).

Most of the literature investigating legal coercion had assumed that the commitment process was coercive and had been experienced as inherently negative by patients (Hiday et al., 1997). Hiday and colleagues (1997) defined perceived coercion as the opposite of the patient's perception of autonomy. Clients felt that their autonomy was revoked when legally coerced into treatment. However, the authors also concluded that admission to an inpatient psychiatric facility allowed clients to have a voice and feel validated. It also allowed clients to be able to avoid the perception of force even when they were admitted without choice. This reflected the positive aspects that may become evident with the use of coercion (Hiday et al., 1997). This study did not indicate that

coercion was not used in the admissions process; rather, it demonstrated that coercion was able to be viewed in a positive light. This also demonstrated that coercion can be effective, although it is critical for mental health providers to understand how it can be perceived positively or negatively. Shannon's study (1976) outlined the negative aspects of perceived coercion such as clients' reports of being physically controlled, being deceived, being brought to the hospital by police, and denied a say in what was happening to them. Each of these negative experiences inhibited their ability to thrive in an inpatient psychiatric setting.

Extra-legal coercion, when compared with legal coercion, often provides individuals with the ability to participate and have a voice in their treatment decisions; this could increase the effectiveness of treatment (Cascardi & Poythress, 1997). Individuals that experienced extra-legal coercion when entering treatment reported their admissions as less coercive and explained that they were treated more respectfully, more fairly, and with more dignity than those legally coerced (Cascardi & Poythress, 1997). These individuals were also less likely to feel as though they had been threatened or forced into treatment by mental health professionals. The use of verbal persuasion, the most prevalent way to entice an individual to enter treatment, has provided clients with suggestions about the reasons why they would benefit from treatment (Monahan et al., 1995).

Extra-legal coercion impacts how voluntary admission to an inpatient psychiatric treatment facility is viewed. Extra-legal coercion can result in legal coercion. For example, an individual may voluntarily seek treatment but later in the admissions process decides that he or she would rather follow up with outpatient treatment. If the admissions

staff believes that the client is in danger of hurting him/her-self they may involuntarily commit the client for treatment. This confirms the belief that the voluntary/compulsory distinction is blurred rather than sharp (Brakel, Parry, & Weiner, 1985). The authors believed that coercion should be viewed on a continuum that cuts across the administrative and legal boundaries of involuntarily and voluntary status, because the use of persuasion can often result in threats of hospitalization. Clients who are admitted voluntarily could be threatened during their hospitalization with having their voluntary status converted to an involuntary status if they do not choose to stay in treatment. These threats can affect the clients' perceptions of services. Those that did not view their status as genuinely voluntary were more likely to reject the definition of their problems and were more likely to view services negatively (Rogers, 1993). If the presence of coercion can be eliminated or decreased, it has been suggested that adherence to aftercare treatment may increase and readmission rates may decrease (Rogers, 1993).

Studies showing the effect of coercion on treatment

Many of the early studies conducted on coercion used the participants' legal status as a proxy for the patients' subjective experiences of coercion. Many hypothesized that an individual admitted voluntarily would perceive less coercion when admitted, as opposed to an individual who was involuntarily admitted (Monahan et al., 1995). This hypothesis neglected to examine the complexities of the system in which the information was gathered. Without having a clear understanding of the legal system, it was difficult to predict the effect that coercion would have on those in treatment or to identify other coercive pressures that would affect patients when entering treatment (Hiday, 1992; Lidz, Mulvey, Arnold, Bennett, & Kirsch, 1993).

Obtaining information on legal coercion has been difficult, because there is a diversity of commitment systems in existence and these vary from state to state in the United States. This is evident when looking at legal constructs such as “emergency commitment”, “observational commitment”, and long- term “extended commitment” (Monahan et al., 1995). An emergency commitment is often initiated by family, friends, police, and mental health professionals, and requires a judicial approval or psychiatrist evaluation to confirm that the individual is meeting the state’s criteria for an inpatient psychiatric hospitalization. An observational commitment occurs when hospital staff observes the client to determine a diagnosis and administer limited treatment. An extended commitment requires prolonged treatment for the patient’s mental health issues. This form of commitment is completed in a hearing in front of a judge, who makes the final decision about whether or not the client can be held against his or her will and for what period of time. Also complicating matters are states that allow a parent or guardian to “voluntarily” commit a child or incompetent adult for admission to an inpatient psychiatric facility (Monahan et al., 1995). Further complicating the matter, one’s legal status may change during one’s hospitalization from a voluntary admission to involuntary admission and vice-versa (Cuffel, 1992). The rates of involuntary admissions may also be skewed because some legally, involuntarily committed patients may have wanted to receive treatment in an inpatient psychiatric facility (Hiday, 1996; Hoge et al., 1997; Monahan et al., 1995).

Knowledge of legal status

Many clients are unaware of their legal status when they are entering a psychiatric facility, which may cause further confusion and resentment. Studies have shown that

approximately half of the clients that entered treatment were unaware that they were admitted involuntarily (Bradford, McCann, & Mersky, 1986; Edelson & Hiday, 1990). Given this information it is unlikely that one's legal status alone impacts a client's perception of coercion. Additionally, multiple studies were conducted; these found that up to two-thirds of clients that entered treatment under involuntary status were willing to sign themselves in under voluntary status (Edelson & Hiday, 1990; Hoge et al, 1997; Bradford et al., 1986).

Lack of communication between hospital staff and client seems to impact the client's knowledge and understanding of his or her legal status. A study completed by Hoge et al. (1997) examined those admitted under voluntary status and "found that "44% claimed that it was not their idea to be hospitalized; 25% believed that there were other alternatives rather than getting hospitalized, and 39% felt that they would have been civilly, involuntarily committed if they did not seek treatment voluntarily" (Hoge et al., 1997, p 174). "For involuntarily admissions it was found that 22% of clients wanted to be hospitalized, 47% felt that there was no other alternative to being hospitalized, and 81% of those admitted involuntarily would have voluntarily admitted themselves if given the opportunity to do so" (Hoge et al., 1997, p. 174).

Another study conducted by Bradford, McCann, & Mersky (1986) interviewed those admitted to an inpatient psychiatric facility in Canada. The study found that 39% of these clients were unaware that they were involuntarily committed for treatment and approximately half were denied the right to admit themselves voluntarily for treatment. If given the opportunity to sign in voluntarily, 31% of these patients stated that they would have done so. Interestingly enough when interviewed one week later, approximately half

of these clients stated that if they experienced symptom relapse and distress that they would return for treatment and approximately two-thirds of these individuals would recommend hospitalization to a friend should he or she become acutely ill. These rates improved, demonstrating greater compliance with entering treatment at a later time, if clients were informed of their legal status during their admissions.

Effects of coercion over time

The effect of coercion can be detrimental and impactful to a client over time. In order to study this phenomenon many researchers have studied coercion and its relationship with global functioning, recall bias, as well as the positive and negative effects of coercion on treatment. Each of these variables was used and evaluated to determine the effect of coercion on those entering an inpatient psychiatric facility.

Global functioning. The Global Assessment of Functioning Scale (GAF) has been utilized in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000) and it was used to report an individual's overall level of functioning. Global functioning was measured on a numerical scale that was used by mental health clinicians and physicians to rate, subjectively, the social, occupational, and psychological functioning of an adult in treatment. It was often used to determine the severity of the symptoms with which the client was presenting. The scale ranged from 1- 100 with 1 indicating "persistent danger of severely hurting themselves or others, serious suicidal act with clear expectation of death," and 100 indicating no symptoms and having many positive qualities" (APA, 2000, p. 34). Those with better global functioning at admission had lower levels of perceived coercion (Fiorillo et al., 2012). These clients were more willing to be treated in

order to increase their global functioning levels. It was recognized that the client's perception of coercion when entering treatment was related to the client's expected level of global functioning at admission and the functioning level he or she had achieved throughout treatment (Fiorillo et al., 2012).

The Global Assessment Scale (GAS), a revision of the GAF, (Endicott, Spitzer, Fleiss, & Cohen, 1976) was used to identify the differences between those involuntarily vs. those voluntarily admitted for treatment (Hiday, 1996). Steinert & Schmid's (2004) study demonstrated similar results for those involuntarily and those voluntarily admitted, because both showed similar improvements in functioning and symptom reduction from admission to discharge. This demonstrated that legal status did not impact one's global functioning level at discharge (Steinert & Schmid, 2004). These results differed for those who had perceived higher levels of perceived coercion during their hospitalization. These individuals were less satisfied with care, resulting in lower global improvement during their treatment (Steinert & Schmid, 2004).

There are also other factors that can affect one's functioning level during hospitalization. Those experiencing positive symptoms of schizophrenia (delusional thoughts, paranoid beliefs, hallucinations, and disorganized thinking) experienced increased stress due to being constrained in an inpatient psychiatric unit and as a result lacked the ability to avoid or withdraw, which may have been their typical coping strategies. Being in an inpatient psychiatric facility can exacerbate the reasoning bias, which is described as a "jump-to-conclusions" style of reasoning (Linney, Peters, & Ayton, 1998). This bias has been shown to increase individuals' symptoms of paranoia and hallucinations, which can increase their perceptions that they are being coerced

(Fiorillo et al., 2012). If the patients are not properly medicated, in order to reduce delusional thoughts, paranoia, and hallucinations, their therapeutic relationships with hospital staff members are often affected. It could also cause their levels of perceived coercion to continue to be at an intense level. Admission staff members would need to recognize that those exhibiting positive symptoms of schizophrenia, who have lower levels of global functioning are more likely to perceive that they are being coerced into treatment (Fiorillo et al., 2012).

Recall bias. Research has demonstrated that perceived coercion tends to decrease over time (Fiorillo et al., 2012). Recall bias effect is a systematic error caused by differences in accuracy in recalling previous events or experiences and it can partially account for these changes in perceived coercion because patients may forget that they were subjected to coercion after feeling greatly improved psychologically over time or even following discharge from an inpatient psychiatric stay (Fiorillo et al., 2012; Hassan, 2006). Additionally, the relinquishment of the symptoms that led them to their hospitalization could also have allowed the clients to gain better insight into their situations and illnesses and helped them recognize the benefits of treatment and the necessity of the coercive measures that they received (Hassan, 2006; Katsakou & Priebe, 2006). According to Fiorillo et al. (2012), this explanation better accounted for the marked improvement in global functioning and reduction in positive symptoms within their study.

Positive effects of coercion on treatment. Clients who felt that they experienced a “good” admissions process were more likely to report that others acted on their behalf; that they were treated fairly; that they were treated with respect, and without deception;

that they had the ability to tell their side of the story; they were also more likely to report that they were less likely to feel coerced even when the decision to enter treatment was not the one that they had preferred (Dennis & Monahan, 1996; Lidz et al., 1995). Some of the ways in which mental health professionals were able to show their concern for the client included providing them assistance to get help, providing emotional support, and offering them approval to obtain help (Dennis & Monahan, 1996). Providing clients with a voice in their treatment, as well as treating them with respect, helped them obtain treatment that was truly needed (Blanch & Parrish, 1990; Parrish, 1993). Using positive pressures such as persuasion has been helpful in having clients accept the need for treatment. A positive approach is less likely to be seen as coercive and can also mitigate the effect of any negative strategies that may ultimately be used during the admissions process (Dennis & Monahan, 1996).

Negative effects of coercion on treatment. The impact of feeling coerced when entering treatment can result in a client having negative attitudes towards psychiatric services and being more likely to reject hospital admission in the future (Rogers, 1993; Fiorillo et al., 2012; Seo, Kim, & Rhee, 2013). Clients who felt their admissions were truly voluntary were more likely to accept their diagnoses and identify treatment as helpful. Those that considered their informal status to be false; those that were negatively coerced into treatment, were likely to consider the admissions process an unnecessary response to their problems and thought that an alternative to hospitalization should have been offered (Rogers, 1993). As a result those previously and negatively coerced would fear that they would be committed to treatment against their will (Swartz, Swanson, & Hannon, 2003). The use of coercion affects clients' liberty, autonomy, and human

dignity, which in turn can affect the therapeutic alliance established between client and mental health professional. Many clinicians also believe that the use of coercion can damage the relationship formed between the client and therapist (Hiday et al., 1995). If dissatisfied with treatment, the patient may alienate him or herself from mental health care; this can be seen as a result of perceived coercion (Rogers, 1993; Hiday et al., 1995). In addition, clients may be reluctant to seek inpatient or outpatient psychiatric care in the future, may be reluctant to use psychotropic medications, and may be non-adherent to the recommended care after the coercive element has been discontinued or ended (Campbell & Schraiber, 1989; Rogers, 1993). Other research has found that coercion, at times, is beneficial because it allows mental health professionals to treat clients in need of services and engages them in therapy, allowing them to benefit from treatment during their hospitalization (Group for the Advancement of Psychiatry, 1994; Stone, 1975). These differences in perceptions and findings demonstrate that therapeutic outcomes of coercion can vary.

Clients who felt that they were negatively coerced into treatment, with the use of threats, force, or procedural inequity, reported higher levels of perceived coercion (Lidz et al., 1995). In comparison those that were coerced with the use of persuasion and/or inducement, did not have an increase in their levels of perceived coercion (Dennis & Monahan, 1996). A negative approach, such as threatening the client to enter treatment, should be used only as a last resort because this can violate the clients' autonomy and jeopardize their mental health treatment (Kjellin et al., 1997).

Research clearly indicates that the construct of coercion is much more multifaceted than a simple division of coercion into legal and extra-legal coercion.

Rather, research has demonstrated that coercion is a highly subjective and situationally dependent experience (Wertheimer, 1993; Hoge et al., 1993). Even with the use of reliable and valid measures to detect one's perception of coercion, including form, presence and degree, perceptions can vary between and among the patient, family, and staff. Individuals who perceive themselves as being controlled by others and have limited control in their treatment may feel coerced, oppressed and lacking freedom, regardless of their legal status (Cascardi & Poythress, 1997). Research studies have shown that perceived coercion is not only directly linked to one's legal status (voluntarily or involuntarily committed), but rather that one's social experience of the admissions process is related to a person's perception of being coerced (Bindman et al., 2005; Monahan et al., 1995; Kjellin et al., 2004; Priebe et al., 2011).

Chapter 4: Ethical Dilemmas

Coercion has been used in psychiatric care to ensure that those who are mentally unstable receive care to assure their safety as well as the safety of others (Kjellin et al., 1997). This conflicts with the ethical obligation to respect one's autonomy, although there also is an ethical obligation to use compulsory care to provide safety and stability. Mental health professionals work to determine the goals of inpatient psychiatric treatment, which are to help the client achieve crisis stabilization in order to function safely in the community again; however, the use of coercion may result in the violation of the autonomy principle. The *American Psychological Association (APA)'s Ethical Principles of Psychologists and Code of Conduct (2010)* offers guidelines for mental health professionals when providing treatment to clients. Coercion has often been identified and viewed as unethical by many clients entering treatment. On the other hand, many mental health professionals have felt that using coercion is justified because it prevents a client from being a danger to himself/ herself or others (Kaltiala-Heino, Laippala, & Salokangas, 1997). It has also been used for clients to enter treatment in order to provide help and safety, or to control agitation, aggression, or other harmful behavior (Kaltiala-Heino, Laippala, & Salokangas, 1997).

APA's Ethical Principles of Psychologists and Code of Conduct

According to the APA's Ethical Principles of Psychologists and Code of Conduct, there are five general principles that are aspirational goals helping guide psychologists toward the highest ideals of the field (APA, 2003). These five principles include beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity (APA, 2003). Each of these principles is intended to guide

and inspire psychologists towards the highest ethical ideals of the profession (APA, 2003).

Beneficence and Nonmaleficence. Beneficence is an action that is completed for the benefit of others; nonmaleficence is to do no harm (Grace & Hardt, 2008).

Beneficence is the action that is done to help to prevent or to remove harm or to improve the situation of others. Although mental health professionals have an obligation to refrain from causing harm, they also have the responsibility to help and to assist the client in achieving stability. The use of coercion may impact beneficence when it does not allow mental health professionals to protect and defend the rights of others, although it may assist a client who is in danger and lacks the cognitive capacity to recognize this. With regards to nonmaleficence, it is critical that mental health professionals weigh the possible benefits of action against possible risks of action. Each can affect the client's autonomy, the ability of a person to make his or her own decisions. Those that are involuntarily committed for treatment lack autonomy because their rights to choose whether or not to enter treatment are removed and they are forcefully committed against their will. Respecting the client's autonomy can reduce the likelihood of harming a patient although it, is at the same time, the duty of mental health professionals to help clients access needed services to keep them safe (Grace & Hardt, 2008). Mental health professionals are often faced with difficult decisions when clients refuse to enter treatment, but exhibit behaviors that require treatment (Testa & West, 2010). When in this state clients lose their autonomy because they are unable to make rational decisions, which require an inpatient psychiatric admission to secure protection.

Kjellin et al. (1997) compared loss of autonomy and legal status in an inpatient psychiatric facility. The results showed that 26% of those involuntarily committed reported that they had not been respected as a person; 45% felt that they had been violated as a person, and 57% stated that they had been exposed to a measure against their will, resulting in a total of 65% of those involuntarily admitted for treatment reporting that they had experienced the violation of their autonomy. On the other hand, 13% of those voluntarily admitted for treatment reported that they had not been respected as a person; 19% felt that they had been violated as a person, and 21% stated that they had been exposed to a measure against their will, resulting in a total of 36% of clients who voluntarily admitted to having at least one violation of their autonomy during their hospitalizations. Within this study one-third of those individuals involuntarily committed reported ethical benefits only, which in this study included only beneficence and autonomy. Although they lost their autonomy, they were prevented from harming themselves or others. More than half of those voluntarily admitted for treatment reported ethical benefits only (Kjellin et al., 1997). This clearly demonstrated that the clients' level of autonomy is impacted, based on their legal status. Lack of autonomy could impact the therapeutic alliance, which could hinder treatment. As a mental health professional it is critical that one recognizes and understands the benefits and costs associated with coercion and autonomy while attempting to avoid harm and improve the client's psychological state.

Fidelity and Responsibility. Fidelity and responsibility acknowledge that psychologists should respect the trust placed in them by their clients, and should take responsibility for their own actions (APA, 2003). Mental health professionals look to

establish trust with clients at the start of treatment. When working with those in an inpatient psychiatric facility, the development of trust begins at admission. Coercion can have a damaging effect on rapport because it can negate the client's freedom and free will. If coerced into treatment the client may gradually feel that he or she is losing the ability to make independent choices. This may result in treatment barriers, because the client may feel that he or she lacks free choice in his or her treatment. Although psychologists recognize the importance of their professional role and are obligated to follow an ethical role it is critical that the client be provided a voice during the admission process and be validated and treated respectfully and fairly. Reminding the client how he/she is included in the admissions process can initiate the therapeutic alliance and allow it to continue throughout his or her hospitalization.

Integrity. Integrity insists that psychologists should not commit professional fraud or be dishonest, although deception may be used therapeutically in special circumstances (APA, 2003). It is a mental health professionals' objective to promote accuracy, honesty, and truthfulness in the field of psychology. The use of deception may be ethical in nature if it provides maximal benefit for the client and minimizes harm. It is critical that mental health professionals recognize the consequences and the responsibility of their actions that may eventually result in mistrust or harmful effects with the use of coercion. Mental health professionals need to identify the fact that their knowledge of psychology and their professional standing often place them in a position of power and trust. It is necessary to recall that mental health professionals cannot use coercion for their own benefit; rather, it may be used only to benefit the best interest of the client, the profession, and others that may be impacted by the client's psychological instability.

Having the mental health professional effectively communicate his or her concern to the client and explain the rationale about the reasons why he or she may require treatment can promote honesty and truthfulness to the client. As mentioned previously with process exclusion, when a client perceives that a mental health professional was acting without bias and in good faith, the client was more inclined to believe that the hospital admission process was justified (Bennett et al., 1993) and was less likely to perceive that coercion took place (Hoge et al., 1993; Monahan et al., 1995).

Justice. Justice states that psychologists should conduct business with regard to fairness and social equality (APA, 2003). This general principle is used to provide all people with access to and benefits of psychological treatment as well as equal quality in the process, procedure, and services that are offered by mental health professionals (APA, 2003). As a mental health professional, it is critical to treat all clients in a just manner despite their legal status. Those coerced into entering treatment may not necessarily view the admissions process as equal when compared with those not coerced, because they may have lacked the choice to enter treatment, were pressured into entering treatment, were threatened, or may not have felt as though they were treated fairly and respectfully in the admissions process, each resulting in inequality. As a result, it may prevent those from entering treatment at a later time (Swartz, Swanson, & Hannon, 2003). It is essential that mental health professionals determine that all clients have the ability to express their rights, opinion, desires, and dignity during the admissions process. This promotes fairness and social equality for all clients, even those that may have been coerced into entering treatment.

Respect for People's Rights and Dignity. Respect for people's rights asserts that psychologists must respect the privacy, confidentiality, and autonomy of clients (APA, 2003). Mental health professionals engage in conduct that promotes equity and the protection of the clients' human rights, moral rights, and legal rights (APA, 2003). This is often achieved by obtaining informed consent and by assisting the clients to make the decision to proceed with treatment, without coercion. Even with the use of coercion it is essential that mental health professionals continue to collaborate with clients and respect the clients' individual, cultural, and role differences throughout treatment (APA, 2003). Some of these factors include gender, age, gender identity, race, culture, ethnicity, national origin, sexual orientation, religion, disability, sexual orientation, and socioeconomic status (APA, 2003). These factors need to be recognized and considered when providing treatment because it is part of the ethical obligation of the clinician and other mental health professionals. Although the use of coercion is common when entering treatment, psychiatric care should focus on reducing and lowering the rates of perceived coercion as much as possible during the admissions process, allowing clients to benefit from treatment (Bindman et al., 2005), and promoting the clients' rights and dignity.

In order to reduce levels of perceived coercion, hospital staff members need to understand the characteristics that are associated with increasing and decreasing levels of perceived coercion at admission (Fiorillo et al., 2012) as well as the general principles that provide guidance for mental health professionals. It is essential that mental health professionals are cognizant of and utilize the code of ethics because it is used to provide guidance for psychologists and upholds the standards of professional conduct (APA, 2003). Even with the use of coercion one still needs to practice beneficence and

nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity when providing treatment for those in an inpatient psychiatric facility.

These general principles will aid in the client's treatment during his or her hospitalization.

Chapter 5: MacArthur Study

During the 1990s a considerable amount of research was conducted evaluating the use of coercion. The MacArthur Coercion Study, supported by the Research Network on Mental Health and the Law of the John D. and Catherine T. MacArthur Foundation, was a preliminary study that investigated the experiences of patients during an inpatient psychiatric admission.

The MacArthur Foundation Research Network on Mental Health and the Law set out to properly define and study coercion. The MacArthur study helped in defining the nature, extent, and effect of coercion on mental health treatment (Treffert, 1998). It eventually led to expanding and redefining the definition to include perceived coercion. This was a critical development in the field because some may enter treatment voluntarily but are nevertheless coerced into treatment, but those involuntarily committed may have experienced little or no coercion. The MacArthur study has allowed data to be evaluated between and among those admitted voluntarily for treatment, those involuntarily admitted for treatment, and those that were not recommended treatment, demonstrating its impact on treatment and outcomes of treatment (Treffert, 1998). It also provided recommendations about how coerced care can best be managed in order to maximize treatment and decrease the impact that it may have on clients' present and future psychiatric treatment, while respecting the client's rights and liberties (Treffert, 1998). It has examined the nature and need for coerced treatment, as well as the competency standards and violence risk assessments, in order to provide the most beneficial treatment for all individuals entering treatment. The research has helped in establishing unbiased

standards and solutions in order to help assist patients, family members, and the public with the reality of coercion.

Admission Experience Survey (AES)

The MacArthur Research Network on Mental Health and the Law developed the Admission Experience Survey (AES), which was used to evaluate clients' global perceptions of their inpatient psychiatric hospitalizations (Gardner et al., 1993). The AES was derived from the Admission Experience Interview (AEI), which is a thirty minute structured interview assessment. Gardner and colleagues (1993) demonstrated that the AES, separate from the AEI, can be used to measure perceived coercion. The original AES, which contained forty-one items, was later modified and was simplified into a fifteen item, true and false/ yes or no questionnaire (Gardner et al., 1993). It was condensed because the original version of the AES had asked questions that led up to hospital admission as well as to events that occurred during hospital admission. Questions were rephrased and compressed in the AES-15, which minimized the number of questions asked. This comprehensive and condensed version has been used since. The AES has been used with several different cultures (Poulsen, 1999; Seigel, Wallsten, Torsteinsdottir, & Lindstrom, 1997) and also in outpatient commitment programs (McKenna, Simpson, & Coverdale, 2006; Swartz et al., 2002) in order to measure levels of perceived coercion.

Use of the AES. The AES is used to measure perceived coercion, not actual coercion (Gardner et al., 1993). Although the AES has many positive attributes, it is unable to differentiate between the client's perception of coercion and the client's perception of the quality of the inpatient psychiatric environment (Gardner et al., 1993).

Also, the AES is able to gauge the patient's account of perceived coercion, but is not able to consider the perceptions of others involved in the admissions process. Utilizing only one source of information to measure perceived coercion can lead to significant error, although a patient's recollection of this information appears to be more complete and superior when compared with other sources (Lidz et al., 1997).

Dimensions of the AES. The AES consists of three subscales, which include the five-item Perceived Coercion Scale, six-item Perceived Negative Pressure Scale, and four-item Process Exclusion Scale. The factors included in each subscale can affect a client's perception of the admissions process, which may hinder his or her ability to benefit from treatment while in an inpatient psychiatric facility. The Perceived Coercion Scale, Perceived Negative Pressure Scale, and Process Exclusion Scale provide a true understanding of the role of perceived coercion and its effect on treatment adherence. Each of the scales is necessary to gauge one's perception of coercion. The MacArthur study found that patients who had little voice or validation during the admissions process (process exclusion), or who had experienced threat or force (negative pressure) during the admission process, perceived high levels of coercion. This demonstrated that procedural inequity and negative pressure predict perceived coercion (Lidz et al., 1995). A strong positive correlation among these three constructs was found (Hiday et al., 1997).

Subscales of the AES. The Perceived Coercion Scale has been demonstrated as psychometrically sound and internally reliable in measuring a patient's perception of being coerced (Nicholson et al., 1996; Gardner et al., 1993) it also has satisfactory retest stability (Cascardi, Poythress, & Ritterband, 1997). Hiday et al. (1997) demonstrated that the item-total correlations ranged from 0.60 to 0.73, which showed satisfactory

homogeneity. Cronbach's alpha was 0.86, indicating high internal reliability. This study also demonstrated that perceived coercion was bi-modal, with over half of the responses falling at either extreme of the scale, with a mean of 2.90. When used in other studies, the scale has demonstrated good criterion validity, having strong positive correlations with legal status, and with family and clinician perceptions of coercion (Hoge et al., 1993, 1998; Nicholson et al., 1996). This scale has also been used in multi-cultural studies (Poulsen, 1999; Hoyer et al., 2002; Iversen, 2002). The five items examine the influence, control, choice, freedom, and idea of one's perception of being coerced (Gardner et al., 1993). These terms were chosen on the basis of their face validity because each is an everyday synonym of autonomy (Gardner et al., 1993).

The Perceived Negative Pressure Scale has been used to identify whether or not the client has experienced negative pressure; that is, pressure of worsened consequences if one resists entering treatment (Hiday et al., 1995). The Perceived Negative Pressures Scale is a 6-item subscale ranging from 0 to 6. According to Hiday et al. (1997), the item-total correlations ranged from 0.54 to 0.70. Cronbach's alpha was 0.84, indicating high internal reliability on the scale. Within this study the average client scored 3.31 on the negative pressures scale, roughly at the mid-point, with a standard deviation of 2.17.

The Process Exclusion Scale measures clients' evaluation of whether or not the admission process was fair, their perceptions of others' motives in the admissions process, and whether or not their views were considered during the process (Hiday et al., 1995). The Process Exclusion Scale is a four-item subscale, ranging in scores from 0 to 4. The Cronbach's alpha is 0.76 and has an item-total correlation between 0.52 and 0.60. The mean for clients within the study was 2.09, roughly at the midpoint of the scale, with

a standard deviation of 1.51 (Hiday et al., 1997). Both the Perceived Negative Pressure Scale and Process Exclusion Scale have been predictive of perceived coercion (Lidz et al., 1998).

AES and patient legal status. The study conducted by Gardner et al. (1993) examined those voluntarily and involuntarily admitted for treatment, relative to perceived coercion. With those voluntarily admitted for treatment, 34% of the clients felt as though they did not have a mental illness and 49% stated that admission to the hospital in order to receive treatment was initiated by someone other than themselves. Of those admitted voluntarily, 49% attributed the idea of being admitted to someone else, and 25% felt that there were reasonable alternative forms of treatment other than being hospitalized. Last, 39% of the clients that entered treatment voluntarily felt that they would have been committed against their will if they chose not to enter treatment willingly. This study also examined those involuntarily entering treatment. Of those that entered treatment on an involuntary basis, 34%, felt that they had a mental illness. The study also found that 22% of patients involuntarily committed to treatment reported that it was their idea to enter treatment, and 20% stated that they had initiated treatment. Approximately 47% of those that entered treatment felt that there was no other, alternative form of treatment r than that of inpatient. Last, 18% of those involuntarily admitted for treatment were unaware of their legal status while in treatment, and 81% were not provided the opportunity to sign themselves into treatment voluntarily (Monahan et al., 1996).

AES and pressures. After being administered the six-item Negative Perceived Pressure Scale, 46% reported that they did not feel pressured into entering treatment. This study demonstrated that 31% experienced positive pressure only; 12% experienced

negative pressure only, and 11% experienced both negative and positive pressure to enter treatment. Specifically, patients reported a mean of 0.62 positive pressure per individual (SD= 1.37) and a mean of 0.37 negative pressure per individual (0.83). For the purpose of this study, positive pressures included persuasion and inducements and threats and force were categorized as negative pressures.

AES and process. Low scores on the four-item Process Exclusion Scale indicated “high” process (being provided a degree of voice during their admissions process), but a high score was indicative of a “low” process (not being provided much of a voice during their admissions process). Within the study, 59% of the clients felt that they were treated very well during their admissions process (0-0.8 on the four point scale). Although 26% of clients scored between 1.0-1.8, 8% of clients scored between 2.0-2.8 and 7% of clients scored between 3.0-4.0, showing a decline in the process of the admissions experience.

AES and perceived coercion. To test for perceived coercion, the MacArthur Perceived Coercion Scale was used. Scores intervals were set for each range: value= -0.1 to 0.2; value 1= 0.5 to 1.4; value 2= 1.7 to 2.3; value 3= 2.6 to 3.5; value 4= 3.8 to 4.4, and value 5= 4.7 to 5.3. Scores varied between each range, with 46% reporting little or no perceived coercion in making the decision to enter treatment (value=0). Fifteen percent were within value 1; 9% within value 2; 4% within value 3; 6% within value 4, and 20% within value 5. The MacArthur study investigated those that scored within value 4 and 5 to determine whether positive or negative pressures were associated with their level of perceived coercion. Of those that scored within value 4 and 5 on the MacArthur Perceived Coercion Scale, only 8.3% did not feel pressured into entering treatment. 10.2% felt positive pressure only; 89.5% felt negatively pressured only, and 35.3% felt

both positively and negatively coerced into entering treatment. In order to investigate whether process affected perceived coercion, process scores were split into three categories: high process scores (-0.95 to -0.628), medium process scores (-0.627 to 0.124) and low process scores (0.125 to 2.90). The study found that 2% of those with high process scores (i.e. having a voice during the admissions process) felt highly coerced into entering treatment; 11% of those with medium process scores felt highly coerced into treatment, and 52% of those with low process scores felt highly coerced into treatment.

AES and conclusion. In conclusion, the study identified the fact that the AES-15 is a reliable measure of people's perceptions of coercion independent of their formal legal status (i.e. involuntary or voluntary). This demonstrated that legal status is at best a crude proxy for people's experiences of coercion (Monahan et al., 1996). Next, high levels of coercion were found when others attempted to influence the individual to enter treatment by using negative pressures. On the other hand, there was no increase in perceived coercion with those influenced into treatment using positive pressures. Clients who experienced both positive and negative pressures to enter treatment reported intermediate levels of perceived coercion. Last, clients who explained that their admissions process was "good" reported that others were concerned about them, treated them fairly, treated them with respect, treated them without deception; they felt that were given the opportunity to tell their side of the story, and were considered in the decision to enter treatment; they also reported feeling less coerced even when they did not prefer to enter treatment (Monahan et al., 1996). The authors of the study stated that these results cannot be automatically accepted due to the possibility of the clients exhibiting a self-serving

bias. Also the clients' mental disorders may possibly have impacted their perceptions and judgment.

Chapter 6: Group therapy attendance, participation and leaving AMA

An acute inpatient psychiatric hospitalization represents the most intense level of psychiatric care. Multidisciplinary assessments and multimodal interventions are provided when a client is in a 24-hour secure and protected environment, consisting of support staff and behavioral health professionals. The goal of an acute inpatient psychiatric admission is to stabilize an acute psychiatric condition. During treatment clients are stabilized, administered psychiatric medications, are expected to attend group therapy and possibly individual therapy; these are used to treat the clients' current symptomology, allowing them to have greater control and choice in their treatments, which will provide them with increased control and initiative in their lives.

The use of perceived coercion can impact one's care during an inpatient psychiatric admission, specifically his or her adherence to treatment. This could affect the group therapy attendance and level of participation in a group therapy setting. It could also result in the client signing himself or herself out against medical advice. A client may be disgruntled with the treatment provided and may be reluctant to engage in the proposed treatment plan; the willingness or unwillingness to stay invested in treatment could result in the client's success or in the client terminating services. Group therapy has been used to assist those with their current psychological impairments, to share their personal history and emotional experiences through concomitant opportunities to give and receive feedback. Group therapy attendance, group therapy participation, and leaving against medical advice are critical issues related to perceived coercion; there is a need for further investigation in order to understand the impact of coercion on one's treatment.

Group Therapy

Group psychotherapy is a modality of treatment in which clients utilize interaction with other clients and with the therapist to develop improved social skills because their needs are met through acceptance, mutual support, and help in overcoming maladaptive behavioral patterns and encouragement in self-disclosure during the group process. Group therapy emphasizes understanding and changing one's current behavioral patterns, and sharing emotional experiences and personal history, while being given the opportunity to receive feedback and experience that is not available through individual modalities of treatment (Burlingame, Fuhriman, & Johnson, 2001). The context of group therapy is a system of many individuals and many relationships as opposed to the single relationship between client and mental health professional evident in individual therapy (Burlingame et al., 2001). A comprehensive definition of group treatment includes guidance, preventive counseling, and training groups (Barlow, Burlingame, & Fuhriman, 2000). Group therapy treatment has been utilized in a multitude of settings including: mental hospitals, correctional institutions, health maintenance organizations, counseling centers, outpatient clinics, and private practices (Cheifetz & Salloway, 1984; Dies, 1986); it has also been used in non-traditional settings such as: sheltered workshops, special education classes, employee assistance programs, religious institutions, convalescent homes, geriatric centers, medical hospitals, and community agencies (Zimpfer, 1984).

Group therapy has been used to treat psychopathology problems as well as specific problems; it can range in duration from short term to long term, and can take place in a multitude of settings (Barlow, et al., 2000). Although in a majority of hospitals

the length and duration of sessions can vary, group therapy is provided on a daily basis when in an inpatient psychiatric setting; each session is typically an hour in length and a total of three hours of group therapy is offered daily (Page & Hooke, 2009). The use of group therapy has been effective for clients who are depressed, anxious, psychotic, dually diagnosed, have multiple personalities, and have avoidant and borderline personalities (Alden, 1989; Coons & Bradley, 1985; Denny & Lee, 1985; Ely, 1985; Holman, 1985; McDermut, Miller, & Brown, 2001; Meltzer, 1982). Group therapy has been shown as being beneficial to those obtaining its services. However, uncertainty becomes a factor, and clients can become skeptical when entering an unfamiliar setting. Entering group therapy treatment with 8-12 unknown individuals, and each one dealing with his or her own issues can be anxiety provoking, resulting in decreased attendance, decreased participation, and treatment dropout. The fear of members breaking confidentiality, experiencing rejection, and being surrounded by unstable clients may cause a client to become fearful of the group therapy process; this is in addition to being hospitalized in an inpatient psychiatric facility. In order for mental health professionals to provide services that can increase adherence to treatment and provide clients with greater control and choice in their treatment, it is essential to understand the characteristics that are associated with decreased rates of group therapy attendance, group therapy participation, and leaving AMA.

Group Therapy Attendance

Therapy is established and maintained through the development of a therapeutic rapport. This relationship allows the client to feel comfortable with the therapist and feel safe in the therapeutic setting. Forming a therapeutic alliance between client and

therapist, also known as the “individual alliance”, is essential because it demonstrates to the client that the mental health professional is taking interest in his or her problems, is showing support and acceptance, and allows for a higher continuance rate of treatment (Bostick, 1987). As a mental health professional it is critical to provide warmth, empathy and friendliness, and be considerate and genuine because each of these can help in developing a therapeutic rapport. Johnson (in press) reported that a stronger individual alliance (in a group setting) predicted improved outcomes including reduced symptoms and lower dropout rates in 11 of the 13 group therapy studies spanning various clinical populations and theoretical orientations.

A “group alliance” or relationship between the client and the entire group has been measured as a unique construct (Budman et al., 1989). This dimension is important because it allows clients attending group therapy to rate interpersonal factors, including relationship-climate and other- versus self-focus, as more important when compared with those factors present in individual therapy (Holmes & Kivlighan, 2000). These factors may play a more prominent role in a group modality.

Therapeutic alliance. Given the importance of developing a therapeutic alliance, it is critical to identify factors that predict a stronger alliance in a group therapy setting. A study conducted by Beckham (1992) explained that first impressions are important in increasing group therapy attendance. The client distinguishes whether or not he or she is able to formulate a relationship with the therapist, is able to view the therapist in a positive light, or determine whether the mental health professional's personality and approach can meet his or her needs (Beckham, 1992). The formation of a good therapist-client relationship early in treatment can inhibit a client's dropping out of group therapy

(Murphy & Cannon, 1986). Clients who expected to engage in active collaboration with the mental health professional stayed in treatment longer, when compared with clients who expected to passively receive advice during group therapy (Heine & Trosman, 1960; Beckham, 1992). Mental health professionals must provide a structure that augments the process of becoming a group member, allowing the member to feel comfortable with the process of group therapy. Lacking structure (i.e. having a substitute therapist) can result in a decrease in attendance (Dinnen, 1971; Beckham, 1992).

Motivation. Even though structure is important, motivation is a necessary component of treatment because it allows the clients to become actively engaged and personally invested in changing their behaviors (Overholser, 2005). Clients are more highly motivated to attend group therapy treatment if they are inspired to relinquish their current symptoms (Dodd, 1971; Prendergast, Greenwell, Farabee, & Hser, 2009). It is critical that clients continue to stay motivated during their treatment, identifying the benefits of their group therapy treatment. There are two forms of motivation: intrinsic and extrinsic. Extrinsic motivation consists of outside pressures (i.e. wife, boss, etc.), who drive the patient into entering treatment; intrinsic motivation is a desire to get better for one's own sake. Extrinsic motivation can eventually be converted into intrinsic motivation (Baekeland & Lundwall, 1975). Having the ability to recognize the need for change, understanding the need to obtain help, and being able to formulate long term goals can influence dropout rates, attendance, and participation (Baekeland & Lundwall, 1975).

Clients who want to participate in the process of their treatment have been provided a sense of autonomy by the mental health professional (Ryan, Lynch,

Vansteenkisten, & Deci, 2005). The concepts of motivation and autonomy assist in the process of group therapy and behavior change and in sustaining that change over time (Ryan et al., 2005). Motivation and autonomy are necessary components when developing a therapeutic relationship. Formulating and developing a therapeutic bond is imperative to the treatment process and can allow treatment to flourish. It has been demonstrated that a client's positive view of the setting, satisfaction with the treatment, and a willingness to self-disclose have benefitted clients and have enhanced their attendance at group therapy treatment (Bostick, 1987). Mental health professionals need to meet with clients as early as possible to gauge their expectations of group therapy and their satisfaction with previous group therapy because each can motivate the client to attend and participate in treatment (Bostick, 1987). As it pertains to the recovery paradigm, clients have the right not to attend groups although the treatment team is encouraged to meet with the client to discuss and decipher what may be more beneficial in assisting the client if he or she cannot be encouraged or motivated to attend and participate in a group therapy modality (Baker, Sanderson, Challen, & Price, 2014).

Factors benefitting treatment. Mental health professionals often examine factors or previous experiences that will assist in the client's recovery. Clients that were either self-referred or were referred by family or friends remained in, and attended, group over a longer duration when compared with those referred by mental health professionals (Bostick, 1987). Variables such as higher education levels and higher socioeconomic status (SES), which can increase the client's level of treatment motivation, have been associated with treatment continuity, (Rabin, Kaslow, & Rehm, 1985). Having experienced individual therapy prior to entering group therapy, and also receiving

individual therapy in conjunction with group therapy, have contributed to clients' remaining in group therapy (MacNair & Corazzini, 1994). These clients were aware that therapy can result in increased self-awareness and insight. Those that attended group therapy in the past reported more positive expectations about the group (MacNair-Semands, 2002). Having taken part in individual therapy in the past allowed these clients to understand the goals and intentions of therapy. Stone and Rutan (1984) found that 84% of those who received individual therapy or were concurrently receiving group therapy and individual therapy chose to stay in group therapy. Attending both individual and group therapy strengthened the therapeutic alliance between client and mental health professional, motivating the client to further explore their problematic behaviors in each therapeutic modality.

Factors detrimental to treatment. When clients fail to attend group therapy it can be detrimental to the client and to the entire group. Poor attendance has been found to relate negatively to clients' hopes and expectations for group therapy (McKisack & Waller, 1996). Dropouts can cause instability in the group and can cause setbacks in the group's work, resulting in a "wave phenomenon". This eventually results in the client and the group failing to benefit from treatment (Bostick, 1987). Regular attendance has been demonstrated as a marker of group cohesion; more cohesive groups have been found to have fewer members who drop out of treatment (Falloon, 1981). A study conducted by Kanas & Cox (1998) found that approximately 18% of the content in group therapy was a discussion of general orientation to group therapy and group attendance issues. Group members were much more inclined to share information when attendance was stable, and

also if other members within the group were committed to treatment (MacNair-Semands & Corazzini, 1996).

Specific factors or characteristics may hinder a mental health professional's ability to provide adequate group therapy treatment. A study which examined attendance in a university counseling setting found that those with angry hostility and social inhibition were less likely to attend group therapy (MacNair-Semands, 2002). A client's anger can interfere with the mental health professional's ability to be helpful and compassionate (Van Wagoner, 2000). Other group members may also begin to push this member away or reject him or her because of the member's increased hostility, resulting in a low desire to attend group (MacNair-Semands, 2002). Those suffering from social inhibition may be hesitant to become involved in a group context. They may begin to display anxious avoidance due to the discomfort they feel being in such a setting (MacNair-Semands, 2002). Those with introverted personality types find self-expression difficult, limiting the benefits of group therapy treatment (MacNair & Corazzini, 1994). Placing these individuals in a group therapy modality may be detrimental because they may have difficulty being intimate with a group of strangers. It has been argued that these individuals attend individual therapy in order to learn the necessary skills to thrive in a group setting (MacNair & Corazzini, 1994).

Those suffering from alcohol or drug problems, somatic complaints, fighting with others, and those who are introverted were more likely to drop out of group therapy, in a university setting (MacNair & Corazzini, 1994). It was reported that those with alcohol problems often have low expectation for success in interpersonal relationships, use denial, are insensitive to mood states, and have faulty attribution patterns (Ferencik,

1989). Drinking is often used to compensate for the clients' lack of social assertiveness and their social anxiety (Mooney, Fromme, Divhanan, & Marlatt, 1987); when they are not drinking these characteristics manifest, making it less likely that they will attend group therapy treatment. Each of these variables needs to be addressed with these clients in order to promote treatment effectiveness.

Group Therapy Participation

Once the clients begin to attend group therapy their own discretion will dictate how comfortable they feel in discussing their currently symptomology. A client's feelings, which can be positive or negative, can be communicated in two ways, verbally and non-verbally; these need to be attended to by mental health professionals (Bostick, 1987). Participation in group therapy can also be active or passive. If a client chooses to be passive and not communicate during groups, the mental health professional should not assume that the client is being resistant to treatment. The mental health professional may need to meet with the client individually to discuss some of the environmental obstacles that may be interfering with his or her verbal participation in group therapy (Bostick, 1987). Verbal participation in group therapy treatment has been associated with an increased chance of change and improvement, while silent phases have been associated with a decreased chance of change and an increased likelihood of negative change (Fielding, 1983; Jaeger et al., 2013).

Factors impacting participation. In order to promote participation in a group therapy setting a mental health professional would need to explore whether or not the client views self-disclosure as threatening. Issues associated with self-disclosure may be a result of rejection by family, friends or other clients (Bostick, 1987). This issue, which

may need to be resolved, could help the client to feel comfortable participating in a group therapy modality (Bostick, 1987). Rejection from family and friends could result in bouts of depression. Depression could lead to being withdrawn and guarded. Often, those that experience loneliness or isolation, specifically older individuals, would benefit from group therapy treatment because it promotes social interaction (Potter, Atix, & Chen, 2006). The need to belong has been described as a fundamental human motive (Baumeister & Leary, 1995) and groups help satisfy this basic need. Social interaction within the group can result in cohesiveness within the group and can also promote acceptance of their symptomology (Butler & Fuhrman, 1983). Helping the client to feel comfortable in such a setting can encourage the client to discuss his or her personal struggles. Increasing a client's level of participation can influence his or her interpersonal style, allowing the client to improve the way that he or she relates to others (MacNair-Semands, 2000). Members within a group setting are much more likely to be sympathetic and understanding of another's problems and behaviors, increasing the possibility that he or she will not feel ridiculed when discussing his or her thoughts and self-destructive behavior. Increased participation can result in an increase in compliments and praise, helping increase one's self-esteem. Being able to open up and discuss one's problems in a group therapy setting can allow a client to feel more comfortable discussing his or her issues with family and friends.

A client's expectation for group therapy, including reservations and anxieties, has influenced interpersonal behaviors; it has also influenced a willingness to participate in a group therapy setting (Yalom, 1995). Fear of self-disclosure and finding it difficult to talk meaningfully about oneself has resulted in poor group participation as well as increased

rates of drop out (Sethna & Harrington, 1971; Baekeland & Lundwall, 1975; Wallsten, & Lindström, 2006). Mental health professionals can decrease such reservations by discussing with the client what his or her expectations for group therapy are. This has been shown to have a positive effect on group cohesion; it also increases satisfaction and comfort with the group therapy experience (Couch, 1995; Santarsiero, Baker, & McGee, 1995). This initial discomfort associated with group therapy needs to be dealt with effectively as early as possible in treatment. This decreases anticipatory anxiety and decreases inter-personal risk (i.e. feeling comfortable participating in group) (Burlingame et al., 2001). Interpersonal elements of cohesion which can be found in the client's sense of belonging, acceptance, personal commitment and allegiance to the group can result in increased participation. Intragroup elements including attractiveness and compatibility among group members, mutual liking and trust between group members, support, caring, mutual stimulation resulting in learning, and a collective commitment to the group, increase the likelihood of participation in a group therapy setting (Burlingame et al., 2001).

Therapist modeling. Therapist modeling in a group therapy setting can increase member to member interaction, because clients are more likely to model their behavior after the leader of the group as opposed to modeling behaviors after members within the group (Barlow, Hansen, Fuhriman, & Finley, 1982). The mental health professional can unambiguously set the norms and reinforce interaction leading to greater interaction between members (Burlingame et al., 2001). Client improvement and increased cohesion can occur when group interaction predicates itself on member to group and member to member relational themes (Fuhriman & Burlingame, 2000b). It is essential that clients

know how to provide and give appropriate feedback to one another, because each is vital when building interpersonal skills and member to member relationships. The acceptance of feedback during group therapy predicates itself on the psychological trustworthiness, closeness, and attraction among members (Burlingame et al., 2001). Clients who verbally participated in group therapy sessions tended to value the group and found the group session helpful. They stated that they received help, made a contribution, and found the session relevant (Sechrest & Barger, 1961), which increased their treatment adherence.

Leaving Against Medical Advice

Leaving against medical advice (AMA) has been problematic for patients and hospital staff. Irregular discharge, absconding, AWOL, eloping, and walking out are terms associated with leaving, AMA. Leaving AMA is essentially a client's choice to not follow and/or the right to not follow a physician's treatment recommendation. Clients threatening to sign out AMA sometimes are viewed as behaving irrationally and experiencing intense emotional distress, which may result in self-destructive behavior. Patients often request to leave AMA because they see no solution to cope with their emotional distress (Albert & Kornfeld, 1973; Pages et al., 1998). Contributing factors include unrecognized transference reaction, impasses with staff members, intense, unmet dependency needs, and family difficulties (Albert & Kornfeld, 1973). Staff members have recognized that patients began to manifest overt signs of emotional distress prior to leaving against medical advice; these included complaints of poor sleep, daytime restlessness, and bouts of anger (Albert & Kornfeld, 1973; Pages et al., 1998). These factors can occur in a multitude of settings and can drastically impact the client who is attempting to obtain the necessary help to address his or her psychiatric issues.

Rates of AMA. Multiple studies have been completed, examining clients leaving AMA, and identifying AMA discharges from general medical hospitals, psychiatric hospitals, and alcohol treatment centers (Smith, 1982; Pages, Russo, Winderson, Ries, Roy-Byrne, & Cowley, 1998). Approximately 1-2% of those in general hospitals left against medical advice (Smith & Telles, 1991). These rates fluctuated for those in rural hospitals, ranging from 0.6% to 2.2% (Seaborn & Osmun, 2004), and for those in inner city hospitals with approximately 13% leaving AMA (Anis, et al., 2002). Another study demonstrated that individuals are more likely to leave AMA on weekends (Greenberg, Otero, Villaneuva, 1994; Michelson, 1979). Approximately 20% of people who left AMA did so on multiple occasions, accounting for 40% of all AMA discharges (Kraut, et al., 2013). The rates of AMA discharges have fluctuated within psychiatric hospitals, ranging from 5% (Plansky & Johnston, 1976) to 16.7% (Miles, Adlersberg, Reith, Cumming, 1976), although Miles et al. (1976) report that this percentage could be as high as 31%. Those abusing drugs and alcohol were the highest diagnostic group that chose to leave AMA, at 11.71% (Kraut, et al., 2013). Those that received substance abuse treatment in the past and had experienced inadequate treatment for their addiction were at even greater risk for leaving AMA (Jeremiah, O'Sullivan, & Stein, 1995).

Factors influencing AMA. AMA discharges were more common in general medical hospitals for those who were male, those who had lower average household incomes, had a history of drug and alcohol abuse, and had HIV/AIDS (Kraut, et al., 2013). Ibrahim, Kwoh, & Krishnan (2007) reported that clients who choose to leave AMA are members of disenfranchised groups, which include those of different race or ethnic backgrounds, excluding Caucasian, those of lower socio-economic status, with

Medicaid insurance or no insurance, as well as those patients suffering from mental health issues. African Americans patients have also displayed higher rates of self-discharge, which may be due to the patients' perceptions of disrespect and receiving unfair treatment (Blanchard & Lurie, 2004). It is essential that mental health professionals provide empathy, unconditional positive regard, and validate the client, showing the client that he or she is being heard. This may decrease the likelihood that the client will feel disrespected, thus decreasing the chance of leaving, AMA. Family involvement prior to and during treatment can decrease the likelihood that one will leave AMA because it can demonstrate to the client that others are supportive in his or her road to recovery (Miles et al., 1976; Brook, Hilty, Liu, Hu, & Frye, 2006).

A study conducted by Schofield (1978) demonstrated that the high rates of AMA discharges from alcohol treatment programs were due to higher internal/ lower external locus of control scores, indicating that these individuals felt as though they were unable to control their destinies (Greenberg et al, 1994). A patient may disagree with the physician's judgment of his or her health status and feel as though he or she is ready to be discharged (Ibrahim, et al., 2007). A client who feels that his or her questions are being evaded or met with indifference may become angry, feels too proud, or becomes frightened, resulting in threats to leave treatment (Albert & Kornfeld, 1973; Pages et al., 1998). Other variables that have been associated with AMA discharges include: overwhelming fear, depression, and psychotic reactions (Albert & Kornfeld, 1973; Brook et al., 2006). Those experiencing fear, psychotic symptoms, or those in denial of their mental illnesses can develop increased anxiety, feeling the need to escape (Freedman et

al., 1958; Brook et al., 2006). These clients are often labeled “uncooperative” (Kaplan, 1956).

Mental health professionals or other hospital employees who dismiss clients as “uncooperative” may minimize the mental instability of the client in a holistic manner. Research utilizing the Minnesota Multiphase Personality Inventory showed that males that left AMA from an inpatient psychiatric facility tended to have depressive neurosis and females had personality disorders (Daniels, Margolis, & Carson, 1963). Those that were discharged AMA from a general hospital had a significantly greater incidence of suicide attempts and antisocial acts (Milner, 1966; Brook et al., 2006). These clients also had increased hospital readmissions up to 180 days after discharge in a general hospital setting (Garland, et al., 2013). Also, those that left AMA tended to have prior inpatient psychiatric admissions, demonstrating that failure to accept treatment may be a function of the chronicity of their psychiatric conditions (Smith, 1982). Each of these characteristics needs to be considered when working with a client threatening to leave AMA. It may be helpful as a mental health provider to sit and listen to the client's concerns and determine whether he or she would be willing to re-consider leaving treatment. A mental health professional may need to bargain with the client, discussing the benefits of staying in treatment. If the client continues to be adamant about leaving against medical advice, a psychiatrist or medical doctor would need to evaluate the client's mental capacity and determine whether or not the client has the capability to make such a decision. If a psychiatrist or medical doctor feels that the client is still a danger to himself or herself or to others, these professionals may choose to convert the status from voluntary to involuntarily, thus preventing the client from leaving AMA,

because this could be a liability to the medical doctor and to the hospital (Byatt, Pinals, & Arian, 2006).

Chapter 7: Hypotheses

Proposed hypotheses

It is hypothesized that statistically significant differences will be found between individuals in an inpatient psychiatric facility who perceived that they were coerced into receiving treatment, as compared with those who did not perceive that they were coerced into receiving treatment, with respect to their attendance in group therapy sessions, participation in group therapy sessions, and choice to leave treatment against medical advice. These hypotheses are as follows:

1. Participants who perceive that they were coerced into receiving treatment, as compared with those who did not perceive that they were coerced into treatment, are less likely to attend group therapy sessions while in an inpatient psychiatric facility.
2. Participants who perceive that they were coerced into receiving treatment, as compared with those who did not perceive that they were coerced into treatment, are less likely to participate in group therapy sessions while in an inpatient psychiatric facility.
3. Participants who perceive that they were coerced into receiving treatment, as compared with those who did not perceive that they were coerced into treatment, are more likely to leave against medical advice while in an inpatient psychiatric facility.

Chapter 8: Method

Overview

According to Cascardi & Poythress (1997), there is a need for research to examine the association among perceived coercion, treatment outcomes, and participation in treatment. Research evidence has suggested that those who have experienced high levels of coercion are often less inclined to participate in treatment and as a result will experience poorer treatment outcomes. This association needs to be investigated. In order to measure perceived coercion, the MacArthur Admissions Experience Scale (AES-15) was administered retroactively. This measure consists of 15 true/ false, or yes/no questions and identifies levels of perceived coercion, perceived negative pressures, and process exclusion (Bindman et al., 2004). It examines the effects of influence, control, choice, and freedom because each can affect one's level of perceived coercion (Iversen, et al., 2002). Measures of treatment participation including self-reported recollection of attendance and participation in assigned group therapy sessions and treatment outcomes (whether the client completed treatment or left AMA), are the dependent variables. This study investigated the relationship of level of perceived coercion and its impact on treatment attendance and participation in group therapy as well as treatment outcome.

Participants

One hundred, fifty-two participants (73 men and 79 women) who fulfilled the inclusion and exclusion criteria participated in the study which examined perceived coercion and its impact on group therapy attendance, participation, and leaving against medical advice. A total of one hundred eighty-two participants attempted to take part in the study, although thirty were not eligible. Participants ranged in age from 19 to 89, with

a mean age of 45.16 years old. The participants represented those from various racial and ethnic backgrounds, including African American, White, White (non-Hispanic), Asian/Pacific Islander, Hispanic, Multiracial, and Native American.

Inclusion Criteria

Clients were eligible to participate in the study if they were 18 years of age and over, were able to read English, were able to write in English, and had been admitted to an inpatient psychiatric treatment facility within the previous three months. Each client was required to provide consent to take part in the study.

Exclusion Criteria

Clients were excluded from the study if they had ever had a diagnosis of Dementia or a traumatic brain injury, intellectual disability, or a developmental delay (i.e., Autism, Asperger's, or Pervasive Developmental Disorder), or if they had a legally appointed guardian, were under the age of 18, were not able to read or write in English, had never been admitted to an inpatient psychiatric facility or had been admitted to one more than 3 months ago. Each of these criteria could impact the client's perception of whether or not he or she was being coerced into receiving treatment. If a client met one of these requirements the client would be deemed ineligible to take part in the study.

Recruitment of Subjects

Participants were recruited in one of several ways. In one method, Facebook, Twitter, Craigslist, or user group, advertisements related to this study were posted on pages or message boards pertaining to mental health or mental health support. In addition, permission was obtained from the National Institute of Mental Health (NIMH), National Alliance on Mental Illness (NAMI), crisis response centers (CRCs), inpatient

mental health facilities, intensive outpatient programs (IOPs), partial hospitalizations, and outpatient mental health facilities to provide brochures advertising the study, or to post a research call on their websites. Furthermore, all potential participants were asked to share information about this study with as many other individuals as possible who were 18 and over and had been hospitalized in an inpatient psychiatric facility within the previous three months, thus utilizing a snowball sampling method.

Measure

MacArthur Admission Experience Survey (AES-15; Gardner et al., 1993).

The AES-15 is composed of the Perceived Coercion Scale, Perceived Negative Pressure Scale, and the Process Exclusion Scale. As seen in Bindman et al. (2005), those who scored between 8 through 15 were classified as clients who have experienced high levels of perceived coercion, and clients who scored between 0-7 were classified as clients who have experienced low levels of perceived coercion. These scores were obtained by clients who were asked to evaluate, retrospectively, their admissions intake experience during their most recent inpatient psychiatric admission, assuming it had occurred within the previous three months.

The MacArthur Perceived Coercion Scale (MPSC) is a 5-item yes/no or true/false, self-report questionnaire, which acknowledges the amount of autonomy the clients lacked during the admissions process and their decision to enter an inpatient psychiatric facility, specifically in regard to their influence, control, choice, freedom, and idea. (The items included: "I felt free to do what I wanted about coming into the hospital." "I chose to come into the hospital." "It was my idea to come into the hospital." "I had a lot of control over whether I went into the hospital." "I had more influence than anyone else on

whether I came into the hospital.”) (Gardner et al., 1993). Scores on the Perceived Coercion Scale can range from 0 to 5 (mean=1.75, SD= 2.07) (Gardner et al., 1993). Item scores are summed to arrive at an overall score, with a higher score indicative of higher perceived coercion. A score of 5 exhibits the maximal level of subjective coercion (Gardner et al., 1993; Hoge et al., 1997). The Perceived Coercion Scale exhibits good reliability and validity (Gardner et al., 1993). The scale typically yields reliability coefficients in the 0.80s and is used within the literature as an effective measure for identifying those coerced into treatment (Hiday et al., 1997; Swartz, 1999). The Perceived Coercion Scale also demonstrates good internal consistency reliability (Gardner et al., 1993) and an acceptable test-retest stability over time (Cascardi, Poythress, Ritterband, 1997). The item-total correlations ranged from 0.60 to 0.73, indicating satisfactory homogeneity; Cronbach's alpha was 0.86, indicating high internal reliability (Hiday et al., 1997).

The Perceived Negative Pressure Scale is a 6-item, yes/no or true/false self-report questionnaire, indicating that others threatened or forced the client into coming to the hospital for treatment. (The items included: “People tried to force me to come into the hospital”. “Someone threatened me to get me to come into the hospital.” “Someone physically tried to make me come into the hospital.” “I was threatened with commitment.” “They said they would make me come into the hospital.” “No one tried to force me to come into the hospital.”) The Perceived Negative Pressure Scale's item-total correlations ranged from 0.54 to 0.70. Cronbach's alpha was 0.84, indicating high internal reliability (Hiday et al., 1997).

The Process Exclusion Scale looked to measure fairness or inequity of the admissions process. It is a 4-item scale, yes/no or true/false self-report questionnaire that examined the motivation of others involved in the client's admissions process, the client's chance to speak and discuss his or her concerns during the admissions process, and having his or her recollections of the situation be taken into consideration during this process. The scale was used to detect motivation, respect, validation, and fairness of the admissions process. (The items included: "I had enough of a chance to say whether I wanted to come into the hospital." "I got to say what I wanted about coming into the hospital." "No one seemed to want to know whether I wanted to come into the hospital." "My opinion about coming into the hospital didn't matter. "). The Process Exclusion Scale had an item-total correlation of 0.52 to 0.60 and Cronbach's alpha of 0.76 (Hiday et al., 1997).

Design

This study used a retrospective cross-sectional observational study. A retrospective cross-sectional observational design was chosen primarily because of its common utilization in the social sciences and its efficacy in examining the direction, strength, and variability of relationships between variables.

For this study a MANOVA was chosen because it would explore the relationship between a client's perception of coercion at admission and his or her group therapy attendance and participation. A chi-square analysis was chosen to examine the relationship between perceived coercion and leaving AMA. The initial design of the study called for an equal number of men and women to take part in the study.

Procedure

The study was completed over the course of 12 months (September 2014 to September 2015) after obtaining approval from Philadelphia College of Osteopathic Medicine's Institutional Review Board (IRB). The study included participants who were 18 years and older, had been admitted to an inpatient psychiatric facility within the previous 3 months, and had access to the Internet. Participants were recruited via a brochure, which directed them to complete the AES-15 on Survey Monkey, a website used to collect survey data, (<http://surveymonkey.com>). When accessing the questionnaire, the participants were first informed about the study's purpose and procedures (Appendix A). All participants had the right to withdraw from the study at any time without explanation. Participation in the study was completely anonymous. After agreeing to the letter of solicitation, respondents completed the demographic questionnaire to supply descriptive data including age, and to determine if they fulfilled the inclusion or the exclusion criteria (Appendix B). Individuals who did not meet criteria were forwarded to a page notifying them that they did not meet the study requirements, and were thanked for their time and participation.

Individuals who did meet criteria were prompted to complete the study questionnaire, which included demographic and personal information, AES-15, level of their group therapy attendance, level of their group therapy participation, and whether or not they chose to leave against medical advice (completed in that order). In order to examine the participant's level of group therapy attendance, participants were asked, "I attended group therapy during my most recent inpatient psychiatric stay?" (1= all of the time, 2= most if not all of the time, 3= some of the time, 4= very little of the time, or 5=

none of the time). To identify their level of group therapy participation they were asked to rate statements such as, "I participated in group therapy during my most recent inpatient psychiatric stay? (scores ranging from 1 to 5- as listed above). Last, to identify whether or not the participant chose to leave against medical advice the client was asked to respond to statements such as, "During my last inpatient psychiatric hospitalization I left against doctor's advice" (yes or no) (Appendix C). Instructions for completing each measure were provided. Upon completion, participants were asked, "How did you learn about this study?"; different recruitment efforts were listed. At the completion of the survey participants who were interested in taking part in the raffle were directed to e-mail the investigator under a separate e-mail address account in order to be entered into a raffle to win a \$50 gift card. This satisfied anonymity and confidentiality for the client. Last, the data collected from the survey, including the demographic/ personal information, AES-15 questions asked about group therapy sessions attendance and participation, and whether they chose to leave AMA; responses were placed in a spreadsheet and entered into the Statistical Package for the Social Sciences (SPSS).

Chapter 9: Results

Statistical Analysis

A power analysis was performed for the two statistical analyses being utilized in the current study (A one-way multivariate analysis of variance (MANOVA) and chi square analysis/ phi coefficient). The highest number of requisite participants necessary was chosen ($n=158$) with a medium effect size, an alpha level set at 0.05, and a power of 0.80. A chi square test was used to test the third hypothesis. Tests of the three hypotheses were conducted using Bonferroni adjusted alpha levels.

Demographics

Participant demographics are described in Tables 1 through Table 11. Percentages, means, standard deviations, and ranges, when appropriate, were used to describe key characteristics of the sample. The clients ages ranged from 19-years old to 89-years old ($M= 45.16$, $SD= 14.23$). Descriptive statistics were used for organization and summarization of participant data for the overall eligible sample ($N= 152$). Table 12 describes the number of clients who were classified as coerced vs. not coerced from the results of Table 11 (a total score between 0 to 7 on the AES-15 was defined as not coerced and a total score between 8 to 15 on the AES-15 as coerced).

Table 1*Racial composition of the sample*

Race	%	n
White	2.6%	4
White, non-Hispanic	53.9%	82
African American	23.7%	36
Hispanic	7.2%	11
Asian Pacific Islander	4.6%	7
Native American	1.3%	2
Multiracial	6.6%	10
Other (please specify)	0.0%	0
Total (N= 152)		

Table 2*Self-reported gender of the participants*

Gender	%	n
Male	48.0%	73
Female	52.0%	79
Other (please specify)	0.0%	0
Total (N= 152)		

Table 3*Educational level achieved by the participants*

Education	%	n
Completed education to 8th grade	0.0%	0
Completed education to high school	0.7%	1
High school graduate, diploma or the equivalent (for example: GED)	21.7%	33
Some college credit, no degree	17.8%	27
Trade/ technical/ vocational training	5.3%	8
Associates degree	7.2%	11
Bachelor's degree	36.2%	55
Post-graduate degree	10.5%	16
Doctorate degree	0.7%	1
Total= (N= 152)		

Table 4*Marital status of the sample*

Marital Status	%	n
Single	27.0%	41
Married or domestic partnership	48.7%	74
Widowed	6.6%	10
Divorced	7.2%	11
Separated	10.5%	16
Total= (N= 152)		

Table 5*Self-reported times participants been previously admitted to an inpatient psychiatric facility?*

Number of inpatient psychiatric admissions	M	SD	Range
Total= (N=152)	3.74	3.19	0-16

Table 6

Percentage of patients reporting voluntarily or involuntarily admission during their most recent inpatient psychiatric hospitalization

Admission status	%	n
Voluntarily admitted (chose to be admitted)	83.6%	127
Involuntarily admitted (forced to be admitted)	16.4%	25
Total= (N= 152)		

Table 7

Location of most recent inpatient psychiatric stay?

Inpatient psychiatric hospital setting	%	n
An acute facility/ community inpatient mental health facility	88.8%	135
A state hospital	0.0%	0
A forensic inpatient facility	0.0%	0
An extended acute inpatient hospital facility	11.2%	17
Total= (N= 152)		

Table 8

Number of days hospitalized during your most recent inpatient psychiatric hospitalization?

Number of days hospitalized	<i>M</i>	<i>SD</i>	<i>Range</i>
	8	5.05	3 to 36
Total= (N= 152)			

Table 9

Number of times participants were involuntarily committed (if previously involuntarily committed)?

Number of involuntary admissions	<i>M</i>	<i>SD</i>	<i>Range</i>
	0.70	1.27	0 to 8
Total= (N= 152)			

Table 10

Frequency distribution of self-reported discharge diagnosis given to you at the time of discharge?

Discharge diagnosis	%	n
Anxiety Disorder	6.6%	10
Depression NOS or Major Depression	43.4%	66
Bipolar Disorder	28.9%	44
Schizophrenia	4.6%	7
Schizoaffective Disorder	11.8%	18
Panic Disorder	2.0%	3
Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder NOS, or other eating disorder	1.3%	2
Impulse Control Disorder	0.7%	1
Other (please specify)	0.7%	1
* Alcohol Dependence		
Total= (N= 152)		

Table 11

Frequency distributions of items on the Admissions Experience Survey (AES-15)

I felt free to do what I wanted about coming into the hospital		
	%	n
Yes	65.1%	99
No	34.9%	53
Total= (N= 152)		
*Y=0, N=1		
People tried to force me to come into the hospital		
	%	n
Yes	55.9%	85
No	44.1%	67
Total= (N= 152)		
*N=0, Y=1		

I had enough of a chance to say whether I wanted to come into the hospital		
	%	n
Yes	67.1%	102
No	32.9%	50
Total= (N= 152)		
*Y=0, N=1		
I chose to come into the hospital		
	%	n
Yes	68.4%	104
No	31.6%	48
Total= (N= 152)		
*Y=0, N=1		
I got to say what I wanted about coming into the hospital		
	%	n
Yes	69.1%	105
No	30.9%	47
Total= (N= 152)		
*Y=0, N=1		
Someone threatened me to get me to come into the hospital		
	%	n
Yes	55.3%	84
No	44.7%	68
Total= (N= 152)		
*N=0, Y=1		
It was my idea to come into the hospital		
	%	n
Yes	64.5%	98
No	35.5%	54
Total= (N= 152)		
*Y=0, N=1		
Someone physically tried to make me come into the hospital		
	%	n
Yes	32.2%	49
No	67.8%	103
Total= (N= 152)		
*N=0, Y=1		

No one seemed to want to know whether I wanted to come into the hospital		
	%	n
Yes	32.9%	50
No	67.1%	102
Total= (N= 152)		
*N=0, Y=1		
I was threatened with commitment		
	%	n
Yes	50.7%	77
No	49.3%	75
Total= (N= 152)		
*N=0, Y=1		
They said they would make me come into the hospital		
	%	n
Yes	60.5%	92
No	39.5%	60
Total= (N= 152)		
*N=0, Y=1		
No one tried to force me to come into the hospital		
	%	n
Yes	40.8%	62
No	59.2%	90
Total= (N= 152)		
*Y=0, N=1		
My opinion about coming into the hospital didn't matter		
	%	n
Yes	33.6%	51
No	66.4%	101
Total= (N= 152)		
*N=0, Y=1		
I had a lot of control over whether I went into the hospital		
	%	n
Yes	63.8%	97
No	36.2%	55
Total= (N= 152)		
*Y=0, N=1		

I had more influence than anyone else on whether I came into the hospital		
	%	n
Yes	66.4%	101
No	33.6%	51
Total= (N= 152)		
*Y=0, N=1		

Table 12*Coercion Levels based on the AES-15*

Classification	%	n
Coerced	36.8%	56
Not Coerced	63.2%	96
Total= (N= 152)		

** A score of 0-7 on the AES-15 would classify the client as not coerced. A score of 8-15 would classify the client as coerced

Hypothesis I

Hypothesis I: Participants who perceive, at admission, that they are being coerced into receiving treatment are less likely to report attending group therapy sessions during an inpatient hospitalization. To test for hypothesis I a MANOVA was utilized. Level of coercion is the independent variable with 2 levels (no coercion or perceived coercion) and group therapy attendance as the dependent variable (1= all of the time, 2= most if not all of the time, 3= some of the time, 4= very little of the time, 5= none of the time).

Hypothesis II

Hypothesis II: Participants who perceive, at admission, that they are being coerced into receiving treatment are less likely to report participating in group therapy sessions during an inpatient hospitalization. To test for hypothesis II a MANOVA was utilized. Level of coercion is the independent variable with 2 levels (no coercion or perceived coercion) and group therapy participation as the dependent variable.

A multivariate of analysis of variance using coercion as the independent variable (coerced vs. not coerced) and the likelihood of participation (1= all of the time, 2= most if not all of the time, 3= some of the time, 4= very little of the time, 5= none of the time) as the dependent variables was calculated. The total number and percentages of each of the clients that took part in the study regarding their group therapy attendance and group therapy participation are listed in Table 13 and Table 14).

Table 13

Frequency Distribution for Group Therapy Attendance: I attended group therapy during my most recent inpatient psychiatric stay?

Response	%	n
All of the time	22.4%	34
Most if not all of the time	36.8%	56
Some of the time	25.0%	38
Very little of the time	15.1%	23
None of the time	0.7%	1
Total= (N= 152)		

Table 14

Frequency Distribution for Group Therapy Participation: I participated in group therapy during my most recent inpatient psychiatric stay?

Response	%	n
All of the time	19.7%	30
Most if not all of the time	32.2%	49
Some of the time	28.9%	44
Very little of the time	16.4%	25
None of the time	2.6%	4
Total= (N= 152)		

The assumptions of the MANOVA were met. First, there was a significant, positive correlation between the dependent variables. Second, Box's Test of the

hypothesis that the observed co-variance matrixes, which generalize the notion of co-variance to multiple dimensions, of the dependent variables are equivalent across groups was not significant. This means that the co-variance matrixes were equivalent across groups (Box's $M = 1.250$, $p = .746$). The Levene's test of Equality of Error Variances, testing the assumption that the variances of the dependent variables is equivalent across groups, was not significant, meaning that the variances across the groups on the dependent variables are in fact equivalent, demonstrating homogeneity of variance (as shown on Table 15).

Table 15

Levene's test of Equality of Error Variances

Dependent Variables	F	Sig.
Group Therapy Attendance	0.965	0.327
Group Therapy Participation	0.635	0.427

A multivariate analysis revealed that there was an overall significant difference between the groups (Wilks' $\lambda = .497$, $F(2, 149) = 75.52$, $p < .000$, partial eta squared = .50). Then, a test of the significance of the differences between the groups revealed that there was a significant difference between the coerced and not coerced groups on attendance in group therapy ($F(1, 150) = 130.98$, $p < .000$, partial eta squared = .76) and groups on participation in group therapy ($F(1, 150) = 128.68$, $p < .000$, partial eta squared = .462). The means and standard deviations of the dependent variables across groups are included in Table 16.

Table 16*Descriptive Statistics*

Dependent Variables	Coercion Level	M	SD	n
Group Therapy Attendance	Not Coerced	1.82	0.73	96
	Coerced	3.25	0.77	56
Group Therapy Participation	Not Coerced	1.95	0.80	96
	Coerced	3.45	0.76	56

These findings reveal that those who were not coerced reported attending group therapy between *all of the time and most if not all of the time*. Those who stated that they were coerced into receiving treatment reported that they attended group between *some of the time and very little of the time*. Also, the findings demonstrate that those who were not coerced reported participating in group therapy *all of the time and most if not all of the time*, but those that were coerced reported that they participated in group between *some of the time and very little of the time*.

Hypothesis III

Hypothesis III: Participants who perceive that they are being coerced into receiving treatment at admission are more likely to leave against medical advice while in an inpatient psychiatric facility. To test for this hypothesis, a chi-square analysis was utilized, identifying whether or not there is a relationship between perceived coercion and leaving against medical advice. Specifically, the chi-square analysis was used to determine if significant relationships between perceived coercion and leaving against medical advice exists. The two dependent variables, leaving against medical advice or completing inpatient psychiatric treatment, are measured at a nominal level. Because there were over 20 clients within the study and no more than 20% of the cells had an expected value under 5, a chi-square analysis was used (Field, 2009). A Phi Coefficient

was also calculated to measure the strength of association between the two categorical variables.

In order to test Hypothesis 3, a chi-square analysis using coercion as the independent variable (coerced= 1 vs. not coerced= 0) to examine the relation between leaving against medical advice was calculated. (did not leave against medical advice= 2, left against medical advice= 1) (Table 17).

Table 17

Leaving against medical advice: During my last inpatient psychiatric hospitalization I left the hospital against the doctor's advice (i.e. left AMA)?

Response	%	n
Yes	11.8%	18
No	88.2%	134
Total= (N=152)		

The relation between these variables was significant, because coercion is negatively correlated with leaving against medical advice (Phi Coefficient= -0.311 $p < .000$) as evident in Table 18.

Table 18

*Chi-square analysis-
Symmetric measures*

Nominal by Nominal	Value	Approximate Significance
Phi Coefficient	-0.311	0.000
Cramer's V	0.311	0.000
Pearson Chi-Square	14.704	
N of Valid Cases	152	

This correlation means that those that were coerced at admission were more likely to leave the hospital against medical advice. Also, those that were not coerced at admission were less likely to leave against medical advice (Table 19). The effect size is 9%, demonstrating that 9% of the variability of leaving against medical advice is associated with whether or not one was coerced into receiving treatment.

Table 19*Chi square analysis*

Coercion Level	Left Against Medical Advice		Total
	Yes	No	
Not coerced	4	92	96
Coerced	14	42	56
Total	18	134	152

Chapter 10: Discussion

Benefits of the study

The study examined outcomes of coerced and non-coerced acute admissions of adult general psychiatric clients to a psychiatric hospital. The study included clients that were coerced and those that were non-coerced into treatment; coercion became evident after the clients completed the AES-15. Each client was recruited via Survey Monkey, after receiving his or her permission to take part in the study. This study demonstrated the impact that perceived coercion can have on one's group therapy attendance, group therapy participation, and choosing to leave AMA, suggesting the need to address the concept of coercion with clients at the start of their inpatient psychiatric treatments. As a result, CRCs may want to administer the AES-15 at admission to differentiate those with higher levels of perceived coercion and provide intervention in order to address this issue. Having the opportunity to identify those with higher levels of perceived coercion can allow staff to address the impact of coercion with these clients, in the hope that their levels of coercion will diminish, and as a result, they will become more active in attending and participating in their group therapy. Decreasing the client's level of perceived coercion would be beneficial for administrators as well as policy makers because it would decrease the likelihood of the client being re-admitted to an inpatient psychiatric facility. A study conducted by Kaltiala-Heino et al. (1997) demonstrated that those with lower levels of perceived coercion were more likely to adhere to their outpatient psychiatric treatment, continue to take their psychotropic medications, and continued to show improvement over time, decreasing the likelihood of re-admission.

As evident in the results, those that displayed higher levels of perceived coercion were less likely to be engaged in their inpatient psychiatric treatment. With the utilization of the recovery model, a collaborative effort between client and mental health professionals, which instills empowerment, hope and optimism, knowledge, and life satisfaction throughout treatment, allows a client to access and engage in effective treatment. Resnick, Fontana, Lehman, and Rosenheck (2005) defined empowerment as the power to take responsibility for one's treatment and the feeling that the mental health professionals involved in one's treatment are helping the client achieve personally meaningful goals. Hope and optimism are measured by the client's expectations for the future, determination in accomplishing one's goals, and desire for maintaining relationships with supportive individuals, each of whom instills hope. Knowledge, as defined within Resnick et al's (2005) study, is the perception of the client's knowledge about his or her own mental health and treatment. Last, life satisfaction was acknowledged as feeling satisfied, specifically as it pertains to the client's family, friendships, housing, safety, and sense of community (relationships with others and safe housing).

In order to foster a sense of empowerment, hope and optimism, knowledge, and life satisfaction, mental health professionals should employ motivational interviewing (MI), which is a collaborative, person-centered counseling style that is designed to elicit and strengthen a person's own motivation for change (Miller & Rollnick, 2012) and is also aligned with the central principles of the recovery model. The MI counselor attempts to understand the client's frame of reference, clarifies the relationship between current behavior and goals, and supports self-efficacy in order to increase motivation for change.

Utilizing this form of treatment in an inpatient psychiatric facility has helped clients to be more engaged and more likely to attend treatment (Martino, Carroll, O'Malley, & Rounasville, 2000; Swanson, Pantalon, & Cohen, 1999), leading to improved psychosocial outcomes.

Summary of Findings

A series of statistical analyses were conducted to test each of the hypotheses. Results supported hypothesis one, which focused on identifying whether or not the level of perceived coercion experienced by a client at admission has a direct effect on a client's attendance in group therapy. Statistical analyses showed that clients who experienced high levels of perceived coercion at admission were less inclined to attend group therapy during their inpatient psychiatric admission.

Results also supported hypothesis two, as it was focused on identifying whether or not the level of perceived coercion experienced by a client at admission has a direct effect on the client's participation in group therapy. Statistical analyses demonstrated that clients who experienced high levels of perceived coercion at admission were less likely to participate in group therapy throughout his or her inpatient psychiatric hospitalization.

Last, findings also supported hypothesis three, which focused on recognizing whether or not the level of perceived coercion experienced by a client at admission had a direct effect on whether the client chose to leave against medical advice. Statistical analyses verified that clients who experienced high levels of perceived coercion at admission were more likely to leave the hospital against medical advice. These findings are significant because they demonstrate that a client's level of perceived coercion at admission to an inpatient psychiatric facility has a direct effect on his or her attendance in

groups, participation in group therapy, including the choice to stay and complete the course of treatment.

These results are in accord with previous research indicating that clients who felt formally coerced into seeking treatment may be less likely to attend treatment, to participate in treatment, and potentially, to request to leave against medical advice (Cascardi & Poythress, 1997; Gardner et al., 1993).

The results of this study are in alignment with Brehm's (1968) psychological reactance theory, which posits that individuals believe they possess a set of "free behaviors" that they can choose to act upon at any time (Dillard & Pfaur, 2002). This theory specifically indicates that when people desire freedom of choice and when that freedom of choice is removed by external constraints (i.e. perceiving that they are coerced into admission to an inpatient psychiatric facility) then there will be a negative, aversive response (i.e. clients will be less likely to be invested in treatment, which would be evidenced by their lack of attendance or participating in group therapy), as a way to assert their freedom (Baumeister, Catanese, & Wallace, 2002). Being mandated to an inpatient psychiatric facility will in essence limit their range of alternatives (i.e. attending another form of treatment or not receiving treatment). As such, this threat of limiting their freedoms can result in an excitatory motivational state, specifically devised at recollecting their freedoms, and motivating clients to engage in freedom-restoration behaviors (Fogarty, 1997, Miron & Brehm, 2006). Clients who want to re-establish freedom will often act opposite to what was desired by the manipulative source (Kirchler, 1999). This was evident in the results of hypotheses one, two, and three. That is, clients who were coerced into receiving treatment were less inclined to attend and participate in

group therapy, and were more inclined to leave against medical advice, because each of these was desired by the manipulative source.

Limitations

Several limitations should be considered. First, baseline scores were assessed up to three months after discharge from an inpatient psychiatric hospital and not at the time of the admission. Symptoms may have already changed significantly between the time of admission and the first assessment (Kallert, 2011); frequently, there is a decrease in symptom recollection. Studies have shown that attitudes of clients towards their mental health hospitalization change from admission to discharge; their attitudes become more positive and that this change is related to their feelings of being helped by the treatment that they received during their hospitalization (Edelsohn & Hiday, 1990; Hiday, 1992). The clients recruited for this study may have felt less coerced had their interview closely followed their admission to the inpatient psychiatric hospital or shortly after their discharge. Recall bias could also affect the results because clients may have forgotten that they were subjected to coercion after feeling much more improved psychologically over time or even following discharge from an inpatient psychiatric stay (Fiorillo et al., 2012; Hassan, 2006). They too may have gained better insight into their situations and illnesses after their symptoms decreased over the three month period of time, and they recognized the benefit of treatment and the necessity of the coercive measures that they received (Hassan, 2006; Katsakou & Priebe, 2006). Also, this study is reliant on self-report measures. Clients may have been inclined to produce a better picture of themselves when providing a detailed account of their experiences while in an inpatient psychiatric facility in the previous 3 months. Having access to their records would have provided a

more accurate account of their group therapy attendance, group therapy participation levels, and their choices about whether or not to leave against medical advice.

Second, this study revealed threats to statistical conclusion validity. The limited sample size ($N= 152$) reduced the overall power and effect size. The small sample size not only limits the generalizability of the findings beyond the participants that took part in the study, but also causes difficulty in detecting actual differences that may have existed.. However, the current study had sufficient power to make a meaningful step in understanding the role of perceived coercion and its impact on group therapy attendance, participation, and departure against medical advice for those in an inpatient psychiatric facility.

Next, because these participants were generally recruited via internet and other online means, there is a possibility of selection bias. Individuals discharged from an inpatient psychiatric facility who are engaged in online forums, such as Facebook, Twitter, Craigslist, blogs, organizations, etc. may display characteristics different from those who do not utilize such services. These individuals may be less likely to be homeless and may be more financially stable, as well as be organized enough to visit libraries in order to have access to computers. They, too, may have additional family support, social support, and encouragement from others, urging them to obtain treatment. Such individuals may be more willing to seek treatment and services for their mental instability, making it more likely that they may have attended groups, participated in groups, and were less likely to leave against medical advice. Therefore, the generalizability of this study is affected and may not be a representative sample of those coerced and those not coerced into receiving inpatient psychiatric treatment.

This study depended on self-report to provide accurate information regarding inclusion criteria. There is the possibility of dishonesty among individuals. Specifically, there is the likelihood that individuals may under-report, over-report, or even state that they are eligible to take part in the study possibly in order to obtain the gift card, which was offered as an incentive to take part in the study. Although rewards are often part of studies, they do bear significant limitations because of people's motives to enter the study. Similarly, because the study is of retrospective design, the participants' memories may have been compromised due to the extended period of time between having been hospitalized and having taken part in the study. A retrospective study relies on the accuracy of written record or recall of individuals. It is difficult to control bias and confounders. Both of these could have affected the generalizability of the results of the study. Distorted responses could also have skewed the data, resulting in invalid findings.

Next, this study would have benefitted from being a longitudinal study, following clients from their inpatient psychiatric treatment into their aftercare treatment (Monahan et al., 1995). This would have been beneficial in distinguishing whether or not a client's perception of coercion had changed after receiving treatment. It would also have helped in identifying a relationship between perceived coercion and adherence to outpatient psychiatric treatment.

Last, Appendix C of the survey, states: "What was your discharge diagnosis given to you at the time of your discharge?"; the discharge diagnoses does not list Post-traumatic stress disorder (PTSD). This is problematic because approximately 7-8% of individuals admitted to an inpatient facility will have PTSD at some point in their lives (Breslau, Davis, Andreski, 1991) and these rates increase to approximately 11-30% for

those who have served in the military (Greiger et al., 2006). PTSD had been classified as an anxiety disorder in the *DSM-IV-TR* but now has been included within Trauma- and Stress- or Related Disorders within the *DSM-5*. Although there was the possibility for the client to choose the discharge diagnosis as “other”, and then have clarified this with the PTSD diagnosis, no one did so. Clients may have chosen to list their PTSD diagnosis with the anxiety disorders or may have chosen another diagnosis that was listed within the options provided.

Implications

Given the fact that this study is examining the usage of coercion, legal status could impinged on the clients' group therapy attendance and participation. Receiving treatment that was against the client's will could lead to the clients feeling that they could be committed once again against their will (Swartz, Swanson, & Hannon, 2003), leading the clients to alienate themselves from treatment (Rogers, 1993; Hiday et al., 1995). Clients may become reluctant to seek inpatient or outpatient psychiatric care in the future, may be reluctant to use psychotropic medications, and may be non-adherent to the recommended care (Campbell & Schraiber, 1989; Rogers, 1993).

Mental health professionals often believe that they are acting in the client's best interest when they attempt to persuade an ambivalent client to enter inpatient psychiatric treatment. Clinicians are often attempting to remove the threat of harm or to improve the situation of others, also known as beneficence, while also attempting to promote nonmaleficence, which is to do no harm. Many of those admitted voluntarily still report feeling coerced when entering treatment, which can influence a client's group therapy attendance, group therapy participation, and decision to leave against medical advice. As

a result one may need to consider alternative levels of care to decrease such levels of perceived coercion or feelings of coercion; this needs to be explored and addressed during the admissions process and/or during group therapy sessions. It is essential that mental health professionals consider the ramifications that perceived coercion can have on a client's current inpatient psychiatric treatment, outpatient psychiatric treatment, and future psychiatric treatment. Factors including clients being able to express their views, believing that their views are considered during the clinical decision making process, and feeling that they are being treated with dignity, respect, politeness and concern during the admissions process (Lidz et al., 1995; Lind, Kafner, & Earley, 1990; Cascardi & Poythress, 1997). Each of these can influence a client's level of perceived coercion at admission.

It is necessary that mental health professionals consider these variables during the intake process in order that clients may obtain treatment that can diminish their mental instability. Also, it is necessary to recognize the fact that clients who experienced higher levels of perceived coercion at admission, when compared to those who had lower levels of perceived coercion at admission, were less likely to attend group therapy, to participate in group therapy, and were more inclined to leave AMA, as evident in the results of this study. Therefore, it is necessary that mental health professionals create groups that are oriented toward addressing the concept of coercion shortly after a patient is admitted to an inpatient psychiatric facility. Having the opportunity to obtain additional psycho-education about coercion and its use could help in decreasing the level of perceived coercion, allowing the patient to benefit from the interventions provided. It also may be necessary for mental health professionals to devote more time to those admitted with

higher levels of perceived coercion in order to develop a well-established therapeutic alliance. This could help clients become more accepting of the treatment provided on the inpatient psychiatric unit. As clinicians it is an ethical obligation to abide by the APA Ethical Principles of Psychologists and Code of Conduct and advocate for justice and autonomy, in order to increase the likelihood that the client will benefit from the treatment received while in an inpatient psychiatric facility. Allowing the clients to express their rights, opinions, desires and dignity throughout the admissions process will promote social equality for all clients served, and also will allow clinicians to uphold the rights and responsibilities of the profession.

Future Direction

Future research should replicate this study with a larger sample in order to increase data collected. A larger sample size would increase the power and perhaps provide a better conceptualization of perceived coercion and its effects on inpatient psychiatric treatment. Also, clients should be recruited as early on as possible into their treatment, which would allow clients to provide a more accurate account of their levels of perceived coercion during the admissions process to an inpatient psychiatric facility. This may minimize the barriers that could become evident throughout treatment if coercion is evident. Results of this study included a majority of those primarily speaking English. Future research should include a larger portion of non-English speaking clients, in order to obtain a sample size that is much more representative of the population.

This study suggests that crisis residential centers should consider providing a perceived coercion measure at admission in order to identify whether or not this variable will impact their adherence to inpatient treatment and to their follow up after care.

Interventions within hospitals should be developed (i.e. designing a specific group that is geared toward addressing the concept of coercion throughout a client's treatment) and tested to improve outcomes for clients who perceive coercion in the admissions process (Kallert et al., 2011).

According to Hoge et al. (1997) diagnosis and the quality of the clinician-client interaction were important factors in the admissions process. It may be necessary to administer a clinician-client alliance scale, specifically examining the relationship between client and primary therapist and client and psychiatrist, in conjunction with the AES-15 during one's treatment to distinguish whether the therapeutic alliance correlates with perceived coercion. This can help differentiate whether or not the therapeutic alliance directly impacts perceived coercion and adherence to treatment during a client's psychiatric hospitalization.

Last, in order to determine whether or not treatment was effective in diminishing a client's perception of coercion during admission, the AES-15 should be administered at discharge. This would allow researchers to obtain pre- and post- perceived coercion scores. Research should focus on administering a study, consisting of both an experimental and a placebo group, examining the effects of perceived coercion during treatment. All clients entering treatment would take the AES-15 in order to distinguish whether they qualify as having high or low levels of perceived coercion. The experimental group, which would consist of those with high levels of perceived coercion, would have two group therapy sessions specifically addressing the concept of coercion. The placebo group would also participate in two therapy sessions, although that one would not address coercion. After the two sessions, specifically geared at the concept of

coercion, the experimental group would continue with their daily treatment plan. At discharge all clients would be re-administered an AES-15. This study would determine whether or not this intervention had been effective at decreasing perceived coercion during a client's hospitalization by comparing their AES-15 scores at admission with their AES-15 scores at discharge.

Overall, additional research pertaining to perceived coercion and its effect on group therapy attendance, group therapy participation, and leaving against medical advice needs to be explored more thoroughly. Identifying factors that reduce or foster perceptions of coercion while in the admissions process as well as throughout one's hospitalization are areas that need to be addressed in future studies. Identifying strategies that provide the client with a voice and with feeling validated and comfortable with the admissions process will improve a client's adherence to treatment while hospitalized; these strategies will also assist with adherence to aftercare, improve quality of treatment, reduce a client's rates of re-admission to an inpatient psychiatric facility, and provide the client with the tools needed to understand and manage his or her illness.

Summary and conclusion

High levels of perceived coercion have a direct effect on a clients' treatment throughout their inpatient psychiatric hospitalization, specifically their rate of attendance and participation in group therapy, as well as their being more prone to leaving against medical advice. Therefore, throughout their admissions process, having others validate their opinions and hear their views regarding their hospitalization would decrease their levels of perceived coercion at admission. The utilization of the recovery model, which is based on the concepts of strength and empowerment, encourages clients to have more

control and choice in their treatment because it allows for increased control and initiative in the clients' lives. It increases clients' motivation levels, promoting self-responsibility. The recovery model initiates the development of hope, obtaining a secure base and sense of self, developing supportive relationships, becoming empowered, increasing social inclusion, coping skills, and meaning, allowing the clients to obtain the tools to understand and manage their illnesses as well as increasing the likelihood of treatment compliance (Frese, Stanley, Kress, & Vogel-Schbilia, 2001). Those employed at CRCs and inpatient psychiatric facilities should receive training not only about the role and effects of perceived coercion and its impact on treatment but also on the use and impact of the recovery model. This training could allow clinicians and physicians to understand how coercion has a direct impact on a client's treatment adherence as well as psycho-education pertaining to the concepts of coercion and its forms. Obtaining this information would allow staff members to decrease the likelihood of employing coercive techniques at admission, thus increasing the client's choice to participate in treatment during the client's inpatient psychiatric hospitalization.

Overall, to benefit clients who have been hospitalized in inpatient psychiatric facilities, providing them with a voice, allowing them to feel heard, and being polite and respectful is critical in establishing a foundation for treatment and therapeutic alliance. Allowing the clients to speak about their situations, and demonstrate that acting in good faith and without bias can increase the likelihood that the clients will continue with the treatment being offered. As psychologists, it is imperative to recognize the effect that perceived coercion can have on a person's well-being; it is also necessary to provide

intervention because this can have a direct effect on their adherence to their current and future treatment.

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Appendix A (Consent to take part in the study)

The purpose of this research project is to see whether perceived coercion, which is force or intimidation to obtain cooperation, affects group therapy attendance, participation, and leaving against medical advice for those in an inpatient psychiatric facility. This research project is being completed by Joseph DiCondina, MS, LPC, as part of his doctorate dissertation at the Philadelphia College of Osteopathic Medicine (PCOM).

Your participation in the research study is voluntary. You may choose to leave this study at any time. The risks to being in this study are very small. Some of the benefits include gaining an understanding of perceived coercion and its impact on inpatient psychiatric treatment so that those who need psychiatric treatment can be better helped.

In order to see whether you qualify to be in this study you will be asked some questions about you and your previous psychiatric treatment.

Your information will be kept private. The survey will not contain information that will personally identify you. After finishing the survey you will be asked if you would be interested in entering a drawing for a \$50 gift card. This information (your email address) will be kept separate from your survey.

If you have already completed the survey, please do not respond a second time as this will affect the results. If there is another person you feel would be willing to fill the survey out, please forward this email with the link so they may participate as well.

If you have any questions about the research study, please contact Joseph DiCondina at josephdic@pcom.edu. You may also contact Joseph's advisor, Dr. Barbara Golden at barbarago@pcom.edu. This research has been reviewed by the PCOM IRB. If you have any questions about that review, please contact Theresa Stem in the Office of Research and Sponsored Programs at teresaf@pcom.edu.

Sincerely,

Joseph DiCondina, MS, LPC
josephdic@pcom.edu

Barbara Golden, Psy.D., ABPP
barbarago@pcom.edu

APPENDIX B (DETERMINING WHETHER THE CLIENT IS ELIGIBLE)

Are you 18 years of age?

Yes

No

Are you able to read English?

Yes

No

Are you able to write in English?

Yes

No

Have you been hospitalized in an inpatient psychiatric facility within the last 3 months?

Yes

No

Have you been diagnosed with Dementia or a Traumatic Brain Injury?

Yes

No

Do have you a legally appointed guardian?

Yes

No

Have you been diagnosed with an intellectual disability or developmental diagnosis?

Yes

No

APPENDIX C

Gender: Male Female Other (please specify)**Age:** years old**What is your race?** White White, non-Hispanic African American Hispanic Asian/Pacific Islander Native American Multiracial Other

Education: What is the highest degree or level of school you have completed? *If currently enrolled, highest degree received.*

- Completed education to 8th grade
- Completed education to high school
- High school graduate, diploma or the equivalent (for example: GED)
- Some college credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Post- graduate degree
- Doctorate degree

Marital Status: What is your marital status?

- Single
- Married or domestic partnership
- Widowed
- Divorced
- Separated

How many times have you been previously admitted to an inpatient psychiatric facility?

During your MOST RECENT inpatient psychiatric hospitalization were you?

Voluntarily admitted (chose to be admitted)

Involuntarily admitted (forced to be admitted)

During your MOST RECENT inpatient psychiatric stay you were hospitalized in?

An acute facility/ community inpatient mental health facility

A state hospital

A forensic inpatient facility

An extended acute inpatient hospital facility

How many days were you hospitalized during your MOST RECENT inpatient psychiatric hospitalization?

If you have been involuntarily admitted previously how many times have you been involuntarily committed?

What was your discharge diagnosis given to you at the time of your discharge?

Anxiety Disorder

Depression NOS or Major Depression

Bipolar Disorder

Schizophrenia

Schizoaffective Disorder

Panic Disorder

Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder NOS, or other eating disorder

Impulse Control Disorder

Other

Admission Experience Survey: Short Form

These questions pertain to your MOST RECENT INPATIENT PSYCHIATRIC STAY.

1. I felt free to do what I wanted about coming into the hospital.
 Yes No
2. People tried to force me to come into the hospital.
 Yes No
3. I had enough of a chance to say whether I wanted to come into the hospital.
 Yes No
4. I chose to come into the hospital.
 Yes No
5. I got to say what I wanted about coming into the hospital.
 Yes No
6. Someone threatened me to get me to come into the hospital.
 Yes No
7. It was my idea to come into the hospital.
 Yes No
8. Someone physically tried to make me come into the hospital.
 Yes No
9. No one seemed to want to know whether I wanted to come into the hospital.
 Yes No
10. I was threatened with commitment.
 Yes No
11. They said they would make me come into the hospital.
 Yes No
12. No one tried to force me to come into the hospital.
 Yes No
13. My opinion about coming into the hospital didn't matter.
 Yes No
14. I had a lot of control over whether I went into the hospital.
 Yes No

15. I had more influence than anyone else on whether I came into the hospital.
____ Yes ____ No

Group Therapy Attendance: I attended group therapy during my most recent inpatient psychiatric stay?

- ____ All of the time
____ Most if not all of the time
____ Some of the time
____ Very little of the time
____ None of the time

Please describe which groups you had enjoyed, did not enjoy attending, or any additional comments about your group therapy attendance: _____

Group Therapy Participation: I participated in group therapy during my most recent inpatient psychiatric stay?

- ____ All of the time
____ Most if not all of the time
____ Some of the time
____ Very little of the time
____ None of the time

Please describe any additional comments that you may have or want to voice about your group therapy participation during your most recent inpatient psychiatric hospitalization?

Leaving Against Medical Advice: During my last inpatient psychiatric hospitalization I left the hospital against the doctor's advice (i.e. leaving AMA, abscond, AWOL, leaving before my 72 hour notice was completed)?

____ Yes

____ No

How did you learn about this study? (Please list below)
