

Family Members' Existential and Moral Dilemmas With Coercion in Mental Healthcare

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Abstract

Coercion in mental healthcare does not only affect the patient, but also the patient's families. Using data from interviews with 36 family members of adult and adolescent people with mental health problems and coercion experiences, the present narrative study explores family members' existential and moral dilemmas regarding coercion and the factors influencing these dilemmas. Four major themes are identified: the ambiguity of coercion; struggling to stay connected and establishing collaboration; worries and distress regarding compulsory care; and dilemmas regarding initiating coercion. Subsequently, coercion can reduce, but also add burden for the family by creating strains on family relations, dilemmas, (moral) distress and retrospective regrets; this is reinforced by the lack of information or involvement and low-quality care. Subsequently, it is a moral obligation to develop more responsive health services and professionals who provide more guidance and balanced information to increase the possibilities for voluntary alternatives and informed decision making.

Introduction

Research shows that a serious long-lasting illness or disability can have a huge impact on the patient's family's health, daily life and life course (Lindemann, 2014). Illness creates a need for increased competence in coping with problems or maneuvering in health services and adds challenges in maintaining interconnectedness and relationships among family members. The family has to strike a balance between their own and the ill relative's needs, trying to negotiate a good working balance between formal and informal care (Adamson & Donovan, 2005; Segev, Levinger, & Hochman, 2017; Witham, Haigh, Mitchell, & Beddow, 2017). Families in mental healthcare have similar overarching challenges (Harden, 2005; Lawn & McMahon, 2014). In addition, they might face special challenges because of changes in personality and mental capacity, unconventional behaviour and stigma (Trondsen, 2012). They also more commonly experience compulsory care in terms of, for example, involuntary hospitalisation, forced medication or coercion in the community, such as community treatment orders. This compulsory care, or coercion, might not only affect the patient, but also the family, because of the serious impact it might have on a person's integrity (Hoyer, 2000). The family is involved in coercion in several, partly contradictory ways (Yeates, 2007). They might contribute to preventing coercion or to facilitating the delivery of care in the least restrictive manner by assisting the person in seeking help or through being an advocate for the patient (Buck & Smith, 2015; Owens & Brophy, 2013). Or on the contrary, family members might exercise power and coercion by initiating coercion from the mental health services or by giving consent to coercive treatment on behalf of a child under 16 years old (Rugkasa & Canvin, 2017). Coercion might also have a direct impact on the family members themselves—for example, by witnessing unwanted involuntary hospitalisation or force inflicted on a loved one (Hallam, 2007; Ranieri et al., 2015).

Prevailing research finds various, partly conflicting, views and experiences regarding coercion among family members. Family members often have positive views of the use of coercion for providing treatment and care for the ill family member, and giving respite and control for themselves in a chaotic situation (Rowe, 2012). However, coercion might also create dilemmas. Coercion is not often undertaken lightly, but family members feel compelled to act. This can create a mixture of ambivalent feelings of relief and guilt (Jankovic et al., 2011; Karp, 2001; Ranieri et al., 2015; Wilkinson & McAndrew, 2008). Coercion might also strain family relations because patients tend to feel abandoned or defeated. This might lead to distrust, family conflicts, and destroyed emotional bonds, making collaborative development of care between the patient and family members challenging (Arya, 2014; Wallcraft, 2012). Moreover, the family members' experiences are influenced by the shaping of mental healthcare. For example, involuntary hospitalisation—after the initial feeling of relief and a sense of resolution—can be experienced as stressful because of a lack of support and involvement in care or worries about poor treatment and care (Hallam, 2007; Jankovic et al., 2011; Rowe, 2012). Furthermore, the organisation of mental healthcare and lack of family involvement can contribute to estranging the family from the ill family member, making relationships difficult and time-consuming to repair. Such experiences create feelings of powerlessness and isolation, combined with a need to be recognised and a desire for partnership. In summary, although coercion might create relief, it can also be a complex, traumatic or stressful experience for the family and can sometimes adversely affect the family members' mental and physical well-being.

Research aims

The burden of ill mental health on the family has been researched extensively (Lawn & McMahon, 2014), and the previous studies show dilemmas regarding the use of coercion. However, there is still a lack of knowledge about family members' existential and moral dilemmas and concerns regarding coercion and the factors influencing these dilemmas. This is especially true regarding family members and an adolescent with a mental illness because the use of coercion occurs in a vulnerable part of the child's life, when there is a stronger parental responsibility (Sanci, Sawyer, Kang, Haller, & Patton, 2005). Hence, the overall aim of the present article is to develop in-depth knowledge about coercion from a family perspective. Our research questions are the following: 1) Which moral concerns and dilemmas do family members face in relation to the use of coercion in mental healthcare, and how do these dilemmas affect family members? 2) How does the organisation of mental healthcare and health professionals' ways of working influence the family members' dilemmas, and how can their concerns be handled better (e.g., by improved quality of care)?

To grasp the family members' concerns and dilemmas, how these unfold over time and the interactional processes with mental health services, we use a combination of a thematic and dialogical narrative analysis (Frank, 2010; Riessman, 2008).

Theoretical framework

The analysis will draw on insights from theories on coercion, use a triadic perspective, as well as theories on families, and research on family's dilemmas regarding mental health problems.

The use of coercion and the triadic perspective

Coercion is a broad phenomenon and includes a formal (legally regulated) and informal use (such as pressure and threats) in all kinds of mental health services (Bindman et al., 2005).

The serious effects of coercion on individual autonomy and liberty make coercion an intrinsically moral phenomenon (Hoyer, 2000), giving rise to ethical challenges and moral distress for everyone involved. Coercion is also understood as a contextual and situational phenomenon, one that is deeply intertwined with the mental health problem itself, the home situation, the provision of alternative treatment and care opportunities and the shaping of mental healthcare (Norvoll & Pedersen, 2016).

The triadic perspective underlines the importance of the interactions between the family, the ill family member and the mental health services for the family's situation, relationships and dilemmas during coercion (Amering, Mikus, & Steffen, 2012), and it includes a more holistic perspective on the patient as a person and full family member, for example, as a daughter or a son (Molyneaux, Butchard, Simpson, & Murray, 2011). It also shows how the family's dilemmas and burdens might stem from the mental health services and communication with staff (Karp, 2001). Therefore, many solutions to the family's dilemmas must be sought in the reshaping of mental healthcare or in better triadic interactions between the patient, family and health professionals.

The family and their existential and moral concerns

Our analysis of family members' dilemmas also draws on theories from sociology and family ethics, underlining the richness of the family's life-world (Lindemann, 2014; Smart, 2007).

The family is a site for biography, love, interconnectedness and emotional bonds, as well as responsibility, power relations and information-sharing patterns. These basic family traits and relational aspects are important reasons why mental health problems, coercion or low-quality

care have such a large impact on the health and well-being of family members. For example, research shows that spouses felt they belonged within the relationship, rather than in a caring role. Love, loyalty and commitment were the central emotions, often creating significant emotional pressure (Lawn & McMahon, 2014).

Serious mental health problems also give rise to many new existential and moral dilemmas and challenges for the family, that is, normative uncertainties of attitudes and actions as right or wrong. Moral concerns and dilemmas arise on the individual level (e.g., reasoning and moral integrity), but are also socially situated and influenced by the institutional processes that shape and constrain them (Lindemann, Verkerk, & Walker, 2009).

The family's existential and moral dilemmas often occur because the illness so thoroughly disrupts family life, a sense of coherence and control of everyday life, calling attention to the taken-for-granted, normally invisible boundaries of social relationships (Karp, 2001).

Subsequently, the family is posed with the challenge of finding a good balance between involvement and distance and between wanting protection and allowing freedom to manage outside the protective family circle. They also must deal with emotions regarding the feelings of responsibility and commitment to care (Lawn & McMahon, 2014; Rowe, 2012), which again are based on ongoing interpretations of what they morally owe their ill family member. Finding such a balance is a process, characterised by efforts to negotiate a balance between the requirements of care and maintaining the family members' own well-being. Further, a decision to withdraw from the obligation to care can be emotionally very difficult because the family members then are confronted with their internalised conception about what it means to be morally good. The moral boundaries of caregiving are, therefore, constantly under construction and are dependent on the meanings generated through the ongoing interactions. However, the family members' existential and moral dilemmas are also influenced by the

mental health system and might—as we will show in this article—increase during coercion, which intensifies these challenges and puts extra strain on the family relationships.

Methods

Study context

Despite having unique variations, Norwegian legislation and political debates regarding coercion follow international trends. Mental healthcare in Norway is publicly funded and organised as ‘specialised health services’, that is, hospital trusts (hospitals and outpatient clinics), and as ‘community health services’ (general practitioners, local emergency care, and home care). Formal coercion (e.g. seclusion and restraints) is mainly performed within specialised health services for adults or adolescents while community health services require involuntary hospitalisation. Parents must consent to treatment on behalf of their child who is 16 years old or younger, and parents of adolescents aged 16 to 18 receive the necessary information to fulfil their parental duties. According to the Mental Health Care Act, compulsory care may be applied if it is clearly the best solution for the person concerned or if there is an obvious and serious risk to the person’s or others’ health, lives and safety. An independent Supervisory Commission assesses the use of coercion and complaints from patients and next of kin.

This study is part of a large-scale project in Norway called ‘Mental healthcare, ethics and coercion’ (PET), running from 2011 to 2016. The project aims to explore views on and experiences with coercion and involvement in care from all stakeholders’ perspectives as well as implementing systematic ethics reflection in mental health care in order to be able to deal with ethical challenges regarding the use of coercion in a better way.

Research design

This study has a qualitative design that uses focus groups and interviews with individuals and parents. We chose to use a focus group because group interactions can stimulate an open, democratic dialogue and more expansive stories about people's experiences with coercion (Frank, 2010; Riessman, 2008). The participants' stories of their views on and experiences with the use of coercive measures constituted the data for the in-depth analysis.

Ethical considerations

The study was conducted in accordance with the Helsinki Declaration. The informed written consent of the participants was obtained. The study was evaluated by the Regional Committee for Medical and Health Research Ethics (REK South-East, September 13, 2012, project number 1329) and approved by the National Data Protection Official for Research (NSD September 18, 2012, project number 31302) and the local research committees at the participating hospitals. We encouraged the ill family member to self-regulate his or her confidentiality individually and inside the group. Further, anonymity is preserved in the text, and all names are pseudonyms.

Recruitment and participants

We used a combination of purposive and convenience recruitment of participants. The inclusion criteria were broad because we were interested in the general views and experiences of coercion: adults (over the age of 18) with an adult or adolescent family member who had mental health problems and had experienced coercion. No potential participants were

excluded. Family members to adult patients were recruited through local carer organisations in three counties in south-eastern Norway, and family members to adolescents were recruited from three adolescent wards in two hospitals.

The study includes three focus group interviews and one individual interview with family members to adults, and three focus groups and one interview of parents with adolescents, totalling 36 family members and 33 ill family members. Interviews were conducted between November 2012 and March 2013. All relatives had been involuntarily admitted once or several times. Four adolescents had been hospitalised with parental consent before the age of 16. They had various mental health problems and coercion experiences, such as involuntary commitment, forced medication or restraints. Experiences varied from one recent episode to multiple and extensive use of coercive measures over several years. Many participants were still using services. An overview of the participants, type of family relations and mental health problems is shown in Table 1.

Table 1. Overview of the participants

	Family members to adult patients (N= 20)	Family members to adolescent patients (N = 16)
Age of interviewee	30–65 years	35–55 years
Family relations	Father (1) Mother (13) Sister (2) Daughter (3) Female partner to male (1)	Parents (5) Mother (5) Father (1)
Age of ill family members	23–57	16–20
Type of mental health problems	Psychosis/schizophrenia (majority) Bipolar disorder Depression/suicidal thoughts	Anorexia nervosa Anxiety/depression Suicidal thoughts/self-harm

	ADHD and Asperger's syndrome Substance abuse problems	Psychosis/bipolar episode
Duration of problems	1–20 years	One short episode–5 years.

Interviews

The focus group interviews, consisting of 4–7 participants, were held in the carer-organisations' meeting rooms or in the hospitals, and the individual and parents interviews were in private locations. Group interviews lasted for 3 hours, including a break, and the individual and parental interviews lasted for about two hours. The long interviews made it possible to get longer sequential stories from each participant, as well as dialogue between the participants that display various experiences and views. Individual and parents interviews were conducted by Norvoll (first author) and the group interviews by mainly Norvoll and Hem (second author). Norvoll was the moderator. The researchers assisted one another in being attentive to the group dynamics and in asking suitable follow-up questions.

Semi-structured interview guides were finalised by Norvoll and Hem after review by the research group (See Appendix 1). The interviews started with the researchers giving an introduction, which included the researchers saying that all views and experiences with coercion were welcome. Afterwards each participant introduced his or her situation and experiences with coercion. The interviews were then organised around five main themes: What is coercion? Is coercion right or wrong, and why? (including ethical dilemmas). Is the way coercion is carried out of importance? What are their views on and experiences with involvement in care, particularly when coercion is used? Are there alternatives to coercion?

Participants were also encouraged to illustrate their views and experiences with concrete examples and were given the opportunity to create and convey their own narratives.

Data analysis

The interviews were taped and transcribed verbatim in Norwegian, and informal conversations with the participants were written down as field notes. The transcripts and field notes of the interviews (approx. 600 pages) formed the basis for the narrative analysis of the data, that is, interpreting text that has a storied form characterised by consequential linking of events or ideas (Riessman, 2008). We focused on personal narratives that encompassed longer sections of talk, which gave us extended accounts of the participants' lives in the context and the actors' interpretations of their experiences.

In the current study, we chose to use a thematic narrative analysis, focusing mostly on the content of what was 'told', that is, the participants' reports of events and experiences, rather than aspects of 'the telling' (Riessman, 2008, p. 54). However, we also conducted a limited socio-dialogical narrative analysis with a close reading of the transcripts that concerned the participants' dialogues during the group interviews (Frank, 2010), hence analysing the interactive and co-constructive aspects of their stories. The interactions between those who told and those who were listening were used as valuable data sources to obtain a better understanding of the participants' dilemmas.

The study was not originally designed to have a narrative analysis. However, the initial data analysis showed the social embedded nature and complexity of the participants' dilemmas regarding coercion and that *time* was important for the family members' meaning-making of coercion because many had long-lasting experiences (Rowe, 2012). Thus, we found that a narrative analysis allowed for more holistic and sequential approach than fragmented coding

of the data. Narrative analysis was also useful in doing more contextual analysis of their experiences and that aligned with our sociological and triadic perspectives. It also enabled us to explore the contrast between their expectations to get help and their actual experiences, for the family members' meaning-making of coercion (Riessman, 2008; Rowe, 2012). Further, a narrative analysis was useful in understanding the moral complexity of coercion and the participants' moral dilemmas because stories often have an 'inherent morality' or reflect the 'ethos of self' that comes before the learning of ethics principles (Frank, 2010; Nelson, 1997). The evaluative aspects of stories also often reflect people's sense of what counts as good and bad, dilemmas regarding how to act and how not to act and tales of blame and forgiveness (Riessman, 2008).

The data analysis consisted of five main steps: 1) Norvoll and Hem read all the transcripts to obtain an overall impression of the participants' views and experiences, considering important issues and themes. 2) Afterwards, after considering a need for narrative analysis as described above, we conducted a thematic narrative analysis based on a narrative reconstruction of the participants' biographical experiences (Williams, 2008). In practice, Norvoll sorted and saved each participant's stories using Nvivo Version 10. Thereafter, we made a summary of each participant's personal story, encompassing the story of coercion as it unfolded during the interview. These summaries were useful for intensifying the individual narrative and elucidating on the contexts of these experiences over time. Furthermore, we analysed the compressed stories to identify the main themes regarding the participants' views on and experiences with coercion in and across the individual stories. 3) Afterwards, Norvoll related the findings to the transcripts to secure the context of meaning and made a socio-dialogical narrative analysis of the themes that occurred in the group discussions. 4) Thereafter, the findings from the narrative analysis of interviews with family members to adults were compared with the stories from parents to adolescents to identify the similarities and

differences in their views and experiences. 5) Finally, Norvoll and Hem re-analysed the empirical findings based on the theoretical perspectives described above, which is presented in the Findings section. Lindemann (third author) participated in the final theoretical analysis and writing.

The findings are illustrated by several participants' own words. Additionally, we present a more comprehensive and contextualised picture of family members' experiences and dilemmas by elaborating on five stories told by Linda, Ellen, Ann, the parents Bill and Laura, and Mary. These stories were chosen because they give a vivid and illustrative picture of many family members' experiences and dilemmas regarding coercion and the triadic processes that shaped their experiences.

Findings

Many stories were emotional and of an existential nature. We found four major moral concerns in the participants' stories about coercion. The stories are ordered almost chronologically by starting with the problems at home, then the drama of involuntary hospitalisation, their worries about the family member's situation under compulsory care and, finally, the ongoing dilemmas regarding initiating or collaborating in exercising coercion. The four concerns are not separate; rather, they must be viewed as intertwined but with different focal points because they manifest themselves in different ways and support each other. The family members had many similar concerns, even across age groups. However, parents who had adolescents with a mental illness were particularly concerned about the potential harm of coercion because of the adolescent's young age, the possible adverse effects on the adolescent's future and confidentiality problems that conflicted with their parental responsibilities.

‘Necessary, but terrible’—Coercion as an ambiguous solution to care responsibilities

Facing many challenges: getting help and accurate placing of responsibility for the problems

The family members said that they faced many challenges concerning the mental health problems, stemming from the emotional strains of seeing their loved ones suffer or continuous worry and unease about the situation or safety issues, such as suicide threats, self-harm, starving and aggressive episodes. Further, they struggled with many practical care obligations or the person’s problems of functioning in daily life, for example, such as not being able to function as a mother, not wanting to go to school or not being able to take care of the finances and the home. These challenges sometimes created a desperate urge to get help for the ill family member (often expressed as: *he needs help!*) or necessary respite for them as a family member.

Furthermore, many participants expressed a deep sense of responsibility in taking care of their beloved family member. This feeling created many relational and moral dilemmas. Several participants told us that the feeling of responsibility made it hard to leave the ill person, even when they felt exhausted and needed relief from the burden of caring for their loved one. They also struggled with how to draw a morally acceptable line between what should be their responsibility versus the healthcare system, or the ill family member.

This theme is seen in Linda’s story. Since Linda was a child, her mother had been ill and undergone several involuntary hospitalisations. Linda said that she felt obliged to be responsible for her mother, even if Linda was tired. She could not just leave. However, she desperately felt she needed to start drawing boundaries. This presented her with an existential moral dilemma: should she say no? Should she draw some boundaries to save herself? What about the consequences for her mother? Could her mother manage (or not) on her own or be left alone to healthcare services? Linda’s story, as well as the others, reflects a negotiation or balancing the

family member's responsibility of care versus letting public health services take over. Linda wanted the responsibilities to be shared with the health services and thought that mental healthcare should take more caring responsibility. However, she also wanted a change in the way the services approach people with mental health problems; she would have liked the services to focus on the patients as human beings and establish dialogues among all the stakeholders involved regarding how to proceed with the care.

Coercion as an ambiguous solution

Many family members described coercion as a way to handle the challenges they faced because of the mental health problems and to secure the necessary help for their ill family member. Karin, the mother of a 39-year-old daughter, put it this way: *'It is not easy at all. However, I feel that when she gets psychotic again, she needs coercive measures. Otherwise, she might injure herself'*. Several participants also said that coercion, such as involuntary hospitalisation or forced medication, was important in alleviating their own emotional strains and practical workload of caring for a family member daily, sometimes even around the clock. Further, coercion had the potential to create order and control in an unpredictable situation or could contribute to order and stability in the family, increasing the whole family's quality of life and freedom.

However, even though the family members found that coercion could contribute to alleviating these problems, coercion was also experienced as a dramatic and difficult intervention. Hence, one important dilemma from the participants' stories was the ambiguity of coercion, or coercion as a double-edged sword. The ambiguity of coercion can be seen in Linda's story. Linda found the use of coercion as degrading for her mother and contributing to bad family relationships. Still, it was also necessary because it created relief and security, as she stated: *'When our mother*

is so sick that we don't know what is going to happen in half an hour, it is vital for us that there is the possibility of using coercion'. The same ambiguity of coercion was also shared by Irene, who had a schizophrenic daughter in her thirties: 'She injured herself seriously. Yes, it was both hell and relief when she was taken care of'.

The ambiguity of coercion as a solution was often intensified by the mental health services' lack of responsiveness to the family members' struggles. For example, the fact that Linda's mother was offered help too late was a heavy load on the family because they ended up with coercive interventions that they had to take responsibility for. What followed coercive hospitalisation was perceived as deeply problematic and formed part of the ambiguity.

I think the use of coercion is a good thing because of self-harm or suicide—in order to protect the person. However, it's the treatment they receive when coercion is undertaken that I find very, very scary. I mean, the patients are dehumanised, they are treated as if they belong to a different race. ... It's so terrible for us to be aware of all the things going on inside the hospital: overmedication, they don't receive any treatment because there is never a question of getting a consultation with a psychologist, to talk about what's wrong, or what we as family can do, to meet a social worker and so on. And this brings up the question: What are we going to do about the use of coercion? We are so dependent on it, at the same time it's so terrible.

Such situations created difficulties because the mother was admitted too late, which again led to heavy medication. Heavy medication was not a treatment option; it was degrading to the person. Linda was desperate because she felt that the use of coercion was detrimental, yet she depended on it. For Linda, the importance of early intervention was that it prevents the use of coercion. Furthermore, she was frustrated because when her mother was coercively admitted, Linda was not informed by the staff. This was especially troubling because she had been

actively engaged before her mother was admitted against her will, for instance, staying up all night and looking after her in case she became self-destructive.

‘I just wanted to convey to her that we love her’—Struggling to stay connected and establishing collaboration during involuntary hospitalisation

Coercion is dramatic and threatens the connections within the family

The seriousness of the situation leading to the use of coercion and the coercive interventions themselves (e.g. the use of police) made coercion a dramatic event, even for family members. This is clear in the story from Linda above and in Ellen’s story about her daughter in her early forties. She had been committed many times over the last 10 years. Now, she stayed at home and did not take medication. Ellen told us that the use of coercion was dramatic for everybody involved, even when there was no ‘objective’, external drama.

Ellen and other participants related the drama of involuntary hospitalisation to the intrinsic seriousness of coercion itself, noting the intruding effects on the person’s autonomy and self-determination. The dramatic impact on family members was also closely related to their emotional bonds and interconnectedness with the ill family member: ‘*What affects them affects us*’, Ellen stated. Another participant, Karen, told us: ‘*My sister and I are very close. When my sister recovers after a psychotic episode, we have long conversations about everything. She is a fantastic woman*’. This closeness left family members vulnerable in their interactions with healthcare professionals, and the experience of being excluded could intensify feelings of distress. For example, Ann talked about being locked out of her son’s life by the healthcare services, even though she, as a mother, has been involved when he was ill: ‘*I receive only cold letters*’, she said while weeping, referring to the formal information sheets she received when

her son was restrained with belts, all done without her being able to speak to him or health professionals.

The drama of coercion for the family members was also related to the fact that coercion, such as involuntary hospitalisation, could lead to a rupture in the relationship between the patient and the family. Consequently, one issue in the family members' narratives was the importance of sustaining the relationship with their ill family member, despite the use of coercion. *'I just wanted to convey to her that we love her'*, said Ellen; she related that during one hospital stay, she was not allowed to visit her daughter and asked the professionals to tell her daughter, who was in seclusion, that she loved her. She had a strong wish to stay connected and struggled to maintain a close relationship when they were separated because of the hospitalisation and seclusion. Only later did she discover that her message had not been passed on to her daughter.

For Ellen, the fact that the professionals did not understand the importance of staying connected with her daughter during important times in their lives was very disappointing. For Ellen, it felt like the professionals did not acknowledge her vulnerability as a mother when her daughter was coercively admitted.

The need for communication with the health professionals

The stories from most participants revealed the significance of good communication with health professionals. For example, Ellen said that in the beginning, when her daughter was hospitalised, it was very scary to meet the 'system' from within. She felt overwhelmed with questions. She needed the healthcare professionals to engage in a dialogue with her. Whether the healthcare professionals smile, show respect and demonstrate that they acknowledge the family member is an important indicator of whether coercion is perceived as a violation or help, as a failure or success. Thus, the way coercion was exercised was important for Ellen and most

of the other participants in our study. Being shown trust and acceptance from health professionals could be of great help and relief. The opposite, for instance, was when Lisa cried as she told us how traumatised their family felt when her son was involuntary admitted with assistance from the police:

Our son has never been violent or anything like that. It is SO humiliating! Once I received a phone call when they had put him in belts. They did it because he refused to take his medication. This hurts so much! I am almost not able to talk about it.

Dealing with harmed family relations: A need for reconciliation work

Despite variations, several family members said that the use of coercion, or fear of coercion, had created distrust, tension, distance, conflicts and broken bonds between the family and their ill relatives. Coercion could also contribute to difficult communication patterns in the family or to reduced and concealed information in the family, for example, in terms of withholding information, resisting sharing information or ‘faking well’ during consultations with health personnel. The family members tried to solve the dilemma of securing care and keeping trusting family relations by avoiding being too directly involved, for example, during involuntary admission. Some also told us that they had been through a long process of forgiveness regarding the involuntary hospitalisation. Only a few had received assistance from health services in improving communication about the coercive episode (e.g., involuntary admission), but those who did find it helpful.

‘But how does he feel inside?!’ Worries and distress regarding compulsory care

Many participants also reported that they felt uneasy about their family member being under compulsory care. It was pivotal for them to know how their family member was doing and to feel ensured that they received good treatment and care.

Fear of harm

Several participants said that they feared that coercion—for example, involuntary hospitalisation or forced medication—could have a negative impact on the family member. Liv, who was the mother of a 28-year-old man who had been involuntarily admitted several times, talked about her son’s detention:

It [coercion] is frightening because I don’t know how he feels about it, if he is in pain. And I also have this fear that he will resist. Well, my son hasn’t resisted that much yet, but I didn’t know that beforehand. So it’s this terrible anxiety if he will put up a fight, and, really, how does he feel inside?

Such worries and uneasiness were enhanced by the lack of information or actual experienced side effects, psychological distress or trauma for the family member. Some participants also said that the fear, or actual experience of harm, could give rise to distress that had a strong impact on the participants’ health and well-being.

Ann’s story about her son, who is in his late twenties and was diagnosed with schizophrenia, provides a profound example of how deep of an impact the use of coercion might have on the family. She started the interview describing how she was in a terrible situation because her son has been forcibly medicated. Her son called her and asked for help to stop the forced medication. She wanted to help but could not. It was a feeling of total powerlessness.

Furthermore, the situation was worsened by the lack of communication and collaboration with the mental health services and the low-quality care these services provided:

He had been asking his psychiatrist who had called him in for a meeting, and he asked her: 'For how long do I have to take this medication?' She answered: 'Two or three years or maybe for the rest of your life'. Then he said: 'Mum, this is suicide, I can't stand it anymore. I can't it stand anymore!' There are two parts to this: Partly, it is the humiliation of being collected and taken to the clinic, but he had overcome this. 'But what about the long-term side effects of the drugs? What do I know about how they will affect my brain over time?' And I agree with that one hundred percent.

She said that neither she nor her son had received any information about the medications or managed to establish a dialogue with health professionals. This increased the worries regarding medication, together with what she considered a lack of active treatment and care and the hard-handed use of force. She cried and continued by saying that they both could have endured the humiliations if they had known that the medication would be good for him in the long run. Ann also said that she took the initiative to get help from the mental health services because of the burden of taking care of her son alone. Her initiative led to involuntary commitment with the use of various coercive measures, including forced medication. However, she had never expected that it would be like this when she had him committed. It was a complete shock to her, and she thinks that her son lost trust in her because of this. Thus, her own need for support from the society to take care of him had been at the expense of loss of trust between them.

Uncertainty whether coercion is the right treatment

Several family members also expressed uncertainty and dilemmas in terms of coercion being the right or best choice of treatment. This dilemma is seen in Bill and Laura's story, parents to

a seventeen-year-old girl. During the interview, the parents kept returning to the question whether their consent to the use of involuntary commitment was right or if their daughter should be treated at the outpatient clinic. The problem for the parents was that the help from the outpatient clinic was too limited. They also felt that her illness became worse and that they couldn't cope with the situation any longer. They stated:

Bill: But in fact, when you are in the middle of the situation, it is terribly difficult to decide; What's the right thing to do? What shall we do? (...) it keeps coming back at me. Laura: Yes, but it does. It keeps coming back. Was it the right thing we did that time? What would have happened if we hadn't been pressing so hard? Or if I hadn't pressed so hard that she should be committed. And since her illness escalated a bit after she was committed, then . . . I have thought a lot about it . . . how would it have been, would we have managed? Bill: But, on the other hand, we could have been left with a dead girl just now. This could also have been the situation.

They also felt it difficult to have a daughter who is staying in a locked unit for such a long time because it is a bit like seeing your child in a prison. They were also worried whether her desire to live would weaken with prolonged institutionalisation. She had been staying inside the hospital for such a long time and had to watch how her friends carry on with their lives as adolescents. As Bill stated: *'That gap gets even larger. The joy of living disappears by being inside here'*.

Consequently, they would have preferred if the hospital personnel had taken more time to sit down and to talk through the dilemmas and options. Other parents to adolescents also doubted the use of commitment because the children had lost trust in the services at a young age.

The burden of low-quality care

Like Linda and Ann, several participants reported that their distress regarding coercion stemmed from what they considered low-quality care, such as a lack of adequate treatment and custodial care and the use of coercion based on staff convenience or bad attitudes, shortage of staff or available services. Charlotte said the following:

My son gets very ill when he is psychotic. When he is committed, it's like, oh now I'm able to sleep one night, you can relax in a way. But that doesn't mean that the ward is a good place for him to be. They don't get any treatment. It has got more to do with custody. It is so sad seeing this lack of treatment. You see the guardian sitting outside (the seclusion room) reading the newspaper, and you have to deliver your own bag to be checked. I mean, it was such a shock to come and visit him in the hospital. It is almost like he's in jail. ... It is almost like you are crying when you are driving away from there. You are so sad in a way.

Withheld care could add serious burdens to the family members because of the love and interconnectedness with their ill relatives. As Ellen said: '*It hits us when we experience that our children receive bad treatment*'.

Retrospective regrets

Similar to Ann's and Charlotte's accounts, several family members reported that they had not anticipated the course of coercive events when first initiating involuntary hospitalisation. Some mentioned having great expectations regarding involuntary hospitalisation because they were finally getting help and treatment for their relative. Instead, they ended up frustrated because of the lack of treatment or experiencing the hospital stay as '*only storage*'. The gap between expectations and actual experiences could result in retrospective regrets, feelings of blame and moral distress about initiating the hospitalisation process. This dilemma was enhanced by the

lack of adequate information about the actual content, and possible effects, of involuntary hospitalisation, as demonstrated in Bill and Laura’s story, or in Irene’s story about her daughter:

I think this has certainly been my dilemma regarding coercion; I would have appreciated knowing more in advance, about what I actually was contributing to coercing her into: forced medication and mechanical restraints because she was afraid, and it was dark, and only strangers around her.

‘Can’t we allow him these weeks without medication?’—Dilemmas regarding exercising power and coercion in everyday life

Family members’ moral concerns were not only related to their experiences of powerlessness, but also to the possibility of exercising power or coercion, either as an advocate for their ill family member or as an ‘initiator’ or a ‘co-coercer’ in collaboration with the services. These dilemmas concerned, for example, how active the family member should be in the process of hospitalisation and medication or in physically holding their family member during distress without destroying the relationship, or how to inform the services in a good way.

Balancing need for control with freedom

Another concern discussed was how to balance their own need for respite and control with the ill family member’s needs for freedom, self-determination and recovery. The fear of relapse (i.e., psychosis) or harmful behaviour could result in a constant state of alertness and vigilance. Even though they expressed few dilemmas regarding their own responsibility for the mental health problems, some struggled with their tendency to push the family member into a sick role and to find the right level of caring (i.e., not being overprotective), as illustrated by Charlotte:

He wants to be normal, and he tries; it is four years since he was committed. He has been receiving depot injections, and now he has started to take tablets. I am starting to get anxious about him being responsible for taking his meds. I feel he is about to change, and I am thinking; 'Oh, are you starting to get sick'. I tend to think of sickness when some changes occur, forgetting that he is a human being and not a diagnosis.

Bill and Laura were also experiencing many challenges regarding how to handle the risk of harm at home if their daughter was on leave, or discharged. The balancing of control is difficult. One time, they had to loosen up control to establish a more normal life for their daughter. On the other hand, freedom can be misused to do self-harm.

How to notify the services in a good way

Such dilemmas and how they unfold over time in a triadic interaction process are also vividly demonstrated in Mary's story about her son who had been ill for over 20 years and involuntarily committed and forcibly medicated almost every year, each time in a dramatic way. Mary explained that her son was very positive the first time he was hospitalised, but he resisted afterwards because he did not find the treatment and medications helpful; rather, they worsened his problems. However, she thought that he needed involuntary hospitalisation when psychotic, so the next time a psychotic event occurred, she sent a notice of concern. He later read about this in his medical records and held it against her, so they ended up being on bad terms. Their relationship had improved over the years, but she found that he was not open to her because he was afraid of her bringing him to the hospital. After that, she found it difficult to know how to handle the information she had about her son in a positive way.

In Mary's case, she understood and respected her son's need for freedom from medication, but she was unsure how to reduce the medication in a responsible way. Her dilemma was enhanced

by a lack of information and communication with health professionals; this made it difficult to establish good collaboration about the medication. She continues:

When he's on meds, he is only a disabled slug who does nothing more than exist. The only thing he is able to do is to go shopping and make himself some food. But, then, he skips the medications because he finds them so awful. I can see how he gradually gets back to being himself. He starts to clean the house, he starts to mow the lawn. He meets friends. He is normal again. This continues for some weeks, and it is so wonderful. Then it stops, and the illness comes sneaking up on him, and it is so sad. His brother, my other son, and I, say: 'Can't we allow him these weeks and months where he's feeling well?' We don't inform the health services. It is so obvious that he functions poorly when he takes the medication his therapist thinks he should have. There has to be some middle way. I wish we could collaborate on that, that he takes as little as possible without being ill. Wouldn't that be ideal?'

However, during all these years, she had not been able to establish this collaboration.

Therefore, exercising coercion could be found dubious and stressful, increasing through the lack of sufficient information and collaboration with mental healthcare. This made it difficult for the family member to be a moral agent and exercise power in a good way, or to realise voluntary alternatives.

Discussion

Methodological considerations

The present study is small, and more research is needed. We only have data on the participants' stories from one particular interview-situation, and we do not have observations or information about the coercive episodes, quality of treatment or the patients' or staff's views. The use of focus group interviews instead of individual open interviews also made it harder to grasp the full chronological order of events, and we had to rely more on the spontaneous storytelling. However, the study's ambition was not to do a full triadic analysis or to picture the whole biographical story of each participant, but rather to use their short stories as constructed during the interviews. Despite the methodological weaknesses, we found focus group interviews useful in initiating social and moral dialogue about coercion (Frank, 2010; Riessman, 2008). The narrative analysis also gave valuable insight into the variety of coercive views and experiences, the complexity of family members dilemmas and how this meaning-making took form as a continuous social and individual process over time. And finally, because these stories are not totally detached from the material world but rather influence each other mutually (Frank, 2010), the family members' stories can point to important aspects of mental healthcare that need to be addressed.

How can we understand the family members' dilemmas regarding coercion?

Despite variations, the present study shows that family members face many difficult and complex dilemmas regarding coercion. The ambiguous nature of coercion also seems to make it a delicate moral enterprise for the family members in the sense that the social and moral order can be easily shaken. The moral delicateness was also reflected in the group interactions, where the participants sometimes expressed distrust in the validity of the other participants' stories. Others' disbelief could increase distress for those experiencing wrongful

use of coercion or when their stories of doing the morally right thing by using coercion were questioned.

Consequently, the study shows that the use of coercion might have a profound effect on the family members' health and well-being. How can we understand the profound impact the use of coercion may have on the family members?

Family relations, coercion and moral dilemmas

The study confirms previous research, as described in the introduction part, that poor mental health brings many practical, emotional and relational challenges to a family unit (Eaton, Ohan, Stritzke, Courtauld, & Corrigan, 2017; Mohr & Regan-Kubinski, 2001; Pejler, 2001). The family members also often must balance multiple concerns and opposing feelings (Karp, 2001; Weimand, Hall-Lord, Sallstrom, & Hedelin, 2013), which might not always be possible, inducing various ethical dilemmas. Therefore, to use coercion might be a difficult existential choice, a story that is hard to live with or an everlasting moral tension on how to get relief in a morally justifiable way from the heavy burden of informal care. These profound dilemmas give rise to the increased need for recognition and support from mental health professionals and to the need for being involved. However, one striking finding in the present study is that there seems to be a gap between, on the one hand, the family members' willingness to support and help their ill family member because of their emotional interconnectedness and, on the other hand, their experiences of their lack of involvement in care, especially regarding locked wards. This finding opposes the importance of upholding interconnectedness and relational bonds during involuntary hospitalisation, which are at stake for many family members. The family members suffering might be created from the feeling of being socially excluded and alienated

from care and being put in a powerless role (Ewertzon, Lutzen, Svensson, & Andershed, 2010; Hallam, 2007; Puotiniemi, Kyngas, & Nikkonen, 2002; Wilkinson & McAndrew, 2008).

Further, the serious impact of coercion on family members also seems related to the use of coercive interventions (Hallam, 2007; Owens & Brophy, 2013). Family members' distress and suffering were, for example, most profound in the stories from participants whose children had a diagnosis of schizophrenia and who reported extensive and possibly habitual use of coercive measures (cf. Lisa's and Ann's stories) or for parents who were witnessing extensive use of coercive measures and long-lasting institutionalisation toward their adolescent child (cf. Bill and Laura's story). Thus, the use of coercion leads to many moral dilemmas for the family. They must deal with the continuous moral ambiguity or uncertainty of coercion adding burdens on the family. The use of coercion might also—if not always—create relational damage, leading to distrust and broken bonds between the family members and a need for reconciliation work (Arya, 2014).

One more important finding in the present study is the gap between the positive expectations of coercion, especially involuntary hospitalisation, and the actual experience of it (Rowe, 2012). Many had little knowledge of what coercion, such as involuntary hospitalisation, actually meant, and the consequences it may have in terms of feelings of humiliation or trauma. This mismatch seems to lead to shock and moral stress for some family members, increasing their suffering and burdens. Thus, the family members wanted to get information that is more balanced from healthcare professionals and to discuss the dilemma regarding the potential harmful effects that coercive measures might have in a more thorough way.

The impact of systemic aspects, the quality of mental healthcare and health professionals' ways of working

Another reason for the profound impact coercion might have on family members also seems related to their vulnerability toward the healthcare services' lack of capacity to be responsive to their situation and needs and its lower quality of patient care. In line with previous research, we find that the family members' situation was heavily influenced by their interactions with the medical culture and mental health services (Harden, 2005; Lawn & McMahon, 2014). The triadic perspective demonstrates the clinical and moral importance of coercive practices themselves and the quality of treatment and functioning of the mental health system for the family's situation. When health professionals do not recognise the parent as a loving and caring person, the importance of interconnectedness or the need to be involved, the healthcare professional might create additional 'system-based' suffering for the family (Hallam, 2007). To witness the unnecessary use of coercion or low treatment quality, especially during coercion—and sometimes for a long period—might have a profound impact on their burden. A lack of voluntary responsive services or help also might force the family into involuntary hospitalisation as the only available solution, even when they had preferred alternative voluntary opportunities. This adds to feelings of powerlessness and distress.

Conclusion

In the present study, many family members told us about difficult challenges, decisions and dilemmas concerning coercion and in being lonely facing these challenges. Subsequently, a big problem is the shaping of mental health services that creates too heavy-handed use of coercion, along with professionals who do not communicate properly with family members. Hence, we argue that there is a moral obligation to develop more responsive and voluntary-oriented services and professionals, not only for patients, but also for families. The family members' stories underline the need for improved communication, information and family support from

health professionals regarding their dilemmas (Eaton et al., 2017). Real participation in care and informed consent require dialogue and a more thorough information about the possible effects of coercive measures compared to the alternative treatment possibilities or solutions. Furthermore, the findings seem to reflect systemic problems within the healthcare system, including the general lack of use of the input of family members (Barken & Lowndes, 2017). There is a moral duty for professionals, as well as the government, to secure quality care during coercion, to provide information that gives the family more opportunities to make the right choices and to be open for the family members' evaluation of how coercion impacts the patient and the family. Coercive practices should be consistently re-evaluated according to this.

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Declaration of interests

The authors declare that there is no conflict of interest.

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