Patients' Preferences for Seclusion or Forced Medication in Acute Psychiatric Emergency in the Netherlands

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Objectives: **This study examined patients' preferences for coercive measures in case of emergency situations on acute psychiatric wards.** ***Methods:*** **From November 2004 until January 2006, 104 adult patients completed a questionnaire after they underwent seclusion, nonconsensual medication, or both on one of three acute psychiatric wards in the Netherlands.** ***Results:*** **Equal numbers of patients preferred seclusion and medication, and both measures were equal in perceived aversiveness and perceived efficacy. Men more often than women expressed a preference for seclusion. Patients who understood why the measure was necessary and acquiesced to it retrospectively held more positive views of the efficacy of the measure.** ***Conclusions:*** **Many patients on acute psychiatric wards have a clear preference between seclusion and medication. Patients appreciated receiving explanations of the reasons for the use of a restrictive measure and discussing their preferences with staff. (*Psychiatric Services* 59:209–211, 2008)**

In acute psychiatry, there is growing awareness that coercion should be reduced to a minimum and that patients' preferences should be followed as much as possible. Although coercion continues to be used frequently, few studies have given attention to patients' preferences and opinions in respect to these measures (1–4). To the best of our knowledge, only one study investigated differences in patients' preferences for seclusion and (forced) medication (5). Of 100 patients on a psychiatric emergency ward in the United States, 57% preferred medication, 24% preferred seclusion, and 10% preferred physical restraint. Furthermore, there is no consensus among professionals between and within countries on which method of restriction is optimal. In Sweden, Australia, and the United Kingdom, for example, medication is the most frequent measure, whereas seclusion is rarely used (6). In the Netherlands, the reverse pattern has been found (7).

In this exploratory study, we examined patients' preferences, in case of emergency, for either medication or seclusion. We also solicited their opinions on aversiveness and efficacy of these restrictive measures. We analyzed patient characteristics and situational variables associated with preference for and perceived aversiveness and efficacy of either measure.

Methods

Data were prospectively collected between November 2004 and January 2006 from patients on three mixed-sex admission wards concerning their first admission during this period. The three wards, with a total of 75 beds, are part of two general psychiatric hospitals in the center and west of the Netherlands, with a total catchment area of 1.4 million. The ethics of the study protocol were approved by the appropriate boards and scientific committees of the hospitals. All patients who underwent a coercive measure (seclusion, nonconsensual medication, or both) were asked to participate during the final two weeks of their hospital stay. After describing the study to the participants, we obtained their written informed consent.

Patients filled out a short questionnaire on several patient characteristics, application of involuntary measures, positive and negative aspects of the measures experienced, preference for either seclusion or medication, and the efficacy and degree of aversiveness of these restrictive meas-

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ures. Patients scored aversiveness and efficacy of seclusion and medication on four 100-mm visual analogue scales (VASs). Nursing staff filled out a standardized data collection form on gender and age, and the psychiatrist of the ward established psychiatric classifications using *DSM-IV*.

Associations between preference, perceived aversiveness, and perceived efficacy of restrictive measures and the independent variables were analyzed with chi square tests, t tests, and analysis of variance. All analyses were performed with SPSS 14 software.

Results

Within the study period 166 patients 18 years of age and older underwent one or more restrictive measures on the three participating wards. We missed 25 patients because they were discharged unexpectedly. We were able to ask the remaining 141 patients for written consent. Of this sample, 104 patients were prepared to participate, resulting in a response rate of 74%. Twenty-four (17%) patients refused to cooperate, and 13 patients (9%) were not capable of completing the questionnaire because of language problems or florid psychosis. The mean±SD age of the participants was 36.5±10.5 years and ranged from 18 to 60. Most patients were male (66 patients, or 64%), and most had a psychotic disorder (59 patients, or 57%). Other main diagnoses were bipolar disorder (23 patients, or 22%) and cluster B personality disorder (seven patients, or 7%). One-third of all participating patients (34 patients, or 33%) were born outside the Netherlands.

Of the 104 participating patients, 49 (47%) reported that they underwent seclusion, three received medication without their consent (3%), and 43 (41%) underwent both measures. For nine patients (9%), information on application of involuntary measures was missing. Sixty patients (63%) underwent more than one episode of seclusion or forced medication. The number of patients in our sample who preferred seclusion was equal to the number of patients preferring medication. Rest, security, or being able to sleep were the most frequently mentioned positive aspects of seclusion (47 patients, or 45%). One-third (35 patients, or 34%) named no positive aspects. Feeling alone and locked in was the most frequently named negative aspect of seclusion (31 patients, or 30%). For medication, the calming effect was reported as a positive aspect, and the most frequent negative aspects were feeling powerless and experiencing aversive side effects.

Table 1 shows that there was a significant difference in preference between men and women (χ^2=10.44, df=2, p<.005). Among men, 46% expressed a preference for seclusion; among women, 60% expressed a preference for medication. Additional chi square and t tests showed no other significant associations with preference. There was, for example, no relation between preference and the type of measure or number of episodes experienced or with residing in a one-person versus a multiple-bedroom arrangement. There was no significant difference in preference between patients who experienced both measures (43 patients, or 41%) and seclusion alone (49 patients, or 47%). Most patients (84 patients, or 80%) indicated that they appreciated being asked about their preference for a restrictive measure and felt respected; the remaining 20 patients left this question unanswered.

Patients evaluated medication and seclusion as equally effective and equally aversive. Perceived aversiveness was not significantly associated with any of the independent variables. We found an interesting but nonsignificant trend that in comparison with people born in the Netherlands, people born abroad evaluated medication as less aversive. Only age was significantly associated with perceived efficacy of seclusion (r=–.35, N=91, p=.001) and medication (r=–.40, N=62, p=.001). In comparison with younger patients, older patients considered both seclusion and medication less effective. Patients exposed to both measures and who were positive about the efficacy of one measure tended to be positive about the other measure as well. Efficacy scores for seclusion were moderately correlated with efficacy scores for medication (r=.54, N=56, p<.001). Remarkably, perceived aversiveness was not related to perceived efficacy within measures.

Looking back on the experience, 76 (76%) secluded patients and 30 (67%) patients who received coercive medication could understand why the measure was taken. More than half of the patients acquiesced to the measure in retrospect, 59% (58 patients) for seclusion and 57% (37 patients) for medication. Patients with more previous admissions retrospectively acquiesced to seclusion more often (χ^2=10.52, df=4, p<.032). Patients who understood why the measure was taken judged both medication (t=3.69, df=58, p<.001) and seclusion (t=5.37, df=87, p<.001) as more effective than patients who did not understand. Acquiescence was also associated with higher perceived efficacy (medication, t=4.57, df=59, p<.001; seclusion, t=6.67, df=83, p<.001). Understanding or acquiescence was unrelated to aversiveness.

Table 1

Preferences of inpatients for restrictive measures used in acute psychiatric emergencies, by gender

	Seclusion (N=38)		Medication (N=39)		No opinion (N=24)		Total (N=101)	
Gender	N	%	N	%	N	%	N	%
Men	30	46	18	27	18	27	66	100
Women	8	23	21	60	6	17	35	100

Discussion

In this study, equal numbers of patients preferred seclusion and medication when surveyed, and the two measures were equal in perceived aversiveness and perceived efficacy. We speculate that replication of this study in countries where seclusion is not a common measure will lead to more negative opinions of seclusion. Bowers and colleagues (8,9) found that approval of containment measures

among staff is culture bound. Coercive measures that are not common in a particular country usually arouse strong negative feeling among nurses, whereas the same measure is seen as acceptable in countries where it is used more frequently. We consider it plausible that the same cultural differences exist in the way that patients experience containment measures and that patients with more experience with restrictive measures will evaluate them as more normal. This hypothesis is underlined by our finding that patients with more previous admissions were more likely to retrospectively acquiesce to this measure.

Furthermore, we found an interesting difference in preferences between men and women, with women preferring medication and men seclusion. We could not explain this effect by differences in diagnostic classification, and gender was unrelated to judgments of efficacy and aversiveness. Concepts of masculinity held by male patients might lead them to associate taking medication with weakness. Compared with women, men may be more fearful of the undermining of their own self-control by taking medication. There might be a parallel with gender differences in suicide methods, where women take overdoses but men use other, often more aggressive methods (10). It would be very interesting if this gender effect could be replicated in further research across countries.

Stolker and colleagues (4) found a significant association between the availability of single bedrooms and a less negative view of seclusion. We did not replicate this effect in this study and found no significant association between type of bedroom and perceived aversiveness of seclusion. This might be explained by a difference in method. In our study, aversiveness was measured as a general concept on a VAS, whereas in the study mentioned above, aversiveness was measured by a combined score on several specific items, such as, "Does seclusion calm down the secluded patient?"

We found that with age, patient evaluations of the efficacy of both medication and seclusion became more negative. It is to be expected that older patients have more chronic illnesses than younger patients. Chronic illnesses are in general less responsive to treatment, so more negative evaluations of efficacy of coercive measures by older patients may be, at least partly, realistic. Remarkably, we found no correlation between aversiveness and efficacy scores on the VAS within measures. This suggests that perceived aversiveness of coercive measures is a unique concept unrelated to perceived efficacy. For this reason, we think that it is important to recommend that staff on psychiatric wards consider not only expected efficacy but also the subjective aversion of the individual patient involved in expressing a preference for a coercive measure.

Most patients reported both positive and negative aspects of coercive measures. These results are comparable with the findings of Stolker and associates (11). In their study 46% of respondents said that rest was an important positive aspect of seclusion, 30% of all patients saw nothing positive about seclusion, and 28% had felt alone and locked in. In our study, these percentages were 45%, 34%, and 30%, respectively.

Caution must be expressed about the interpretation of the findings. We interviewed people in the last two weeks of their hospital stay, so the interval of time that passed between the restrictive measure and the interview was different for each patient. This might be a confounding factor if views change over time. Ryan and Bowers (12) found that many patients interviewed within 72 hours after manual restraint did not have a clear idea about what had happened to them or were incorrect in their perceptions. Studies of compulsory detention showed that views became more positive when more time had passed since detention (13).

Conclusions

This study clearly suggests that patients on acute psychiatric wards who are not in an actual crisis are capable of choosing a restrictive measure they prefer. We think it is important to discuss—if possible—the choice of measures to restrict patients in order to reduce negative experiences. The need for good communication is underlined by the finding that patients who understood the reason for and consented retrospectively to a coercive measure judged the measure as more effective. Most participants in this study indicated that they appreciated it when asked for their opinion. An important future research project would be an examination of whether following patients' preferences results in their reporting greater effect and a less aversive experience.

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