Cultural Differences in the Use of Covert Coercion Among Mental Health Professionals of Latin Culture: A Focus Group Study

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Coercion in Mental Health is related to sociocultural contexts. The purpose of this study is to examine whether the uses and perceptions of covert coercion on the part of professionals from four Latin-culture countries (Spain, Italy, Mexico, and Chile) differ between them and from those described in the literature. We conducted a qualitative research, using focus groups with professionals, with targeted sampling and an iterative process for thematic analysis. Several differentiating categories were found: the use of alternative strategies of covert coercion (deception, emotional blackmail, and directiveness); the role of family and socioeconomic differences; and cultural aspects such as the unique role religion plays in Mexico, a relatively greater toleration of threat as a means of coercion.

Keywords: coercion; pressures; deceit; emotional blackmail; sociocultural aspects; catholic religion

Coercion in its various guises has always been central to psychiatry, a legacy of its institutional origins. Unfortunately many people are still being subjected to coercive psychiatric interventions and there is an increasingly coercive culture in mental healthcare (Sashidharan & Saraceno, 2017). It ranges from no coercion (or full autonomy) to formal coerción (when coercion is exercised within the regulations of the given mental health legislation, as involuntary hospitalization or compulsory outpatient treatment, or at least, with some specific procedure and control as seclusion or restraint) (Hotzy & Jaeger, 2016).

http://dx.doi.org/10.1891/EHPP-D-21-00001

Informal or covert coercion is ubiquitous in the healthcare system, especially in mental health and psychosocial services. It comprises a large range of treatment pressures and interventions that can be applied by the professional with the intention of fostering treatment adherence or avoiding formal coercion. It has been categorized according to its intensity as follows: *persuasion* (giving information and answers to patients' questions and concerns about their treatment); *interpersonal leverage* (use of the professional-patient relationship as a means of influencing the decision-making); *inducement* (suggesting the implementation of support or additional services if involved in the suggested treatment), and *threat* (warning of withdrawal of these supports/services, or mentioning the possibility of using formal coercion) (Szmukler & Appelbaum, 2008).

Despite the common perception that sociocultural aspects play a major role in understanding mental illness and in the use of coercive procedures (Hotzy & Jaeger, 2016), to the point that we could speak of "local customs and habits," (Hotzy & Jaeger, 2016; Szmukler, 2008) all current research is focused mainly on high-income, mainly Anglo-Saxon, countries. That no studies have been conducted in low/middle-income countries, nor in those with different healthcare services or cultural values (such as many countries in Asia, Africa, or South America), is possibly due to the poor development of Community Mental Health Services in such countries (Molodynski et al., 2014).

Okasha (2000, 2002) links the sociocultural context with different aspects of psychiatry, including coercion; in the absence of clear professional legislation or guidelines, the use of coercion is based on psychiatric tradition and sociocultural influences.

We have recently published a focus group study of professionals that examines the use of informal coercion in four Latin countries, highlighting among its findings that the use of this type of coercion is widespread, influenced by a variety of factors: the individual characteristics of the professional who applies it; the illness itself (diagnosis, clinical aspects, and outcome); the individual patient (danger to self or others and degree of insight); the therapeutic alliance, compliance with the treatment regimen, and organizational aspects of care. The use of such coercion is justified, from a clinical point of view, by the resultant increase in patient compliance, and from an ethical perspective, by virtue of its being in the best interests of the patient. There is, in general, a negative perception of the more intense forms of coercion (García-Cabeza et al., 2017).

Following this line of research, we present the current study, the objective of which was to investigate whether the uses and perceptions of informal coercion in the four countries studied (Spain, Italy, Mexico, and Chile) differ from each other and from those described in the scientific literature.

METHODS

This is a secondary study of a larger one carried out in ten countries grouped into five culturally different regions. A focus group methodology was used to elicit participants' attitudes toward and experiences of the use of informal coercion. Countries were selected for reflecting broad sociocultural divide. Two countries of each of five distinct cultural regions were included: Anglo-America (United Kingdom and Canada), Central/Eastern Europe (Germany and Croatia), Latin America (Mexico and Chile), Scandinavia (Sweden and Norway), and Southern Europe (Spain and Italy). Depending on the organization

of the national healthcare system in each country, potential participants were recruited in hospital departments and community services. Lead investigators used personal contacts and/or mailing lists of clinicians working in mental health services. The methodology used in this original study is identical to that described below (Valenti et al., 2015).

In this paper we make a secondary reading and analysis of the Latin-culture countries (Spain, Italy, Mexico, and Chile) attending to several reasons: (a) To analyze the results in the native language of the participants, avoiding potential misinterpretation resulting from translation; (b) The lack of references to the phenomenon of informal coercion in mental health outside Anglo-Saxon countries; (c) To know if despite being countries with similar cultural origins (Latin) and the same religion (Catholic) there are differences in the perception and use of informal coercion attending to others factors as social and health politics, socioeconomic factors, or local religious and cultural elements.

Type of Study

The present qualitative study was carried out using focus groups and thematic analysis of the contents (Braun & Clarke, 2006). This type of analysis allowed us to identify common patterns of data, such patterns being essential for understanding the investigated phenomenon.

Four focus groups were conducted per country, with four-to-eight professionals per group (totaling 98 individuals), figures considered sufficient to achieve intra- and intergroup saturation (Onwuegbuzie et al., 2009).

Participants

An intentional sampling was performed to obtain greater representativeness of the professionals involved in the treatment of Community Mental Health Center patients: inclusion of both genders, inclusion of all significant professions, and variety in terms of the number of years of professional experience.

The inclusion criteria in the focus groups (the requirements each participant needed to satisfy) were as follows:

- Younger than 65 years of age;
- Qualified as a psychiatrist, psychologist, nurse, social worker, or therapist;
- At least 1 year of experience in a Mental Health Center after having finished professional training;
- Working with outpatients with severe mental disorders on whom some form of formal coercion has been applied, mainly compulsory hospitalization.

Gathering of Information

Four focal groups per country were formed, their sessions digitally recorded and subsequently transcribed. (One of Chile's focus groups was discarded because of the poor quality of the recording.)

Each group session lasted between 60 and 120 minutes, opening with a brief description of the project and an introduction of the participants. In the general discussion that followed, participants' understanding of the main topic was explored by unpacking the

assumptions and conceptual content that inform the research, and by clarifying the extent to which participants understood the distinction between formal and informal coercion. The different categories of coercion were then introduced (as defined by Szmukler & Appelbaum, 2008) and exemplified by one or two cases (adapted from Molodynski et al., 2010). Group members were asked if they knew or could think of any other methods of informal coercion, and whether they thought these various types of influence and pressure might possibly form a continuum, an incremental hierarchy of intensity that might prove clinically useful.

After the presentation and discussion of the cases, a second general discussion was held to explore the attitudes of professionals and their views on the possibility of establishing a correspondence between patient particularities and possible types of coercion. They were asked about the impact of coercion on patient satisfaction and adherence, and on the patient's typology, on the basis of which informal coercion is applied; as well as whether each such category of patient might correspond with a specific type of informal coercion. We concluded with a summary of the discussions in a way that would stimulate the voicing of other perspectives and opinions.

Throughout the process, the participants' attitudes and experiences were explored, the moderator using both standardized probing questions and Socratic questioning (inquiring about the meaning of emerging contents) and inviting further clarification and details. Transcriptions were analyzed with the QSR N-Vivo qualitative software package.

Procedures

Community Mental Health Centers, where some patients may occasionally need involuntary treatment, were identified. The study proposal was presented by letter to the heads of the centers and, if they agreed to participate, each service manager presented a detailed list of professionals who met the inclusion criteria. From among these we then randomly selected those who would provide us with the most representative sample possible.

The groups were held in the workplace, in a quiet room suitable for recording the discussions. All sessions took place during the sixteen-month period from January 2013 to April 2014.

Analysis of the Information

The coding was done with material from the 10 countries that had participated in the matrix study. Initially two researchers, including EV, independently performed the coding (line by line) of the 16 transcripts to generate the initial categories. In order to evaluate their reliability, eight researchers (including IGC) used this preliminary framework to code eight randomly selected different transcriptions, obtaining agreement rates ranging from 80% to 98.5%.

Thematic analysis was carried out using an iterative process (Braun & Clarke, 2006). The various emergent categories were then compared and linked to different topics selected through regular discussion with the research team. After identifying the topics, the research team reread each transcription in order to ensure that they were firmly based on the data, to refine the topics, and to locate illustrative citations.

Ethical Considerations

The study met all of the ethical requirements for its realization.

After receiving written information about the purpose and procedure of the study, all of the selected professionals agreed to participate, each then signing his or her own (individually distributed) "informed consent" document.

The analysis of the texts was done respecting the anonymity of the group members at all times, encrypting the focal groups within each country (1–4) and assigning to each one of the total number of participants within the respective country's four groups an additional (unique) number (01–30). Each group's country of origin was designated as follows: SP (Spain); IT (Italy); MX (Mexico); CH (Chile).

The study was approved by The Queen Mary Research Ethics Committee (QMREC2012/80), in Spain by the ethics committee of the Alcorcón Foundation Hospital (2012/66), and in Chile by the General Director of the University Clinical Hospital. In Italy and Mexico, once the overall project was approved, no additional approval by local ethical committees was required.

RESULTS

One hundred seven professionals (38% male) participated in the study, distributed as shown in Table 1.

We found three main categories that differentiated our results from those categories described in the literature or among the four countries studied: (a) additional forms of informal or covert coercion; (b) the family role in decision-making; (c) sociocultural aspects in the use of coercion.

1. ***Additional forms of covert coercion***
   Social or judicial benefits (e.g., handling part of their money or providing housing, substitution of prison sentences, alternatives to hospitalization as a form of pressure), as used in Anglo-Saxon countries, are not possible in the countries studied (see below) and gave rise to our describing other forms of coercion: deceit, emotional blackmail, and directiveness.

TABLE 1. Sample Characteristics

Spain	Psychiatrist:10	Chile	Psychiatrist: 8
(n_{SP} = 30)	Psychologist: 6	(n_{CH} = 20)	Psychologist: 5
	Nurse: 10		Nurse: 4
	Social worker: 3		Social worker: 3
	Others[a]: 1		
Mexico	Psychiatrist: 3	Italy (n_{IT} = 33)	Psychiatrist: 16
(n_{MX} = 24)	Psychologist: 16		Nurse: 12
	Social worker: 2		Psychologist: 4
	Others[b]: 3		Social worker: 1

[a]general practitioner.
[b]medical technician, nutricionist and unknown.

a. *Deceit*

"… I cannot think of another word [for 'deceit']: 'transient deception' [perhaps], in the sense that we often induce the patient to go to the department or the clinic … because it becomes an environment in which we can maybe decide easily … and a specific patient [might say], 'You told me that we were doing one thing and then they had me caged [hospitalized] for three months….You told me a lie.' So I do not know where to put it, the 'false truth' that is useful in some way for strategy" (FGIT103).

"… put [medication] in the patient's food or take the opportunity of putting in a glass of water the drops that he doesn't want to take. This is not coercion because the patient thinks that nothing is being given, [but] it is deception …" (FGSP314).

b. *Emotional blackmail*

"…If he [a patient] has a very close relationship with the mother, we use that natural feeling to pressure him" (FGMX421).

"… I feel as an emotional blackmailer, at the beginning it irritates them [the patients], but obviously it depends on the pathology, and then, in the long run, they are already aware that that was necessary" (FGCh302).

c. *Directiveness*

"… then I thought of something else, because we said that threat is used as a last resort, but I was thinking that a lot of times we use a synonym for 'threat', that it is more elegant, there is less fear and it is 'being directive.' With this we manage the patient …" (FGIT319).

"[We have] to take for granted the circumstances, that is to say, 'This is what is going to happen', and the patient does not mind, right? Something that we sometimes do, that is to say, 'You are going to have an injection,' and the patient is not asked. He is taken by the hand and pricked. He is not threatened [that we will] do anything [else] as a consequence, nor [is he] induced, trying to convince him or anything like that. Just 'Come with me'--and I give [him] the injection, and that is the end of the intervention" (FGSP428).

2. ***The family role in informal coercion***

The family plays an essential role in Latin countries in the use of coercive strategies, both in decision-making and in performance and intensity.

a. *Decision-making*

"… [making the decision about what to do]: The family makes it, even sometimes neighbors or the general practitioner, anyone who comes into short contact with the patient. So control depends on us, but no … that's even more ambiguous … " (FGIT211).

… the family is very important because sometimes they are the first who call and come and bring the patient, … then it is also true that the family serves as a resource in a negotiation [with the patient] that I am not doing well and I often rely on them when there is a good family support" (FGSP104).

b. *Performance and intensity*

"…The psychiatrist relies on the family. If there is a family that is responsible, it falls on them, the decision, and … you make periodic assessments" (FGMX212).

"When relapse is detected, then you say: 'Come with your family, come with your mom,' and if the relationship is close, you can warn … 'I will have to tell your mom or brother' … " (FGCh402).

However, it is also recognized, in all focus groups, that family participation is not always positive, and a conflict of interests may arise between patients and their families:

"Sometimes the family can even hinder treatment" (FGMX213).

"… One can work with the family, it is preferable. Now obviously the family must be the immediate family. There are some relationships that are very pathological for the patient; we also have to evaluate if there are family conflicts or alterations or pathology of the relationship with some or all members. One also has to work with the family on that, and, in the worst case, remove the patient from the family and put him or her elsewhere" (FGCh405).

In addition, in the case of Latin American countries, this responsibility can be assumed by the nearest social group available if there is no family:

"… A patient usually does not come alone, he is accompanied by the wife, the mother, the brother, the boyfriend, the mother-in-law; it is extensive, there is no possibility of this separation, this individuality, … sometimes if we do not have a close family member we have got a friend, … who then supplies this characteristic, the social support. … The psychologist or psychiatrist or doctor always has a referent, a tutor, someone to lend support for patient follow-up or treatment … " (FGMX212).

"[There's the case] of an old lady whose son is psychotic, schizophrenic, and the one who is going to take charge of the hospitalization is the concierge of the building that they have lived in all his life …" (FGCh107).

3. ***Sociocultural aspects***

In this case we can distinguish socioeconomic and exclusively cultural differences.

a. *Socioeconomic differences*

Socioeconomic differences matter in the choice of coercive strategies. This is especially evident in Latin American countries, where people with high income can pay for private treatment, which differs in both quality and type (as reported by the professionals in the focus group) from that which is available in public health settings, with their scarce human and material resources:

"… In a private institution it is different because there is an input of money …. I believe that there are differences, and obviously that there are some differences that do impact on these strategies" (FGMX211).

"… He or she is sent to private clinics because the public system is oversaturated and, clearly, more resources are available and other types of interventions are used …" (FGCh106).

b. *Exclusively cultural differences*
Although the four countries studied are culturally related (sharing Latin and Catholic traditions), we observed some differences in the case of Mexico. For example, while threat in general is no less unwelcomed there than in the other three countries, its use is decidedly more tolerated in Mexico:

> *"… Yes, in Mexico I think that we use this kind of coercion [threat] a lot, yes, because it threatens, it is present in our culture; in that sense we use guilt and threat" (FGMX316).*

Similarly, the role of religion in Mexico can be an element of pressure and influence on patients, something that we have not observed in the other countries:

> *"[We say such things as,] 'Well, what are you doing? These actions that you have done or that you carried out, how do you think God judges them'? or, 'What do you think God thinks about this?' Then this helps us; occasionally the patient reflects and says: 'These attitudes are wrong because they are a sin and I have to stop doing them'…" (FGMX106).*

DISCUSSION

The main value of the study lies in the absence of any previous studies of these characteristics in low- and middle-income countries and in the choice of a qualitative methodology that allowed us to explore the perceptions of professionals from different countries and with different cultures and health systems. The number and variety of professionals who have participated was also important, with 98 professionals in 16 groups, which is not frequently seen in this type of study. The high intergroup saturation suggests that our results are consistent.

A weakness of this study is the fact that in countries with similar cultures it is more difficult to discern differences in familial, social, and treatment patterns; so, being a selection of countries within the study, the group script (and later codification of the information) was common to the matrix study but nonspecific for Latin countries.

As we said in the introduction, almost all existing literature comes from Anglo-Saxon countries. The study of aspects such as coercion, which affects the rights of the mentally ill, is not a priority in developing countries in Africa, Asia, and Latin America (Levav & Gonzalea Uzcategui, 2000). Also, we haven't compared results in terms of professions.

As described by Szmukler and Appelbaum (2008), covert coercion includes persuasion, interpersonal leverage, inducement, and threat. In fact, the coercion understood according to these four levels of pressure entails several means of exerting it, from social services (handling part of their money or providing housing) to the judicial system (substitution of prison sentences, alternatives to hospitalization), which are incorporated into clinical practice as coercive methods to promote adherence for outpatient treatment in both the United States (Monahan et al., 2001) and the United Kingdom (Burns et al., 2011; Canvin et al., 2013). However, in none of the four countries studied does any agreement or relationship exist between mental health and social or judicial services; so, although this kind of coercion is indeed identified by our professionals, the use of inducement or threat in this way is in fact not actually possible in their clinical practice (García-Cabeza et al., 2017).

This gives rise to the description of other forms of informal coercion. We refer especially to deceit, the fact of giving false information to the patient, which seems to be an extensive reality in Latin cultures (e.g., lying about the probable duration of hospitalization to make it more acceptable to the patient, or by giving medication hidden in food) (Calcedo, 2000; Valverde, 2010). In fact, concealing medication intake is a widespread strategy in Asian cultures as well, among other factors because deficiencies in healthcare services and regulation cause ethical issues to be neglected (Sathyanarayana Rao et al., 2012).

Szmukler and Appelbaum (2008) also include deception within coercive strategies, especially as an implicit threat, so the lack of information may lead the patient to believe that a transgression may result in hospitalization; or its use as a form of coercion-related behavior in the psychiatric admission (Lidz et al., 2000) or involving antipsychotic medication (Seale et al., 2006).

Given the impossibility of using physical resources, forms of pressure/coercion are limited to the use of emotional, ethical, moral, or personal ploys, such as making the patient feel guilty (what we have called *emotional blackmail*) (Munetz et al., 1997). Both deception and blackmail are considered ethically questionable given the lack of transparency (Pelto-Piri et al., 2019; Shaw & Elger, 2013).

Finally, we identify a milder form of coercion-although it also infringes on patient autonomy, namely, directive or assertive attitude, a form of covert paternalism whereby the patient's cooperation is induced by stating explicitly what he should do, regardless of his desire or will, its justification always said to be motivated by one or another principle of beneficence (Gert et al., 2006). Such paternalism also reveals that there is less dissonance between the use of threat and its perception in the Spanish-speaking countries (Spain, Mexico, and Chile) (Valenti et al., 2015). With regard to roles, the role of the family in these countries, derived from cultural aspects but also from a greater precariousness of resources, should be emphasized; families have to exercise at home the pressure that otherwise falls on the professional's shoulders, whose ties to the patient are less binding in intensity. It is known that on the part of the patient, such interventions are usually better perceived and with less long-term impact than when professionals intervene (Lidz et al., 2000), probably because of the need to maintain family ties (Valenti et al., 2015).

In Spain and culturally related countries the family plays a much more intense role in treatment, among other reasons because patients usually live in the family home and, in addition, treatment is traditionally based on cultural attitudes and non-professional patterns of care. (Kalla et al., 2002; Molodynski et al., 2014; Vázquez-Barquero & García, 1999). In fact, this model of intervention has been questioned since family intervention can interfere with professional treatment (as we have already observed in our groups) (Salize et al., 1999) since interests may differ in terms of safety and well-being in the face of the patient's autonomy and independence (Ayra, 2014). In this way, in family-centered societies, such as those in Asia and the Far East, individual autonomy may be sacrificed on the basis of family decisions (Okasha & Okasha, 2011).

Finally, the role of socioeconomic and cultural elements in the use of informal coercive measures needs to be highlighted. In developing countries, where access to treatment standards similar to those in Western countries is limited to the financially well-off, and in family-centered societies, the use of coercive methods is both more frequent and more tolerated (Alem, 2000; Okasha & Okasha, 2011). In Mexico and Chile, where there are greater socioeconomic differences than in the Mediterranean countries and where public

health has important limitations, the ethics of such practices are given little to no priority. Only in Mexico, the one country among those studied that is not designated "high-income" by the International Monetary Fund, do we find the use of threat justified from a cultural perspective.

We can find specific explanations for it beyond the fact that in less developed countries ethical aspects in the healthcare systems are not a main concern. Mexico, for example, has a seriously high crime rate (five times that of Chile, fifty times that of Spain and Italy, with all the attendant media impact) (United Nations Office on Drugs and Crime [UNODC], 2017) so it is not surprising that the more intense levels of coercion go unperceived in a country already constantly coping with instances of violence.

We have also noted that in Mexico, as in other countries (mainly in Asia), religion and spirituality may have an influence on personal autonomy (Okasha & Okasha, 2011) and, secondarily, on the exercise of coercion.

In relation to mental health, there is consistent evidence that religion and spirituality can improve treatment outcome, but their assessment and use in clinical practice have yet to be defined (Moreira-Almeida et al., 2014). In our study we found that, in Mexico, religion is often used as emotional blackmail, whereby a person's moral and ethical values are factored into the coercion equation (e.g., guilt and the fear of God).

Although all four of our countries are Catholic, Mexico is atypically, on the one hand religious beliefs are more widespread in society and on the other, rituals and beliefs from pre-Columbian religions still survive (indeed thrive) there in a syncretism of shamanistic and Catholic traditions (Grinberg-Zylberbaum, 1990); one result being that followers could be more disposed to magical thinking (e.g., that disobedience automatically carries the threat of divine punishment).

As a final conclusion, we can affirm with confidence that the types and intensity of informal coercive strategies are influenced by the organization of the environment, healthcare patterns, socioeconomic conditions, and intrinsic sociocultural values and practices.

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Disclosure. The authors have no relevant financial interest or affiliations with any commercial interests related to the subjects discussed within this article.

Funding. The author(s) received no specific grant or financial support for the research, authorship, and/or publication of this article.

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