Science of Nursing and Health Practices

Science infirmière et pratiques en santé

Article de recherche empirique | Empirical research article

The Experienced Coercion Scale: Translation, Validation, and Evaluation of Psychometric Properties of a French-Language Version

L'échelle de la coercition perçue : traduction, validation et évaluation des propriétés psychométriques d'une version francophone

Jean-Simon Drouin https://orcid.org/0009-0005-3511-1610 Faculty of Nursing, Université de Montréal, Centre de recherche de l'Institut universitaire en santé mentale de Montréal, Quebec, Canada

Clara Lessard-Deschênes https://orcid.org/0000-0003-0852-6683 Faculty of Nursing, Université de Montréal, Centre de recherche de l'Institut universitaire en santé mentale de Montréal, Quebec, Canada

Vincent Billé https://orcid.org/0000-0002-2804-3366 Faculty of Nursing, Université de Montréal, Centre de recherche de l'Institut universitaire en santé mentale de Montréal, Quebec, Canada

Mathieu Dostie Centre de recherche de l'Institut universitaire en santé mentale de Montréal, Quebec, Canada

Anne G. Crocker https://orcid.org/0000-0003-0571-8890 Department of Psychiatry and Addiction, School of Criminology, Université de Montréal, Institut national de psychiatrie légale Philippe-Pinel, Quebec, Canada

Olav Nyttingnes https://orcid.org/0000-0003-0991-7176 Health Services Research Unit, Akershus University Hospital, Akershus, Norway

Marie-Hélène Goulet https://orcid.org/0000-0002-7764-6286 Faculty of Nursing, Université de Montréal, Centre de recherche de l'Institut universitaire en santé mentale de Montréal, Quebec, Canada

Correspondance | Correspondence:
Marie-Hélène Goulet
Marie-Helene.Goulet@umontreal.ca

ISSN 2561-7516

Keywords

perceived coercion; forensic; mental health; coercion; validation

Abstract

Introduction: Perceived coercion refers to the subjective experience of coercion by individuals receiving mental healthcare. It has been shown to compromise their recovery process. The Experienced Coercion Scale (ECS) is a validated instrument designed to assess perceived coercion in mental health settings. **Objectives**: This study aimed to translate, adapt, and evaluate the psychometric properties of a French-language version of the ECS among a sample of psychiatric inpatients from general and forensic settings in Quebec (Canada). **Method**: A cross-sectional design was employed for this study. It was conducted across 7 general hospitals and specialized mental health institutions in Quebec, with a sample of 192 patients. Construct validity was assessed using exploratory factor analysis. Internal consistency was evaluated using Cronbach's alpha (α) and McDonald's omega (ω). Convergent validity was measured using a correlation matrix between scores on the *Échelle de la coercition perçue* (ECS-FR) and the French-language version of the Violence Prevention Climate scale (VPC-M-FR). **Results**: The ECS-FR consists of 15 items across 2 subscales: (1) Restriction of Freedom, and (2) Dehumanization. The instrument demonstrated excellent internal consistency (Cronbach's alpha = 0.93 and McDonald's omega =0.93). Convergent validity was supported by a significant negative association between ECS-FR and VPC-M-FR scores (r = -0.63, $p < 0.001$), indicating that a higher perceived violence prevention climate was associated with lower levels of perceived coercion. **Discussion and Conclusion**: The ECS-FR shows good psychometric properties. Its use across various inpatient mental health settings paves the way for further exploration of the factors underlying perceived coercion.

Mots-clés

coercition perçue; psychiatrie légale; santé mentale; coercition; validation

Résumé

Introduction : La coercition perçue désigne l'expérience subjective de la coercition vécue par les personnes recevant des soins en psychiatrie. Or, elle peut compromettre leur processus de rétablissement. L'*Experienced Coercion Scale* (ECS) est un outil validé permettant d'évaluer la coercition perçue. **Objectifs** : Cette étude vise la traduction, l'adaptation et l'évaluation des propriétés psychométriques d'une version francophone de l'ECS auprès de patients hospitalisés en psychiatrie générale et médicolégale au Québec (Canada). **Méthode** : Une étude transversale a été réalisée dans 7 instituts spécialisés en santé mentale au Québec, auprès d'un échantillon regroupant 192 patients. La validité de construit a été vérifiée avec l'analyse factorielle exploratoire. La consistance interne a été évaluée avec l'alpha de Cronbach (α) et l'oméga de McDonald (ω). La validité convergente a été mesurée avec une matrice de corrélation entre les scores de l'Échelle de la coercition perçue (ECS-FR) et de l'Échelle modifiée du climat de prévention de la violence (VPC-M-FR). **Résultats** : L'ECS-FR est constituée de 15 énoncés et 2 sous-échelles : (1) Privation des libertés individuelles, (2) Déshumanisation. L'instrument possède une excellente consistance interne (alpha de Cronbach = 0.93 et oméga de McDonald = 0.93). La validité convergente révèle une association significativement négative entre les scores de l'ECS-FR et de l'échelle VPC-M-FR (r = −0.63, $p < 0.001$), indiquant qu'une perception d'un climat plus favorable à la prévention de la violence est associée à une réduction du degré de coercition perçue. **Discussion et conclusion** : L'ECS-FR présente de bonnes propriétés psychométriques. Son utilisation dans divers contextes de soins psychiatriques hospitaliers ouvre la voie à l'exploration des facteurs inhérents à la coercition perçue.

INTRODUCTION

The physical and psychological repercussions of coercion can affect an individual's life course (Baggio et al., 2024; Chieze et al., 2019). Coercion may generate feelings of shame, guilt, or injustice, and potentially reactivate past traumas (Chieze et al.; Guzmán-Parra et al., 2019). Furthermore, the United Nations High Commissioner for Human Rights (2017) has stated that coercive practices result in the deprivation of personal liberties and, consequently, constitute a form of contemporary torture. Coercion in mental health takes three distinct forms: formal, informal, and perceived (Paradis-Gagné et al., 2021). Formal coercion includes involuntary hospitalization and treatment, which are based on various legal mechanisms, as well as the use of restrictive practices in a mental health crisis, such as seclusion and mechanical or chemical restraints (Pariseau-Legault et al., 2020). In the context of psychiatric care, informal coercion refers to exerting pressure, for example through persuasion or inducement, to influence patients' actions and decisions, or through threats to impose coercive measures (Beeri et al., 2025; Billé et al., 2024; Pelto-Piri et al., 2019). Finally, perceived coercion refers to the subjective experience of coercion within mental healthcare (Lessard-Deschênes et al., 2022; Tingleff et al., 2017).

Research on perceived coercion in mental healthcare highlights a complex and multifaceted etiology. By combining the results on the raw prevalence of coercion, Newton-Howes & Stanley (2012) found that perceived coercion was experienced by 74% of involuntary patients and 25% of voluntary patients. In this regard, the level of perceived coercion among inpatients is notably influenced by a previous sense of loss of control over their own lives (Silva et al., 2023b). Corderoy et al. (2024) described the existence of a "cycle of coercion", in which patients' experiences are characterized by a sense of unjustified power dynamic, which, in turn, is associated with increased exposure to both formal and informal coercive situations. For many, if not most psychiatric inpatients, lack of knowledge about their legal status and rights amplifies this power imbalance (Corderoy et al.). Additionally, certain features of the therapeutic environment, such as the imposition of a predetermined schedule, a physical layout that limits privacy, or the strict enforcement of rules, which patients interpret as an infringement on their autonomy, increase patients' perceived coercion (Lessard-Deschênes et al., 2025; Silva et al., 2023b). Although involuntary hospitalization is associated with higher levels of perceived coercion (Fiorillo et al., 2012; O'Callaghan et al., 2021; Sampogna et al., 2019), many voluntarily admitted inpatients report similar levels of perceived coercion, notably due to their limited involvement in decision-making processes (Katsakou et al., 2011), and a low degree of procedural justice (O'Donoghue et al., 2014). Procedural justice refers to patients' perceptions of fairness, transparency, and degree of participation in the decision-making processes that affect their rights and well-being (Lessard-Deschênes et al., 2024; Lind & Tyler, 1988). However, findings from several studies indicate limited patient involvement in these decision-making processes and a lack of transparency in the information provided by clinicians, with some information even perceived as misleading (Hotzy et al., 2023; Silva et al., 2023a). The feeling of not being treated fairly, lacking space to express oneself, and having one's point of view ignored in decision-making processes, combined with the experience of various coercive situations, can reduce trust in clinicians (Goulet & Larue, 2017; Silva et al., 2023b). Poor-quality relationships further amplify perceived coercion (Sheehan & Burns, 2011; Theodoridou et al., 2012). In addition, previous research suggests that the factors associated with perceived coercion do not differ substantially between populations across forensic and general psychiatric settings (Lessard-Deschênes et al., 2025).

Psychiatric inpatients with high levels of perceived coercion experience a range of repercussions, such as a deterioration in quality of life (Fossum et al., 2024), reduced self-esteem, increased feelings of stigma, and the perception of being forced to undergo treatment considered ineffective and unsuited to their preferences (Silva et al., 2023a). Other studies have highlighted increased patient treatment disengagement,

which, in turn, negatively impacts their recovery process (Silva et al.). A high level of perceived coercion during hospitalization was associated with a higher prevalence of suicide attempts following hospital discharge, regardless of legal status (Jordan & McNiel, 2020). Additionally, experiences of restrictive practices during previous hospitalizations contribute to the avoidance of health services and increase anxiety, mistrust of clinicians, and psychological distress during future voluntary hospitalizations (Martinez et al., 2022).

Over the years, several standardized tools have been developed to assess perceived coercion among psychiatric inpatients reflecting different conceptualizations of the construct. The Coercion Ladder (CL) conceptualizes perceived coercion on a continuum; the MacArthur Admission Experience Survey (AES) focuses on patients' experience during the admission process; and the Coercion Experience Scale (CES) assesses perceived coercion in patients exposed to formal coercive practices. However, each of these instruments presents important limitations. The CL (Høyer et al., 2002), which assesses perceived coercion using a single item on a 10-point scale (1 = minimum use of coercion, 10 = maximum use of coercion), does not capture the multidimensional nature of the construct. The AES (Gardner et al., 1993) is limited to admission context and focuses on the presence of coercive events, without fully accounting for the complexity of factors influencing the patient's lived experience. Similarly, the CES (Bergk et al. 2010), assessing experiences related to coercive practices such as seclusion and restraints does not encompass the broader range of organizational and interpersonal factors influencing perceived coercion. Indeed, perceived coercion extends beyond restrictive practices and is influenced by multiple contextual factors, including therapeutic relationships and care environments (Lessard-Deschênes et al., 2022). Although French versions of the AES and CES have already been adapted and validated (Golay et al., 2017; Golay et al., 2019), their conceptual limitations support the need for the development of more comprehensive measurement tools to assess perceived coercion in mental health settings.

Adopting a patient-centred approach, Nyttingnes et al. (2017) developed the Experienced Coercion Scale (ECS) using samples of adult patients from acute and non-acute inpatient psychiatric units, outpatient care, and supported housing, to address previously identified gaps in existing scales. The ECS is not limited to assessing perceived coercion in specific care contexts and is thus applicable to various treatment modalities. The ECS items focus on patients' perceptions of deprivation of individual liberties and their feelings associated with the subjective experience of constraint in the treatments received, without explicitly referring to coercive situations. Therefore, this scale measures perceived coercion even among patients who have not experienced formal coercion. This approach enables a more in-depth evaluation of the underlying factors of perceived coercion. The final 15-item version of the ECS, originally developed in Norwegian and subsequently translated into English, demonstrated satisfactory psychometric properties (Nyttingnes et al.). It comprises two distinct dimensions: Humiliation and Disillusion, consistent conceptualizations of perceived coercion as encompassing feelings of humiliation and powerlessness in decision-making processes (Lessard-Deschênes et al., 2025). The ECS has since been applied in various mental health settings (Fossum et al., 2024; Indregard et al., 2024).

OBJECTIVES

Given the lack of a validated French version of the ECS, and considering the conceptual limitations of existing French-language instruments, there is a need for a robust, patient-centred tool to assess perceived coercion in French-speaking psychiatric settings. Accordingly, the present study aims to translate, adapt, and evaluate the psychometric properties of a French-language version of the ECS among a sample of psychiatric inpatients from general and forensic settings in Quebec, Canada.

METHOD

1) Setting and Participants

This cross-sectional study was conducted between January and December 2024 across seven general hospitals and specialized mental health

institutions in Quebec, for a total of 21 care units admitting adults for general or forensic psychiatric stays. Four were university-affiliated specialized mental health institutions, one was a university hospital center, and two were regional hospitals. The university-affiliated institutions and the university hospital center were in urban areas, including three in Montréal, while the regional hospitals were in rural areas. General psychiatric units admitted patients with diverse mental health conditions, whereas forensic psychiatric units admitted individuals with mental health disorders and judicial involvement.

The validation of the ECS-FR was conducted as part of a larger mixed-methods research project that aimed to recruit 210 patients using convenience sampling. In accordance with psychometric guidelines recommending a minimum of 10 participants per item (Boateng et al., 2018), a sample size of at least 150 participants was required for the psychometric validation of the 15-item ECS. The inclusion criteria for participation were as follows: (1) being 18 years of age or older; (2) being able to speak and understand French; and (3) being hospitalized in a general or forensic psychiatric care unit. Specialized units for intellectual disabilities, child and adolescent psychiatry, or geriatric psychiatry were excluded for methodological consistency, as the original instrument was neither developed nor validated for these specific clinical populations.

2) Measurement Instruments

2.1) Experienced Coercion Scale (ECS)

The Experienced Coercion Scale (ECS) is a self-report questionnaire designed for patients in mental health settings (Nyttingnes et al., 2017). The items are rated with a Likert scale ranging from 0 to 4 (0 = Strongly Disagree, 4 = Strongly Agree). Based on their validation study, Nyttingnes et al. proposed the following interpretation of the average ECS sum scores: 0-1 = no perceived coercion, 1-2 = low perceived coercion, 2-3 = noteworthy perceived coercion, and 3-4 = high perceived coercion. Therefore, higher mean ECS scores indicate greater levels of perceived coercion. The psychometric properties of a 20-item version of this instrument were evaluated in Norway across five psychiatric facilities, with a sample of 219 patients (Nyttingnes et al.). By selecting the items with the best psychometric properties, the authors developed a final version of 15 items. In its original version, the tool demonstrates excellent internal consistency (α = 0.95) and includes the following dimensions: Humiliation and Disillusion (Nyttingnes et al.). The final 15-item version of the scale was used to address the objective of the present study.

2.2) Violence Prevention Climate Scale

The *Échelle modifiée du climat de prévention de la violence* (VPC-M-FR), the French-language version of the Violence Prevention Climate Scale, is a self-report questionnaire that measures patients' and staff's perceptions of the violence prevention climate in general or forensic psychiatric care units (Goulet et al., 2021). The violence prevention climate, which is part of the social climate of the therapeutic environment, targets organizational, interpersonal, and environmental factors related to the prevention of violence and its coercive response. Inpatients influence the social climate through the quality of their interactions with their environment and the meanings they attribute to it. Adapted and validated in Quebec, the VPC-M-FR demonstrates satisfactory psychometric properties and is composed of the following three dimensions: staff actions, patient actions, and characteristics of the therapeutic environment (Goulet et al.). The items are rated with a Likert scale, ranging from 1 to 5 (1 = Strongly Disagree, 5 = Strongly Agree). Scores are interpreted as follows: higher scores indicate a more favorable climate for the prevention of violence and aggression within the setting.

3) Procedure

The French translation of the ECS was titled the *Échelle de la coercition perçue* (ECS-FR). The tool's main author (Nyttingnes) approved the use of the original scale for its translation and adaptation in the context of Quebec. Initially, a meeting was held between the original scale's author and the Quebec research team to contextualize the meaning of each item, which could lead to different translations.

The translation of the ECS was conducted in accordance with recommended best practices (Corbière & Fraccaroli, 2020). Initially, the original

version was independently translated from Norwegian into French by two certified translators from a professional translation agency based in Canada. A preliminary French-language version of the instrument was then developed by the research team through a comparative review of the original version and the two translated versions, allowing for the identification and resolution of discrepancies between translations. This preliminary version was subsequently reviewed by a bilingual nurse (French and Norwegian) with clinical expertise in psychiatry. A back-translation was then performed from French into Norwegian by two additional certified translators from the same professional translation agency.

Following this step, an expert committee was assembled, consisting of five individuals from Quebec, France, and Switzerland, including nurses, psychiatrists, and French-speaking researchers with expertise in perceived coercion. A meeting was held between the research team and the expert committee, during which the experts conducted a critical appraisal of the items and translated versions of the instrument, with particular attention to item consistency, the appropriateness of the vocabulary, and conceptual coherence with the construct of perceived coercion (Corbière & Fraccaroli, 2020). Among the committee's primary recommendations was the clarification of the wording of certain items. For example, in the first item, "*Les traitements et le soutien reçus briment ma liberté*," the verb "*brimer*" was replaced with "*limiter*" to better reflect the intended meaning.

Subsequently, face validity was assessed using a sample of individuals reflecting the characteristics of the instrument's target population (Corbière & Fraccaroli, 2020; Lim, 2024). A preliminary version of the ECS-FR, revised based on feedback from the expert committee, was submitted to four peer-support workers from the *Société québécoise de la schizophrénie et des psychoses apparentées* (Schizophrenia Society of Quebec) for a qualitative assessment of item clarity and the appropriateness of the vocabulary. These peer-support workers possess experiential knowledge of psychiatric hospitalization and perceived coercion, supporting the relevance of their inclusion as representatives of the psychiatric inpatient's perspective. At this stage, no modifications were required, as the items were considered adequate to ensure comprehension among the targeted population.

Lastly, participants were recruited on a voluntary basis in collaboration with managers and nursing staff. A member of the research team met participants in a private office within the study setting. A consent form was provided, and the research team member was available to answer any questions. Participants were given 30 minutes to complete the sociodemographic questionnaire (age, gender, psychiatric diagnosis, education level), the ECS-FR, and the VPC-M-FR individually.

4) Data Analysis

All analyses were performed using the statistical software JASP, version 0.19.3.0 (JASP Team, 2025). Confirmatory factor analysis was conducted using the R package lavaan (Rosseel, 2012). The analyses were conducted in collaboration with a statistician from the Research Centre of the *Institut universitaire en santé mentale de Montréal*. A significance level of $p < 0.05$ was used. Descriptive statistics were performed to analyze the characteristics of the collected data. Participants with missing data on one or more scale items were excluded from the analyses.

4.1) Data Distribution

Total scores of the ECS-FR were calculated for each participant. Kolmogorov-Smirnov tests, as well as skewness and kurtosis coefficients, were used to verify whether the distribution of total scores followed a normal distribution.

4.2) Construct Validity

Confirmatory factor analysis was conducted to examine the factorial structure of the ECS-FR. Both one- and two-factor models were tested based on the structure proposed by Nyttingnes et al. (2017). Two specifications of the two-factor model were examined: a correlated-factor model and an orthogonal-factor model. Robust maximum likelihood estimation was used to account for the non-normality of the data (Brown, 2015; Li, 2016). Model fit was assessed using the χ^2 statistic, the Comparative Fit Index (CFI), the Tucker–Lewis

Index (TLI), the Root Mean Square Error of Approximation (RMSEA), and the Standardized Root Mean Square Residual (SRMR). CFI and TLI values ≥ 0.90–0.95 were considered indicative of acceptable to good model fit, while RMSEA ≤ 0.06 and SRMR ≤ 0.08 indicated good fit (Boateng et al., 2018; Hu & Bentler, 1999).

As these models showed unsatisfactory fit, an exploratory factor analysis was subsequently conducted to further investigate the underlying factor structure and construct validity (Watkins, 2018). Bartlett's test of sphericity and the Kaiser-Meyer-Olkin (KMO) index were performed to verify whether the sample was suitable for factor analysis. The extraction method used was principal axis factoring, followed by an Oblimin rotation, as the factors were expected to be correlated. A parallel analysis and the use of Cattell's scree test were employed to select the appropriate number of factors. Items loading below 0.40 on a single factor were evaluated for potential exclusion (Watkins), although no items ultimately met this criterion.

Convergent validity was assessed using a bivariate correlation matrix between the total scores obtained on the ECS-FR and the VPC-M-FR, as well as their respective dimensions. Based on the distribution of the data, nonparametric correlations (Spearman's rho) were used. It was expected that subscales measuring the same construct would show moderate to high correlations (Boateng et al., 2018; Schober & Schwarte, 2018). Its theoretical relationship with the ECS-FR supports the relevance of the VPC-M-FR for assessing convergent validity (Netemeyer et al., 2003). The VPC-M-FR evaluates, through its items, various factors related to perceived coercion, including the quality of the therapeutic relationship and perceptions of power dynamics within the decision-making process. Additionally, several items assess staff actions regarding the enforcement of unit rules, as well as how staff interact with and intervene with patients (Goulet et al., 2021). These elements align with the concept of procedural justice, which has been linked to perceived coercion in the literature (Lessard-Deschênes et al., 2025). A higher score on the VPC-M-FR indicates a perception of a climate more conducive to violence prevention, thereby reflecting greater procedural justice (Goulet et al.). Regarding the ECS-FR, higher scores reflect higher levels of perceived coercion. Consistent with previous findings, higher procedural justice has been associated with lower levels of perceived coercion (Lessard-Deschênes et al.; Morandi et al., 2024). Therefore, negative correlations were expected between the ECS-FR and the VPC-M-FR and their respective dimensions.

4.3) Reliability

The internal consistency of the ECS-FR and its subscales was analyzed using Cronbach's alpha (α). An alpha coefficient of 0.70 suggests acceptable internal reliability, while a value between 0.80 and 0.95 is optimal for an instrument (Boateng et al., 2018; Raykov & Marcoulides, 2010). MacDonald's omega was evaluated using the same thresholds (Madadizadeh & Bahariniya, 2025). Adjusted item-total correlations, i.e., the correlations between an item and the remainder of the instrument (excluding the item itself), were calculated using Spearman's coefficient. All items shown adjusted item–total correlations above the 0.30 threshold, and none were excluded (Boateng et al., 2018).

ETHICAL CONSIDERATIONS

This study has received its ethical approval from the *Centre intégré universitaire de santé et de services sociaux* de l'Est-de-l'Île-de-Montréal (MP-12-2022-2787). Additionally, this study adheres to the ethical principles outlined in the Tri-Council Policy Statement for research involving humans (Canadian Institutes of Health Research et al., 2022). All participants received $20 (CAD) financial compensation for their participation. Data from each participant were de-identified and stored in a secure, access-restricted file on the *Espace de stockage actif de volume standard pour la recherche* (ESRech). ESRech is a secure institutional storage platform for highly confidential research data at the *Université de Montréal*.

RESULTS

1) Sample Characteristics

The sample consisted of 192 patients hospitalized in the study setting. Six participants

were excluded from the study due to incomplete responses to certain items of the ECS-FR. The characteristics of the participants are listed in Table 1.

2) Data Distribution

Kolmogorov-Smirnov tests revealed significant results ($p < 0.01$), suggesting that the distributions of total ECS-FR scores did not follow a normal distribution. Nevertheless, the skewness and kurtosis coefficients were -0.54 and 0.42, respectively. Thus, the data collected with the ECS-FR tend toward a normal distribution.

3) Psychometric Qualities of the *Échelle de la coercition perçue*

3.1) Construct Validity

Confirmatory Factor Analysis. The one-factor model, as well as the uncorrelated and correlated two-factor models of the ECS-FR, were tested based on the original 15-item structure of the instrument but showed inadequate model fit (Table 2). Overall model fit and the discrepancy between observed and model-implied covariance matrices were assessed using the chi-square statistic (Boateng et al., 2018; Raykov & Marcoulides, 2010). The chi-square tests were statistically significant, indicating differences between model-implied and observed covariance matrices (Raykov & Marcoulides). Additional fit indices for the uncorrelated two-factor model revealed poor fit (Boateng et al.; Hu & Bentler, 1999). Although the CFI and SRMR suggested acceptable fit for the one-factor and correlated two-factor models, TLI values below 0.90 and RMSEA values above 0.06 showed inadequate fit (Hu & Bentler). Consequently, these findings do not support either the original one-factor structure or the correlated two-factor structure of the ECS proposed by Nyttingnes et al. (2017).

Given the absence of a well-fitting confirmatory model and the limited distinction between competing structures, an exploratory factor analysis was conducted to further investigate the underlying dimensionality of the ECS-FR.

Exploratory Factor Analysis. Bartlett's test of sphericity revealed that the correlation matrix was not an identity matrix, χ^2 (105) = 1512.73, $p < 0.001$, indicating significant correlations between the items. The KMO index showed excellent sampling adequacy, MSA = 0.93. Thus, the collected data possessed the required properties for conducting a factor analysis.

Parallel analysis and Cattell's scree test identified a two-factor model, comprising the Restriction of Freedom subscale and the Dehumanization subscale, which together included a total of 15 items. Table 3 presents the descriptive statistics for the items, their factor loadings on each factor, and the adjusted item-total correlations. No items were excluded, as all had loadings greater than 0.40 on a single factor. After rotation, the Restriction of Freedom subscale explained 27.10% of the total variance in the data, while the Dehumanization subscale accounted for 24.20%, for a cumulative variance of 51.30%. The factors showed a strong positive correlation of 0.72, indicating that they are intrinsically related yet distinct.

Convergent Validity. Correlations between the ECS-FR, VPC-M-FR, and their respective dimensions are listed in Table 4. The total scores of the ECS-FR showed statistically significant, negative, and moderate correlations with the VPC-M-FR scores, Spearman's r = -0.63 (95% CI [-0.71, -0.54]), $p < 0.001$. Regarding the VPC-M-FR subscales, the correlations with the total ECS-FR scores were also significant, negative, and moderate. Specifically, the Spearman's rank correlation coefficients for the subscales of staff actions and characteristics of the therapeutic environment were -0.64 (95% CI [-0.72, -0.54]) and -0.46 (95% CI [-0.56, -0.33]), respectively ($p < 0.001$).

Reliability. The internal reliability of the ECS-FR was analyzed using Cronbach's alpha (α) and McDonald's omega (ω) for all 15 items (M = 42.92, SD = 11.68). The results show excellent internal consistency for the ECS-FR, α = 0.93 (95% CI [0.91–0.94]) and ω = 0.93 (95% CI [0.92-0.94]). For the Restriction of Freedom and the Dehumanization subscales, internal reliability was very good. The alpha coefficients were α = 0.88 (95% CI [0.85–0.90]) and α = 0.89 (95% CI [0.86–0.92]), and the omega coefficients were ω = 0.88 (95% CI [0.85–0.90]) and ω = 0.89 (95% CI [0.87–0.91]), respectively.

Table 1

Sample Characteristics

Characteristics (*N* = 192)	Mean ± SD	
Age (years)	41.07 ± 14.13	
	n	*%*
Gender		
Woman	59	30.7
Man	130	67.7
Non-binary	3	1.6
Education level		
High school not completed	15	7.8
High school	107	55.7
College	36	18.8
University	30	15.6
Not specified	4	2.1
Diagnosis[ab]		
Neurodevelopmental Disorders	15	7.8
Schizophrenia	45	23.4
Schizoaffective	23	12.0
Other Psychotic Disorders	24	12.5
Bipolar Disorders	41	21.4
Depressive Disorders	16	8.3
Anxiety Disorders	8	4.2
Obsessive-Compulsive Disorders	3	1.6
Trauma- and Stress-Related Disorders	3	1.6
Dissociative Disorders	1	0.5
Eating Disorders	2	1.0
Substance-Related Disorders	1	0.5
Personality Disorders	14	7.3
Not Specified	30	15.6

Notes. [a]Self-reported diagnosis; [b]Multiple responses.

Table 2

Fit Indices for Confirmatory Factor Analysis Models of the ECS-FR

ECS-FR Models	Adjustment fit indices					
	df	χ^2	CFI	TLI	RMSEA	SRMR
M1. One-factor	90	233.72*	0.902	0.885	0.091	0.055
M2. Uncorrelated two-factor	90	459.36*	0.748	0.706	0.146	0.283
M3. Correlated two-factor	89	233.54*	0.901	0.883	0.092	0.055

Notes. *p < 0.001; CFI = Comparative Fit Index; TLI = Tucker-Lewis Index; RMSEA = Root Mean Square Error of Approximation; SRMR = Standardized Root Mean Squared Residual.

Table 3

Item Characteristics, Factor Loadings and Item-Total Correlations for the ECS-FR

Item[a]	Item characteristics		Restriction of Freedom	Dehumanization	Adjusted item-total correlations
	Mean ± SD[b]	Median[b]	Factor loading		
1. Les traitements et le soutien reçus limitent ma liberté. [The treatment makes me feel restricted.]	3.48 ± 1.07	4.00	**0.81**	-0.14	0.59
2. Je suis insatisfait(e) de la pression ressentie dans le cadre des traitements et du soutien reçus. [I am dissatisfied with the coercion in this treatment.]	3.06 ± 1.15	3.00	**0.74**	0.02	0.68
5. Je fais confiance aux professionnels de la santé. [I trust the health professionals.]	2.56 ± 1.04	2.00	**0.60**	0.03	0.57
6. Je suis d'accord sur la nécessité de ce traitement et de ce soutien. [I agree that the treatment should be carried out.]	2.67 ± 1.02	2.00	**0.60**	0.01	0.55

Item[a]	Item characteristics		Restriction of Freedom	Dehumanization	Adjusted item-total correlations
4. Je me sens impuissant(e). [I feel powerless.]	3.17 ± 1.11	4.00	**0.59**	0.13	0.65
3. Je me sens atteint dans ma dignité. [I feel violated.]	3.03 ± 1.14	3.00	**0.54**	0.27	0.73
12. Je me sens puni(e). [I feel punished.]	3.06 ± 1.17	3.00	**0.53**	0.22	0.68
11. Je ressens une atteinte à ma vie privée. [My private life has been invaded.]	3.05 ± 1.12	3.00	**0.44**	0.29	0.65
8. Je me sens humilié(e). [I feel humiliated.]	2.56 ± 1.06	2.00	-0.08	**0.88**	0.69
10. Je me sens sans importance. [I feel unimportant.]	2.56 ± 1.04	2.00	-0.06	**0.76**	0.60
7. Je me sens traité(e) comme un objet. [I feel treated like an object.]	2.69 ± 1.08	2.00	0.21	**0.63**	0.74
14. On me menace pour que je reçoive les traitements et le soutien proposés. [I am being threatened to receive treatment.]	2.69 ± 1.15	2.00	0.22	**0.56**	0.69
9. Je me sens paralysé(e). [I feel paralysed.]	2.70 ± 1.08	2.00	0.18	**0.49**	0.59
15. Je me sens considéré(e) comme un diagnostic. [I am treated like a diagnosis.]	2.99 ± 1.18	2.00	0.36	**0.47**	0.73
13. Ma situation s'aggrave en raison des traitements et du soutien reçus. [My situation is getting worse because of the treatment.]	2.66 ± 1.09	2.00	0.33	**0.45**	0.70

Notes. [a]Scores for items 5 and 6 have been reverse-coded; [b]Range: 1-5. Response scale: (1) strongly disagree; (2) disagree; (3) neither agree nor disagree; (4) agree; (5) strongly agree.

Table 4

Bivariate Correlations Between ECS-FR Total and Subscale Scores and VPC-M-FR Scores

Scale and subscale		Échelle modifiée du climat de prévention de la violence (VPC-M-FR)			
		Total Score	Staff action	Patient action	Therapeutic environment
Échelle de la coercition perçue (ECS-FR)	Total Score	-0.63*	-0.64*	-0.21**	-0.46*
	Restriction of Freedom	-0.58*	-0.59*	-0.19**	-0.43*
	Dehumanization	-0.63*	-0.63*	-0.21**	-0.45*

Notes. Spearman's rank correlation coefficient; * $p < 0.001$; ** $p < 0.05$.

DISCUSSION

This study aimed to translate, adapt, and evaluate the psychometric properties of a French-language version of the ECS in the context of Quebec (Canada). Overall, the analyses indicated that the ECS-FR has good psychometric properties.

Confirmatory factor analysis did not provide adequate fit for the tested models. Consequently, the original factorial structure was not confirmed. This may be attributed to differences in sample characteristics and contexts, as the ECS-FR was validated exclusively with inpatients, whereas Nyttingnes et al. (2017) used a mixed sample of psychiatric inpatients, outpatients, and individuals in supported housing. Differences in care settings, such as variations in treatment episodes and institutional environments, may influence patients' experiences of care and perceived coercion, which, in turn, may have affected the instrument's factor structure.

Exploratory factor analysis revealed a two-dimensional factor structure, corresponding to the subscales: 1) Restriction of Freedom and 2) Dehumanization. This structure maintains conceptual validity, particularly in inpatient settings, and aligns with recent findings on perceived coercion and procedural justice, emphasizing dimensions related to the restriction of individual liberties and experiences of humiliation in decision-making processes (Aragonés-Calleja & Sánchez-Martínez, 2025; Husum et al., 2019; Morandi et al., 2024; Silva et al., 2023b). Moreover, both the items of the ECS-FR and its two-dimensional factor structure capture key factors identified in the literature that influence the quality of the therapeutic relationship and perceived coercion, such as procedural justice, relational dynamics, and power imbalances (Lessard-Deschênes et al., 2025).

In the original version of the tool, Nyttingnes et al. (2017) proposed a two-factor model (Humiliated and Disillusioned subscales), although the psychometric properties of a one-factor structure were also found to be satisfactory. However, the composition of the ECS and ECS-FR subscales differs. This discrepancy may be attributed to differences in sample characteristics and study context between the ECS-FR and the original ECS validation study. Despite differences between Norway and Canada regarding cultural and legal contexts, many inpatients in Norwegian mental health settings are exposed to coercion (Nyttingnes et al., 2016), experience limited involvement in decision-making (Haugom et al., 2022), and are affected by therapeutic environments whose configuration may accentuate the coercive nature of psychiatric stays (Indregard et al., 2024). These factors align with key similarities in psychiatric settings in Quebec and Canada (Goulet et al., 2023).

The ECS-FR and its subscales also demonstrated excellent internal consistency, suggesting that the 15 items measure the same underlying construct (Boateng et al., 2018), which is perceived coercion in mental healthcare. Adjusted item-total correlations revealed moderate to strong associations, indicating that each item effectively contributes to the measurement of perceived coercion. No items were excluded from the instrument, thus maintaining 15 items in the ECS-FR, consistent with the original version proposed by Nyttingnes et al. (2017).

The Restriction of Freedom subscale includes items referring to patients' perceptions of a deprivation of their liberty and autonomy in decision-making processes and treatments received (items 1, 2, 3, 4, 5, 6, 11, 12). Past research has shown that deprivation of liberty stems primarily from the experience of both formal and informal coercive situations, leading to a sense of loss of control as well as an infringement on their dignity and rights (Aragonés-Calleja & Sánchez-Martínez, 2025; Silva et al., 2023b). Regarding procedural justice, a recent study found that greater perceived inequity and a lack of transparency from clinicians in decision-making processes and treatment are related to higher levels of perceived coercion, particularly when patients feel excluded from decisions about their care (Morandi et al., 2024). Furthermore, it has been shown that a power imbalance, in which patients' treatment preferences are neglected or ignored, reinforces their perception of a deprivation of liberty and autonomy, intensifying the feeling of being forced to undergo treatment (Silva et al.).

The Dehumanization subscale includes items related to patients' feelings of humiliation and dehumanization in the treatments and care received (items 7, 8, 9, 10, 13, 14, 15). In the factor structure proposed by Nyttingnes et al. (2017), a dimension related to feelings of humiliation is also identified, although some of the items differ from those included in our subscale. Past research has described various relationships between coercion in mental healthcare and the expression of negative emotions by patients (Husum et al., 2019). In this regard, the experience of coercive situations has been shown to lead to feelings of frustration, humiliation, helplessness, and stigmatization (Husum et al.; Nyttingnes et al., 2016; Tingleff et al., 2017). Such situations are also associated with patients' perceptions of no longer being treated as human beings but rather being reduced to their diagnosis and symptomatology (Verbeke et al., 2019). Thus, studies have shown that a higher degree of perceived coercion appears to be linked to the expression of negative emotions, including humiliation, resulting in a deterioration of psychological well-being and self-esteem, as well as the reactivation of past traumas (Husum et al.).

Moreover, the bivariate correlation matrix between the scores on the ECS-FR and the VPC-M-FR, as well as their respective subscales, revealed statistically significant results. These findings suggest that a higher perceived climate of violence prevention is associated with lower levels of perceived coercion among inpatients in mental health settings. Consequently, these two instruments evaluate, through their respective items, different factors related to perceived coercion. In this regard, a systematic review by Aguilera-Serrano et al. (2018) highlights various characteristics of the therapeutic environment associated with increased levels of perceived coercion, such as patients' perceptions of a hostile atmosphere within the care unit, lack of access to recreational activities, or the layout of spaces that limit privacy. Thus, the results of the bivariate correlation matrix suggest that perceived coercion is not limited to the subjective experience of coercive situations but results from an interaction of organizational factors and various characteristics of mental healthcare settings.

Strengths and Limitations of the Study

Certain study strengths can be highlighted. First, the study was conducted in a variety of psychiatric settings, including general psychiatric units, acute or intensive treatment units, and forensic psychiatric units. The sample included patients from diverse clinical and care contexts, providing a more accurate representation of the hospitalized psychiatric population. Furthermore, incorporating peer-support workers into the face validity process enhanced the alignment of the

instrument's items with the real-life experiences of inpatients in mental healthcare settings.

However, our study has several limitations. It should be noted that the instrument's test-retest reliability was not examined. Since perceived coercion remains a psychological variable likely to vary according to different factors, it is not necessarily stable over time. Although such an analysis has methodological limitations in this context, it would have been interesting to assess short-term temporal reliability (e.g., over 1 month). Moreover, as this is a self-report measure, responses may be influenced by social desirability bias. Additionally, as the sample included only inpatients, the ECS-FR has not been validated for psychiatric outpatients or individuals in supported housing. It is also limited to adult psychiatry and has not been validated for children, adolescents, or geriatric inpatients. Furthermore, since this study was conducted in Quebec (Canada), it cannot be assumed that the instrument will perform equally well across the French-speaking world, as cultural, legal, and systemic differences may influence how psychiatric hospitalization and coercion are perceived and experienced, as well as how the items are interpreted. Therefore, caution is warranted when applying the ECS-FR outside the present study's context. While the two-factor structure is conceptually meaningful, its interpretation should remain cautious, as it was derived from the same sample and has not yet been cross-validated.

Potential Clinical Impact and Future Research

The ECS-FR is simple to use and applicable in a variety of settings and care contexts. This scale facilitates analysis of the underlying factors of perceived coercion in mental healthcare. The psychometric properties of this instrument were evaluated in a sample of participants with diverse clinical and sociodemographic characteristics. Thus, its use in clinical settings can be implemented in general or forensic psychiatry, with patients receiving various treatment modalities, whether in medium- to long-term hospitalization units or intensive psychiatric care.

The ECS-FR could contribute to assessing the effectiveness of new interventions aimed at reducing the use of formal and informal coercion in psychiatry. Such future studies would also allow for assessment of the instrument's sensitivity to change.

Conclusion

The French-language version of the Experienced Coercion Scale demonstrates good psychometric properties. The results of this study highlight the relevance of using this tool to assess the underlying factors of perceived coercion in mental healthcare, thereby paving the way for the implementation of interventions that should be explored in future research.

Authors' contribution: AC, MHG, ON and CLD conceptualized this study. VB and MD were responsible for data collection. JSD conducted the statistical analyses and prepared the initial draft of the manuscript. All authors reviewed and approved the final version of the manuscript.

Acknowledgments: The authors would like to thank the *Société québécoise de la schizophrénie et des psychoses apparentées*, the managers and clinicians who facilitated the recruitment, as well as the participants of this study. The authors would also like to thank Charles-Édouard Giguère, statistician at the *Centre de recherche de l'Institut universitaire en santé mentale de Montréal*, for his assistance.

Funding: The study was funded by the Social Sciences and Humanities Research Council of Canada and by *the Fondation de l'Institut universitaire en santé mentale de Montréal*. MHG is holder of a Junior 1 salary award from the *Fonds de recherche du Québec - Santé*. AC acknowledges the support from the Canada Research Chairs' program.

Statement of conflict of interest: The authors declare no conflict of interest.

Generative Artificial Intelligence (AI) and AI-assisted technologies statement: The authors used ChatGPT (GPT-4, Jully 2025) to assist with the translation of the manuscript from French to English. The translations have been checked and edited by the authors, who take full responsibility for the content of this manuscript.

Reçu/Received: 8 Août/August 2025 **Publié/Published:** 24 Mars/March 2026

REFERENCES

Aguilera-Serrano, C., Guzman-Parra, J., Garcia-Sanchez, J. A., Moreno-Küstner, B., & Mayoral-Cleries, F. (2018). Variables Associated With the Subjective Experience of Coercive Measures in Psychiatric Inpatients: A Systematic Review. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *63*(2), 129–144. https://doi.org/10.1177/0706743717738491

Aragonés-Calleja, M., & Sánchez-Martínez, V. (2025). Users' Experience of Treatment and Coercion in an Inpatient Medium-Stay Psychiatric Rehabilitation Unit: A Mixed Methods Study. *Journal of Psychiatric and Mental Health Nursing*, *32*(2), 467–481. https://doi.org/10.1111/jpm.13128

Baggio, S., Kaiser, S., Huber, C. G., & Wullschleger, A. (2024). Effect of coercive measures on mental health status in adult psychiatric populations: a nationwide trial emulation. *Epidemiology and Psychiatric Sciences*, *33*, e35. https://doi.org/10.1017/S2045796024000416

Beeri, S., Baumberger, E., Zwakhalen, S., & Hahn, S. (2025). Conceptualisation of Informal Coercion in Inpatient Psychiatry: A Scoping Review. *International Journal of Mental Health Nursing*, *34*(3), e70076. https://doi.org/10.1111/inm.70076

Bergk, J., Flammer, E., & Steinert, T. (2010). "Coercion Experience Scale"(CES) - validation of a questionnaire on coercive measures. *BMC Psychiatry*, *10*, 1–10. https://doi.org/10.1186/1471-244X-10-5

Billé, V., Lessard-Deschênes, C., Sergerie-Richard, S., Désilets, M., Tansey, J., & Goulet, M. H. (2024). Informal coercion in inpatient mental healthcare: a scoping review protocol. *BMJ Open*, *14*(2), e079549. https://doi.org/10.1136/bmjopen-2023-079549

Boateng, G. O., Neilands, T. B., Frongillo, E. A., Melgar-Quiñonez, H. R., & Young, S. L. (2018). Best Practices for Developing and Validating Scales for Health, Social, and Behavioral Research: A Primer. *Frontiers in Public Health*, *6*, 149. https://doi.org/10.3389/fpubh.2018.00149

Brown, T. A. (2015). *Confirmatory Factor Analysis for Applied Research* (2nd ed.). Guilford publications.

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (2022). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2* (Publication No. RR4-2/2023E-PDF). https://ethics.gc.ca/eng/policy-politique_tcps2-eptc2_2022.html

Chieze, M., Hurst, S., Kaiser, S., & Sentissi, O. (2019). Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review. *Frontiers in Psychiatry*, *10*, 491. https://doi.org/10.3389/fpsyt.2019.00491

Corbière, M., & Fraccaroli, F. (2020). La conception, la validation, la traduction et l'adaptation culturelle d'outils de mesure. In M. Corbière & N. Larivière (Eds.), *Méthodes qualitatives, quantitatives et mixtes : Dans la recherche en sciences humaines, sociales et de la santé* (2nd ed., pp. 721-722, 740-748). Presses de l'Université du Québec.

Corderoy, A., Kisely, S., Zirnsak, T., & Ryan, C. J. (2024). The benefits and harms of inpatient involuntary psychiatric treatment: a scoping review. *Psychiatry, psychology, and law: an interdisciplinary journal of the Australian and New Zealand Association of Psychiatry, Psychology and Law*, *32*(5), 734–781. https://doi.org/10.1080/13218719.2024.2346734

Fiorillo, A., Giacco, D., De Rosa, C., Kallert, T., Katsakou, C., Onchev, G., Raboch, J., Mastrogianni, A., Del Vecchio, V., Luciano, M., Catapano, F., Dembinskas, A., Nawka, P., Kiejna, A., Torres-Gonzales, F., Kjellin, L., Maj, M., & Priebe, S. (2012). Patient characteristics and symptoms associated with perceived coercion during hospital treatment. *Acta Psychiatrica Scandinavica*, *125*(6), 460–467. https://doi.org/10.1111/j.1600-0447.2011.01809.x

Fossum, S. Ø., Moen, Ø. L., Gonzalez, M. T., Schröder, A., & Skundberg-Kletthagen, H. (2024). Investigating the Associations between Patient-Reported Quality of Care and Perceived Coercion: A Norwegian Cross-Sectional Study. *Issues in Mental Health Nursing*, *45*(8), 784–793. https://doi.org/10.1080/01612840.2024.2361336

Gardner, W., Hoge, S. K., Bennett, N., Roth, L. H., Lidz, C. W., Monahan, J., & Mulvey, E. P. (1993). Two scales for measuring patients' perceptions for coercion during mental hospital admission. *Behavioral Sciences & the Law*, *11*(3), 307–321. https://doi.org/10.1002/bsl.2370110308

Goulet, M.-H., Desmarais, M., Pariseau-Legault, P., Larue, C., Jean-Baptiste, F., Turcotte, J.-S., & Crocker, A. (2021). Violence Prevention Climate Scale: Translation, Adaptation, and Psychometric Assessment of the French Canadian Version. *Science of Nursing and Health Practices / Science infirmière et pratiques en santé, 4*(2), 67–85. https://doi.org/10.7202/1086402ar

Goulet, M. H., Latulippe, M., Pariseau-Legault, P., Hallett, N., & Crocker, A. G. (2023). Violence Prevention Climate in Civil and Forensic Mental Health Settings: Common Goal, Different Views?. *International Journal of Forensic Mental Health*, *22*(3), 233–242. https://doi.org/10.1080/14999013.2022.2150335

Goulet, M. H., & Larue, C. (2017). A case study: Seclusion and restraint in psychiatric care. *Clinical Nursing Research*, *27*(7), 853–870. https://doi.org/10.1177/1054773817713177

Guzmán-Parra, J., Aguilera-Serrano, C., García-Sanchez, J. A., García-Spínola, E., Torres-Campos, D., Villagrán, J. M., Moreno-Küstner, B., & Mayoral-Cleries, F. (2019). Experience coercion, post-traumatic stress, and satisfaction with treatment associated with different coercive measures during psychiatric hospitalization. *International Journal of Mental Health Nursing, 28*(2), 448–456. https://doi.org/10.1111/inm.12546

Haugom, E. W., Stensrud, B., Beston, G., Ruud, T., & Landheim, A. S. (2022). Experiences of shared decision making among patients with psychotic disorders in Norway: a qualitative study. *BMC Psychiatry*, *22*(1), 192. https://doi.org/10.1186/s12888-022-03849-8

Hotzy, F., Spiess, M., Ruflin, R., Schneeberger, A., Traber, R., Morandi, S., Jaeger, M., & Theodoridou, A. (2023). Association between perceived coercion and perceived level of information in involuntarily admitted patients: Results from a multicenter observational study in Switzerland. *International Journal of Law and Psychiatry*, *91*, 101934. https://doi.org/10.1016/j.ijlp.2023.101934

Høyer, G., Kjellin, L., Engberg, M., Kaltiala-Heino, R., Nilstun, T., Sigurjónsdóttir, M., & Syse, A. (2002). Paternalism and autonomy: a presentation of a Nordic study on the use of coercion in the mental health care system. *International Journal of Law and Psychiatry*, *25*(2), 93–108. https://doi.org/10.1016/s0160-2527(01)00108-x

Hu, L. T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: a Multidisciplinary Journal, 6*(1), 1–55. https://doi.org/10.1080/10705519909540118

Husum, T. L., Legernes, E., & Pedersen, R. (2019). "A plea for recognition" Users' experience of humiliation during mental health care. *International Journal of Law and Psychiatry*, *62*, 148–153. https://doi.org/10.1016/j.ijlp.2018.11.004

Indregard, A. M. R., Nussle, H. M., Hagen, M., Vandvik, P. O., Tesli, M., Gather, J., & Kunøe, N. (2024). Open-door policy versus treatment-as-usual in urban psychiatric inpatient wards: a pragmatic, randomised controlled, non-inferiority trial in Norway. *The Lancet. Psychiatry*, *11*(5), 330–338. https://psycnet.apa.org/doi/10.1016/S2215-0366(24)00039-7

JASP Team. (2025). JASP (Version 0.19.3.0) [Computer software], https://jasp-stats.org/

Jordan, J. T., & McNiel, D. E. (2020). Perceived Coercion During Admission Into Psychiatric Hospitalization Increases Risk of Suicide Attempts After Discharge. *Suicide & Life-Threatening Behavior*, *50*(1), 180–188. https://doi.org/10.1111/sltb.12560

Katsakou, C., Marougka, S., Garabette, J., Rost, F., Yeeles, K., & Priebe, S. (2011). Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study. *Psychiatry Research*, *187*(1-2), 275–282. https://doi.org/10.1016/j.psychres.2011.01.001

Lessard-Deschênes, C., Goulet, M. H., & Pariseau-Legault, P. (2022). Factors associated with perceived coercion in adults receiving psychiatric care: a scoping review protocol. *BMJ Open*, *12*(10), e065393. https://doi.org/10.1136/bmjopen-2022-065393

Lessard-Deschênes, C., Pariseau-Legault, P., Billé, V., Sergerie-Richard, S., Hudson, E., Silva, B., Drouin, J.-S., Désilets, M., & Goulet, M.-H. (2025). Factors Associated with Perceived Coercion in Adults Receiving Psychiatric Care: A Scoping Review. *Healthcare*, *13*(15), 1868. https://doi.org/10.3390/healthcare13151868

Lessard-Deschênes, C., Pariseau-Legault, P., & Goulet, M. H. (2024). Does mental health practice benefit from procedural justice theory? A critical analysis on the opportunities and pitfalls of procedural justice to address coercion and human rights issues in psychiatry. *Aporia*, *16*(1), 8–20. https://doi.org/10.18192/aporia.v16i1.6947

Li C. H. (2016). Confirmatory factor analysis with ordinal data: Comparing robust maximum likelihood and diagonally weighted least squares. *Behavior Research Methods*, *48*(3), 936–949. https://doi.org/10.3758/s13428-015-0619-7

Lim, W. M. (2024). A typology of validity: content, face, convergent, discriminant, nomological and predictive validity. *Journal of Trade Science, 12*(3), 155–179. https://doi.org/10.1108/JTS-03-2024-0016

Lind, E. A., & Tyler, T. R. (1988). *The social psychology of procedural justice*. Springer Science & Business Media.

Madadizadeh, F., & Bahariniya, S. (2025). Tutorial on Internal Consistency Assessment by Cronbach's Alpha and McDonald's Omega. *Perioperative Care and Operating Room Management, 41*, 100568. https://doi.org/10.1016/j.pcorm.2025.100568

Martinez, D., Brodard, A., Silva, B., Diringer, O., Bonsack, C., Morandi, S., & Golay, P. (2022). Satisfaction and Perceived Coercion in Voluntary Hospitalisations: Impact of Past Coercive Experiences. *The Psychiatric Quarterly*, *93*(4), 971–984. https://doi.org/10.1007/s11126-022-10005-8

Morandi, S., Silva, B., Pauli, G., Martinez, D., Bachelard, M., Bonsack, C., & Golay, P. (2024). How do decision making and fairness mediate the relationship between involuntary hospitalisation and perceived coercion among psychiatric inpatients?. *Journal of Psychiatric Research*, *173*, 98–103. https://doi.org/10.1016/j.jpsychires.2024.03.017

Netemeyer, R. G., Bearden, W. O., & Sharma, S. (2003). *Scaling procedures: Issues and applications*. Sage.

Newton-Howes, G., & Stanley, J. (2012). Prevalence of perceived coercion among psychiatric patients: literature review and meta-regression modelling. *The Psychiatrist*, *36*(9), 335–340. https://doi.org/10.1192/pb.bp.111.037358

Nyttingnes, O., Rugkåsa, J., Holmén, A., & Ruud, T. (2017). The development, validation, and feasibility of the Experienced Coercion Scale. *Psychological Assessment*, *29*(10), 1210–1220. https://doi.org/10.1037/pas0000404

Nyttingnes, O., Ruud, T., & Rugkåsa, J. (2016). 'It's unbelievably humiliating'-Patients' expressions of negative effects of coercion in mental health care. *International Journal of Law and Psychiatry*, *49*(Pt A), 147–153. https://doi.org/10.1016/j.ijlp.2016.08.009

O'Callaghan, A. K., Plunkett, R., & Kelly, B. D. (2021). The association between perceived coercion on admission and formal coercive practices in an inpatient psychiatric setting. *International Journal of Law and Psychiatry*, *75*, 101680. https://doi.org/10.1016/j.ijlp.2021.101680

O'Donoghue, B., Roche, E., Shannon, S., Lyne, J., Madigan, K., & Feeney, L. (2014). Perceived coercion in voluntary hospital admission. *Psychiatry Research*, *215*(1), 120–126. https://doi.org/10.1016/j.psychres.2013.10.016

Paradis-Gagné, E., Pariseau-Legault, P., Goulet, M. H., Jacob, J. D., & Lessard-Deschênes, C. (2021). Coercion in psychiatric and mental health nursing: A conceptual analysis. *International Journal of Mental Health Nursing*, *30*(3), 590–609. https://doi.org/10.1111/inm.12855

Pariseau-Legault, P., Vallée-Ouimet, S., Jacob, J.-D., & Goulet, M.-H. (2020). Intégration des droits humains dans la pratique du personnel infirmier faisant usage de coercition en santé mentale : recension systématique des écrits et méta-ethnographie. *Recherche en soins infirmiers, 142*(3), 53–76. https://doi.org/10.3917/rsi.142.0053

Pelto-Piri, V., Kjellin, L., Hylén, U., Valenti, E., & Priebe, S. (2019). Different forms of informal coercion in psychiatry: a qualitative study. *BMC Research Notes*, *12*(1), 1–4. https://doi.org/10.1186/s13104-019-4823-x

Raykov, T., & Marcoulides, G. A. (2010). *Introduction to psychometric theory*. Routledge.

Rosseel, Y. (2012). lavaan: An R Package for Structural Equation Modeling. *Journal of Statistical Software*, *48*(2), 1–36. https://doi.org/10.18637/jss.v048.i02

Sampogna, G., Luciano, M., Del Vecchio, V., Pocai, B., Palummo, C., Fico, G., Giallonardo, V., De Rosa, C., & Fiorillo, A. (2019). Perceived Coercion Among Patients Admitted in Psychiatric Wards: Italian Results of the EUNOMIA Study. *Frontiers in Psychiatry*, *10*, 316. https://doi.org/10.3389/fpsyt.2019.00316

Sheehan, K. A., & Burns, T. (2011). Perceived coercion and the therapeutic relationship: a neglected association?. *Psychiatric services (Washington, D.C.)*, *62*(5), 471–476. https://doi.org/10.1176/ps.62.5.pss6205_0471

Silva, B., Bachelard, M., Amoussou, J. R., Martinez, D., Bonalumi, C., Bonsack, C., Golay, P., & Morandi, S. (2023a). Feeling coerced during voluntary and involuntary psychiatric hospitalisation: A review and meta-aggregation of qualitative studies. *Heliyon*, *9*(2), e13420. https://doi.org/10.1016/j.heliyon.2023.e13420

Silva, B., Bachelard, M., Bonsack, C., Golay, P., & Morandi, S. (2023b). Exploring Patients' Feeling of Being Coerced During Psychiatric Hospital Admission: A Qualitative Study. *The Psychiatric Quarterly*, *94*(3), 411–434. https://doi.org/10.1007/s11126-023-10039-6

Theodoridou, A., Schlatter, F., Ajdacic, V., Rössler, W., & Jäger, M. (2012). Therapeutic relationship in the context of perceived coercion in a psychiatric population. *Psychiatry Research*, *200*(2-3), 939–944. https://doi.org/10.1016/j.psychres.2012.04.012

Tingleff, E. B., Bradley, S. K., Gildberg, F. A., Munksgaard, G., & Hounsgaard, L. (2017). "Treat me with respect". A systematic review and thematic analysis of psychiatric patients' reported perceptions of the situations associated with the process of coercion. *Journal of Psychiatric and Mental Health Nursing*, *24*(9-10), 681–698. https://doi.org/10.1111/jpm.12410

United Nations High Commissioner for Human Rights. (2017). *Mental health and human rights: Report of the United Nations High Commissioner for Human Rights*. https://docs.un.org/en/A/HRC/34/32

Verbeke, E., Vanheule, S., Cauwe, J., Truijens, F., & Froyen, B. (2019). Coercion and power in psychiatry: A qualitative study with ex-patients. *Social Science & Medicine (1982)*, *223*, 89–96. https://doi.org/10.1016/j.socscimed.2019.01.031

Watkins, M. W. (2018). Exploratory Factor Analysis: A Guide to Best Practice. *Journal of Black Psychology*, *44*(3), 219–246. https://doi.org/10.1177/0095798418771807

Questionnaire sur la coercition perçue dans les services de santé

Veuillez baser vos réponses sur vos expériences de coercition, de pression indésirable ou de contrainte de la part des services de santé. Les questions portent sur le traitement, le soutien ou l'accompagnement que vous recevez actuellement ou que vous avez reçus récemment, et non sur ceux reçus antérieurement.

Veuillez indiquer dans quelle mesure vous êtes en accord ou en désaccord avec les affirmations suivantes concernant votre expérience de traitement et de soutien. Veuillez cocher une réponse pour chaque ligne.	**Fortement en désaccord**	**En désaccord**	**Ni en accord ni en désaccord**	**D'accord**	**Fortement d'accord**
1. Les traitements et le soutien reçus limitent ma liberté	☐	☐	☐	☐	☐
2. Je suis insatisfait.e de la pression ressentie dans le cadre des traitements et du soutien reçus	☐	☐	☐	☐	☐
3. Je me sens atteint dans ma dignité	☐	☐	☐	☐	☐
4. Je me sens impuissant.e	☐	☐	☐	☐	☐
5. Je fais confiance aux professionnels de la santé	☐	☐	☐	☐	☐
6. Je suis d'accord sur la nécessité de ce traitement et de ce soutien	☐	☐	☐	☐	☐
7. Je me sens traité.e comme un objet	☐	☐	☐	☐	☐
8. Je me sens humilié.e	☐	☐	☐	☐	☐
9. Je me sens paralysé.e	☐	☐	☐	☐	☐
10. Je me sens sans importance	☐	☐	☐	☐	☐
11. Je ressens une atteinte à ma vie privée	☐	☐	☐	☐	☐
12. Je me sens puni.e	☐	☐	☐	☐	☐
13. Ma situation s'aggrave en raison des traitements et du soutien reçus	☐	☐	☐	☐	☐
14. On me menace pour que je reçoive les traitements et le soutien proposés	☐	☐	☐	☐	☐
15. Je me sens considéré.e comme un diagnostic	☐	☐	☐	☐	☐