Walking the Tightrope:

The Fine Line Between Balancing Legal Standards and Ethics in the Use of Coercion

A political science study of psychiatrists' decision-making processes concerning the use of coercive practices within the South-Eastern Norway Regional Health Authority

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Abstract

The primary objective of this master's thesis was to study legal and ethical considerations that impact the decision-making of psychiatrists in complex cases concerning the use of coercive practices within Norwegian mental health care. Specifically, the thesis aimed to enhance our understanding of how psychiatrists weigh the legal and ethical dilemmas in decision-making concerning the use of coercion. As such, its objective was to give voice to a topic that is under-discussed within the literature on political science. This thesis intends to fill gaps in the literature on key factors that guide psychiatrists' decisions on the use of coercion, especially lacking in qualitative studies.

By using a qualitative method this thesis employed semi-structured interviews with eight psychiatrists selected through a purposive sampling. This thesis examined the theories of rational choice and social constructivism through preconceived expectations. The main findings from the study suggest that psychiatrists' decision-making regarding the use of coercion emphasizes legal compliance and adherence to human rights alongside normative considerations, highlighting an intricate interplay between decisions based on a rational analysis and ethical reflection. The thesis recognized human rights as a framework encompassing a broad range of concepts that manifest themselves in various spheres, including the domain of coercive practices within Norwegian psychiatry. My findings point to the importance of establishing new rules, guidelines, and policies that can assist psychiatrists in effectively navigating such intricate decision-making processes. Furthermore, this thesis suggests how policies can enhance the protection of the rights of individuals who rely on professionals and legal regulations for decision-making regarding their health.

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Any shortcomings or mistakes made in this master's thesis are my own.

Hanna,

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List of Abbreviations

CRPD	Convention on the Rights of Persons with Disabilities
ECHR	European Convention on Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
HOD	Ministry of Health and Care Services
NIM	Norwegian National Human Rights Institution
RHA	Regional Health Authority
SACS	Staff Attitude to Coercion Scale
SIKT	Norwegian Agency for Shared Services in Education and Research
UDHR	Universal Declaration of Human Rights
UN	United Nations
WHO	World Health Organization

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Chapter 1: Introduction

Scenario 1

Mia, 35 years old, admitted to compulsory mental health care and diagnosed with a severe bipolar disorder. One night, Mia tries to throw her bed out of her room. Both nurses and psychiatrists enter Mia's room and try to calm her down. Mia is angry. In a desperate attempt to leave her room she starts kicking two of the nurses before banging her own head against the wall.

Scenario 2

When Fred looks at himself in the mirror, he sees someone he does not like. He sees an overweight boy, who lacks the right to live his life. He tries to improve his self-image and has therefore stopped eating. He now weighs 36 kg with a height of 185 cm. His mother now knows that Fred has not eaten for 7 days and believes that he must be tube-fed. She contacts mental health services.

To coerce or not to coerce, that is the question. What would you have done?

As psychiatrists grapple with the legal and ethical impactions of utilizing coercion as part of their practice, they navigate complex decision-making with no clear answer. To illustrate the complexity of such situations, the two hypothetical scenarios above are meant to highlight the intricate nature of this subject: when should coercion be employed in cases of mental health care? When deciding, psychiatrists may consider following regulations for their own benefit or regulations that promote the best interest and rights of patients versus groups in society. Moreover, they may prioritize personal values and beliefs regarding coercion. In addition, psychiatrists' decision-making in this context may also be guided by social norms that influence what is considered acceptable or unacceptable behavior in their surrounding environment.

The use of coercive practices in Norway has gained significant attention in recent years, particularly in the wake of the serious incidents that took place in the cities of Kongsberg (psychiatric patient killed 5 innocent people) and Oslo (psychiatric patient shot dead by police after knife-attack) in 2021. In both incidents, society was exposed to patients suffering from mental health illnesses and who had previously been subjected to Norwegian compulsory mental health care. Due to incidents like these, the use of coercion is a subject of concern.

In 2021, the World Health Organization (WHO) labeled the perpetuation of human rights violations within psychiatric facilities as a global emergency (World Health Organization, 2021). This also includes the use of coercive practices within psychiatric facilities. According to the United Nations (UN), coercive practices in Norwegian psychiatry may be at odds with human rights (FN-sambandet, 2023).

Many nations are now reviewing their mental health laws and replacing them with ones that emphasize human rights to a larger degree. However, such legislative change alone will not bring about a change of behavior. These practices within Norwegian psychiatry are complex as coercion lays somewhere in the gap between care and control. The use of coercion within Norwegian mental health care has been the subject of continuous debate (Hermundstad, 1999). Psychiatrists play an important role as they hold the authority to make decisions concerning coercive practices. Thus, when deciding whether to use coercion it is important to study the motivations and considerations emphasized by such psychiatrists, especially their emphasis on regulations and ethical considerations.

As this thesis suggests, although psychiatrists place great emphasis on legal compliance and adherence to human rights principles, their decision-making also consists of normative considerations. Coercive practices within Norwegian psychiatry raise complex issues that need thorough examination of regulatory and ethical issues. This study approaches the utilization of coercion from a human rights perspective, using human rights as a background and motivating factor for studying such considerations. The current study acknowledges the concept of human rights as a broad collection of ideas, including their manifestation within the setting of coercion in Norwegian psychiatry. While there are several human rights principles that are relevant regarding coercive practices, this study will primarily focus on the right to medical treatment, autonomy, and self-determination as these rights are especially salient in the context of coercive practices and this will provide a framework for exploring psychiatrists' regulatory and ethical considerations within such decision-making processes.

Results from the current study demonstrate how human rights principles have become a fundamental component of laws and practices regarding the use of coercive practices. Even though arguments based on rational choice and social constructivism offer valuable insight into such decision-making processes regarding the use of coercion, they do not fully account for the impact of human rights considerations. The findings indicate that these rights have grown to be an essential part of the modern and legal social landscape, guiding both the development and implementation of legal frameworks and policies in situations where psychiatrists evaluate whether to use coercive practices on patients.

Moreover, the intricate and breadth of human rights require psychiatrists to navigate a broad range of legal frameworks and norms, which may be challenging. The current study's results reveal that these considerations are not independent from one another, but rather interweave with each other in dynamic and complex ways.

This argument emphasizes important policy implications, especially policies considering Norwegian mental health care. Moreover, the results indicate that policymakers should work closely together with psychiatrists to be certain that policy decisions are based on recent research and the most adequate best-practices in the field. The complexity of this process is further highlighted by the potential for this interplay between different types of considerations to change depending on the exact context of the decision-making. This interplay between choices based on a rational analysis and normative considerations is likely influenced by mechanisms related to the intentions and motivations of psychiatrists, and contrasting choices in a given context, which, despite having different underlying motives, may lead to comparable outcomes.

In turn, this master thesis seeks to answer the following research question:

What legal and ethical considerations do psychiatrists emphasize when deciding to use coercion within Norwegian psychiatric care?

Through a qualitative approach, substantial in-depth data on psychiatrists' perspectives was gathered. In this thesis, data was collected from eight semi-structured interviews conducted with different psychiatrists within the South-Eastern Norway Regional Health Authority (RHA) as primary sources. The current study employed a definition of coercion within the Norwegian psychiatry that encompasses coercive practices as both a delivery of treatment and a mean to prevent aggressive or violent behavior (Husum, 2011). Nevertheless, this study sheds light on coercion in its entirety with the intent of capturing psychiatrists' decision-making on coercive practices as a whole.

The utilization of coercive practices tends to rely on medical and legal regulations. Thus, interdisciplinary research including a political science approach is important to examine the legal and ethical implications of this practice. Further, a comprehensive understanding must also contain an approach including the aspect of political theory and legal ethics. The examination of political theory and legal ethics is especially relevant to carefully studying the distribution of authority involved and ethical considerations in relation to decision-making regarding coercive practices. For instance, a political theory approach helps us to gain insight on how the use of coercion within mental health care reflects broader beliefs and societal norms. Legal ethics may help guide the complex legal frameworks regarding the use of coercive practices and might contribute with knowledge on how to uphold ethical principles while also keeping up legal compliance.

This is because coercion, especially related to mental health care, entails complex legal and ethical concerns that intersects with political institutions (such as legislative bodies) and policies related to the use of coercion. Findings from this current study therefore highlight important policy implications for promoting coercive practices that aims to establish balance between legal compliance and normative considerations.

Literature on psychiatrists' decision-making concerning coercive practices provided a starting point from which I derived expectations based on existing perspectives related to such decision-making. Concern over the use of coercion in psychiatric treatment has grown in recent years, with advocates and scholars arguing that it violates the human rights of patients and challenge ethical considerations. To unravel central components underlying psychiatrists' decision-making process concerning the employment of coercion, two sub-research questions are explored in further detail:

1) *To what extent do psychiatrists prioritize their own self-interest versus either the interests of patients or society?*
2) *To what extent do psychiatrists rely on their personal ethics or wider community standards?*

This thesis aims to gain insight into different factors that influence psychiatrists' decision-making in coercive practices. Overall, the purpose is to contribute to a more thorough understanding of the ethical and human rights challenges faced by psychiatrists within the South-Eastern Norway RHA. In addition, an overall objective is to provide guidance into the development of policies and guidelines that support human rights and ethical use of coercive practices in Norwegian psychiatry. The importance of such examination is to ensure that these decisions made by psychiatrists align with human rights and ethical standards.

1.1 Outline of thesis

The current thesis proceeds as follows. In Chapter 2, I provide a background of coercion within Norwegian mental health care and its legislative context in which the legal framework of psychiatry and conventions of special importance have developed. Then in Chapter 3, I give a literature review on the existing literature, highlighting research gaps this study seeks to address. The theoretical framework of this thesis is presented in Chapter 4, which includes the theory of rational choice and social constructivism. This chapter also establishes four expectations that provide a foundation for further analysis.

These expectations represent specific predictions that this current study seeks to explore the potential explanatory power of through the data analysis. The four expectations are all derived from the theoretical framework and serves as a starting point for the current research. By examining such expectations, one can contribute to new knowledge within this field. Choice of method is further presented in Chapter 5, followed by the empirical findings from the semi-structured interviews in Chapter 6. In Chapter 7, I analyze and discuss findings of this current thesis. These findings revealed that even though the two theoretical perspectives provide essential insights into psychiatrists' decision-making, human rights are also an important factor that informs such decision-making. Therefore, such rights serve as a background factor that is integrated within both theories, forming how psychiatrists navigate the intricate legal and ethical landscape surrounding coercion within psychiatric facilities. My concluding remarks in Chapter 8 explain how this thesis highlights the importance of considering human rights alongside rational choice and social constructivism when trying to gain knowledge and improve decision-making on coercive practices within Norwegian psychiatry. This chapter will also include a discussion of possible avenues for future research on this topic.

Chapter 2: Coercion in psychiatry – the case of Norway

This chapter will delve into the meaning of coercive practices within Norwegian psychiatry. The purpose for the use of coercion in Norway will be introduced first. Then I will explore its legal background, especially the importance of the Norwegian Mental Health Care Act, followed by the presentation of relevant human rights conventions. Finally, this chapter explains the role of the control commission within the psychiatric facilities.

2.1 Introduction to coercion in Norwegian psychiatry

Definitions of coercion frequently state that coercion occurs when health personnel A makes a coercive request of patient B to do X (either in form of treatment or to prevent danger), and B has no other choice than to comply (Wertheimer, 1993, p. 240). This definition of coercion also reflects a broader conceptualization within the field of political science as the exercise of power to compel compliance by applying force (Uphoff, 1989). Core aspects of coercion include loss of freedom, involuntariness, and absence of self-determination.

Coercion within Norwegian psychiatry can be grouped within two different categories: (i) coercion employed to improve the patients' health condition, and (ii) coercion conducted to prevent the patient from hurting themselves or others (Husum, 2011, p. 1). Put differently, dangerous situations and the need for treatment both serve as the grounds for the legal use of coercion. Common for both these two categories is that the patient must be subject to compulsory mental health care (Helsenorge, 2021). The foundation of the legal framework was the patients' need for adequate medical care and the respect for their human dignity (Syse, 2007, p. 43). In situations where patients are considered dangerous towards themselves or others, use of mechanical restraints, physical restraint, chemical restraint, or isolation is allowed for a short period of time (Psykisk helsevernloven, 1999, § 4-8). These coercive measures are not used for treatment reasons but are instead used to gain control over a patient who displays uncontrolled behavior, is violent or is very aggressive. These kinds of coercive measures must be "absolutely necessary" to prevent harm and it is required that measures that are more lenient have been considered and presumably tried out first (Helsedirektoratet, 2022a). For those with severe psychosis, the treatment criterion enables the use of long-term medication, a compulsory treatment where the aim is to monitor if the patient's condition improves.

Norway's health care system is divided into four administrative regions (*Figure 1*):

- South-Eastern Norway RHA
- Western Norway RHA
- Central Norway RHA
- Northern Norway RHA

Figure 1

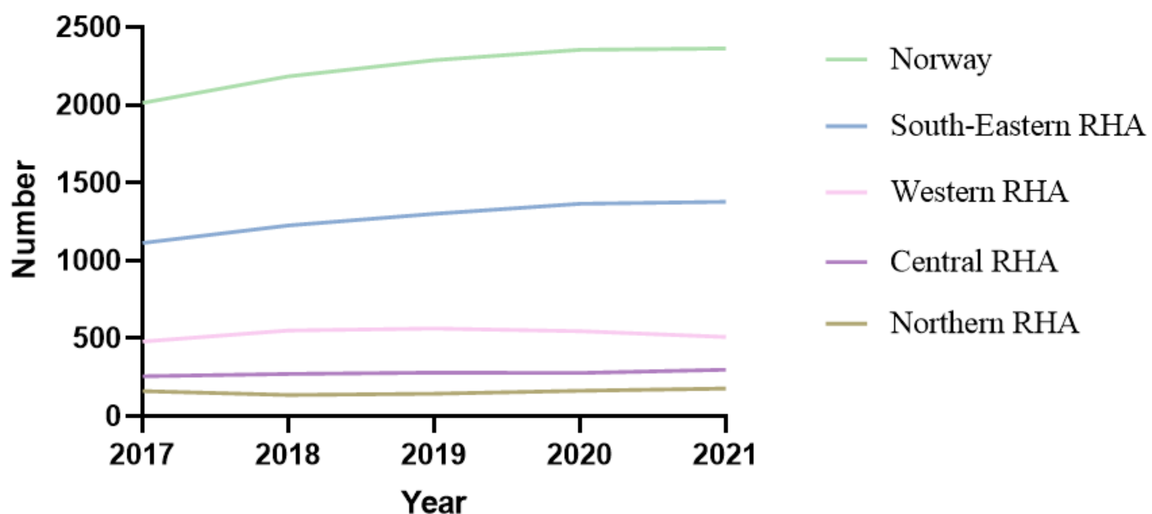
Geographical overview of the four different health regions in Norway. Reprinted with permission from the publisher and corresponding author (Zanaboni & Wootton, 2016).

Every region has its own Regional Health Authority (RHA) with the responsibility for providing specialized health services within its geographic region (Braut, 2022). The Norwegian Ministry of Health and Care Services (HOD) has the overall responsibility for the RHAs.

Figure 2 illustrates that the South-Eastern Norway RHA (from 2017 to 2021) had consistently higher rates of coercion compared to the remaining three RHAs (Western Norway RHA, Central Norway RHA, and Northern Norway RHA). Although the causes of this discrepancy are not fully known, some factors may offer an explanation.

One possible reason is that the South-Eastern Norway RHA has more urban regions and a higher population density, which could result in more complex healthcare requirements and higher prevalence of mental health diseases. However, given these high rates within the South-Eastern Norway RHA it is interesting to study how psychiatrists in facilities within this RHA make decisions regarding the use of coercion when it conflicts with rights and ethical dilemmas of patients and the groups within the rest of society.

Figure 2



The number of patients in inpatient care receiving at least one coercive mean (used to prevent harm) in the 5-year period 2017-2021. Notably, the values on the Y-axis are not adjusted for the population size. Modified from The Norwegian Directorate of Health. (Helsedirektoratet, 2022b).

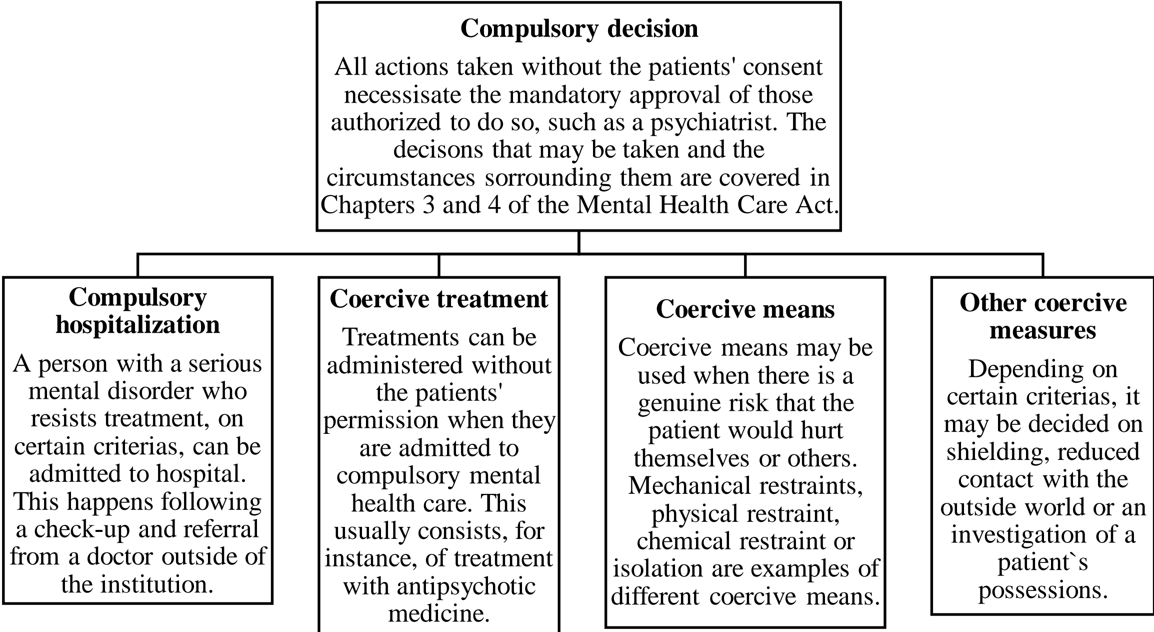
2.2 The legal framework of psychiatry in Norway

Law regulates the use of coercive practices in Norwegian psychiatry. The Mental Health Care Act of July 2nd, 1999, No. 62 governs the use of coercion in Norwegian mental health care (Syse, 2007, p. 21). The Act, which replaced The Mental Health Care Act of April 28, 1961, No. 2, entered into force on January 1st, 2001. From that point forward, the legal regulation of the mental health system was divided between the Act on Specialist Health Care, the Health Personnel Act, the Patient and User Rights Act and the Mental Health Care Act. In other words, as a psychiatrist providing mental health care services in Norway, four different laws bind you, though the latter are the one that is most central when it comes to the use of coercion and will therefore be given the main emphasis throughout this thesis.

In addition, there are also related rules and regulations presented by both the hospital in question and HOD. One is also obliged to adhere to the different human rights provisions in various conventions. The provisions on human rights that Norway is bound by have been rewritten and are considered by the legislatures to be included in our national health laws.

The Norwegian Mental Health Care Act was amended on September 1st, 2017. With this, a capacity-based criterion was added, which states that individuals with the capacity to consent to treatment cannot be exposed to involuntary care (Høyer et al., 2022, p. 1). Notably, this is unless they pose a risk to themselves or others. It was anticipated that with this the coercion-rates would decrease. In addition, the duration of involuntary care episodes was also expected to be reduced (Høyer et al., 2022, p. 1). Increased patient autonomy, as well as human rights compliance in the administration of mental health services were the ultimate goals (Wergeland et al., 2023). The Mental Health Care Act authorizes the use of coercion in a broad range of situations. These can be roughly separated as shown in *Figure 3*.

Figure 3



Key concepts within Norwegian mental health care. Modified from Hatling & Bugge (2022).

2.3 Conventions of special importance for coercion

Shortly after World War II, the United Nations (UN) was founded, and one of its primary duties is the promotion of human rights. The UN General Assembly adopted the Universal Declaration of Human Rights (UDHR) in 1948 (Høstmælingen, 2010, p. 13). Both the UN's two main conventions on human rights from 1966 (the International Covenant on Economic Social and Cultural Rights (ICESCR), and the International Covenant on Civil and Political Rights (ICCPR) and the European Convention on Human Rights (ECHR), signed in 1950 (Husum & Hjort, 2009), have been ratified by Norway. These conventions are preserved in the Human Rights Act of 1999. Further, Norway committed to reduce the use of coercive practices within mental health care when they ratified the UNs Convention on the Rights of Persons with Disabilities (CRPD) in 2013 (Regjeringen, 2022). According to their committee (The UN Committee on the Rights of Persons with Disabilities), different forms of coercive means breach the human rights of patients subject to such coercive practices (Every-Palmer et al., 2021, p. 240).

The idea of an individual's absolute and universal inviolability is the core tenet of these conventions. In addition to the rights to security, equality, freedom of speech, respect for one's privacy, everyone has the right to be protected against humiliation and undignified treatment, and against abuse (Husum & Hjort, 2009). Norway's compliance with ratified human rights conventions is secured by their adherence with the country's legal framework and the available avenues for appeals. Not only do regulatory organs carry with them a responsibility to uphold such conventions, but the individual employee must also comply with the terms of these conventions. Defined as a part of the Norwegian legal framework the conventions mentioned above are incorporated through The Human Rights Act which the Norwegian Parliament passed in 1999 (Menneskerettsloven, 1999, § 2). Everyone living in Norway is required to abide by this Act, including health care personnel, for instance psychiatrists and control bodies operating within the Norwegian healthcare system, to adhere to the human rights contained in these conventions.

2.4 The control commission

The control commission is a government-run, impartial organization whose job is to protect the patient's legal security. The control commission scrutinizes notice of coercion, processes complaints, and conducts welfare inspections (Helsedirektoratet, n.d.). The Mental Health Care Act and its regulations govern the casework of the control commission and, in case of particularly invasive decisions, must contribute to protecting the patients' need for legal certainty (Statsforvalteren, 2022).

The control commission makes both unannounced and planned visits to different psychiatric wards in Norway in order to ensure that the visited hospitals comply with the regulations they are obligated to follow. Within the Norwegian special health service there must be a control commission connected to each unit (institutions and departments) (Statsforvalteren, 2022). The Control commissions has a lawyer as its chairman, alongside a doctor and two other members (without any legal or medical background). Ensuring that the control commissions operate within its given responsibility falls primarily under the authority of HOD.

Chapter 3: Literature Review

This chapter presents literature relevant for my thesis. The review will focus on literature concerning human rights with a focus on the use of coercion in that sphere, as well as literature on medical ethics and the relationship to government regulations in the field of mental health care. It also highlights inconsistent findings and identifies areas requiring further investigation. The overall goals of this chapter are to firstly establish the significance of the topic of the study, and secondly to identify "research gaps". Numerous studies have examined the effects of compulsory mental health care in Norway and mainly focused on the patients' experience of being exposed to the use of coercion, either in form of treatment or to prevent dangerous situations. This thesis deviates somewhat from this approach as I focus mainly on what legal and ethical considerations psychiatrists emphasize regarding the use of coercion.

Political ambitions to reduce the use of coercion in Norwegian mental health care are currently unfolding putting research about what influences psychiatrists' decisions on the use of coercion on the agenda. The background knowledge outlined in this chapter will help clarify the selection of methods and further analysis that are presented in the following chapters. Literature gaps on both human rights perspectives as well as ethical aspects, and why it would be beneficial to study them further and from a different angle, will be outlined throughout this chapter. The primary objective is to demonstrate how fundamentally important human rights and ethical aspects are to the Norwegian mental health care system, indicating that such topics are highly relevant for discussing procedures and factors that influence psychiatrists when making decisions involving coercion. Finally, the research gaps are summarized.

3.1 The human rights framework

Human rights, in essence, are fundamental freedoms and basic rights that both individuals and groups within the society have vis-à-vis the government, such as rules on how to treat people who suffer from various diseases and rules on how to safeguard various groups in society (Høstmælingen, 2010, p. 10). These regulations are outlined in agreements between states to which each state independently decides whether to agree. These agreements are defined as so-called treaties or conventions. States that sign these agreements give up a portion of their right to self-determination, meaning that the states are compelled to treat all individuals on their territory in line with the requirements set out in the conventions (Høstmælingen, 2010, p. 10). Because of this, an international law has direct effect on individuals in the country.

Human rights protect all individuals who are subject to the state's authority (jurisdiction). All people are protected, also refugees, stateless people, criminals, and people who suffer from various illnesses. Gender, ethnicity, sexual orientation, and age are not considered (Høstmælingen, 2010, p. 27).

The use of coercion and restrictions on people with mental illnesses increase the risk of violations and may be a breach of human rights. The democratization of mental health services, patients' rights, user engagement, and empowerment have for decades received more attention, both on the international level, but also nationally (Prior, 2001; Richardson, 2008; Syse, 2006).

The doctrine of human rights has been a cornerstone of public policy around the world in international practice and law, regional and global institutions, in the policies of different states, and in the activities of non-government organizations (NGOs) (Beitz, 2009). Even though the study of, and interpretation of, human rights is essentially a legal issue, other fields of knowledge can add to our understanding of human rights. This includes both regulatory politics and ethical aspects within the field of political science. Political scientists examine the processes of government and the relationships between individuals and state. Such research on how institutions and policies affect human rights may provide insights into how such rights can be secured and protected. From this, we might be able to extract insights into the interplay between regulatory policies and the rights of patients and groups in society. Moreover, this perspective can also help in identifying existing barriers and opportunities for effective human rights principles within the Norwegian mental health care system.

3.1.1 Decision-making in the interface between coercion and human rights

Fundamental concerns about human rights are raised by the utilization of coercion within psychiatric services. For centuries, there has been a discussion on how to reduce coercion in such services. Morandi et al. (2021), who presented findings from a Swiss study exploring mental health care professionals' views and feelings on coercion, is one of the later additions to this discussion. That study revealed that the use of coercion in psychiatry is still widely accepted as a necessary tool that benefits the patients (Morandi et al., 2021).

As with many other nations, Norway has tried to reduce coercive practices and utilize more voluntary services. In 2001, a new modification to the Mental Health Care Act went into effect (Syse, 2007). Since then, it has undergone further revisions.

Related initiatives involved numerous efforts and actions, from campaigns focusing on attitudes to policy statements, as well as the revision of clinical practices employing coercion. However, little is known about the results of these regulatory changes and professional training initiatives. I therefore believe that by studying the decision process regarding the use of coercion from a political science angle can help policymakers make informed decisions on improving the system.

Because of the relevance of the decision-making process in the interface between coercion and human rights, it is of interest to examine how psychiatrists from a specific Norwegian health region – in this case South-Eastern Norway RHA, with its levels of capacity and resources work on decision-making and what factors psychiatrists emphasize during their decision-making process on whether to use coercion. Because of this, my thesis gives attention to how psychiatrists weigh off and balance legal and ethical considerations when put in charge of deciding whether to apply coercion on a patient.

There has been relatively little literature published on the interface between coercion in Norwegian psychiatry and human rights (Diseth, 2013). Instead, previous research has tended to focus on psychiatrists' feelings and attitudes towards coercion, not focusing on how they balance the human rights perspective and other ethical dilemmas against patient and societal consequences when making decisions on whether to utilize coercion or not. Therefore, there is a need for complementing this research further by focusing on the reasons behind their decisions in order to create a more nuanced understanding.

The role of knowledge within Norwegian mental health care and its perspectives towards coercion and the relation to human rights has been the subject of studies conducted by, among others, Norwegian psychiatrists, and other Norwegian human rights organizations such as the Norwegian National Human Rights Institution (NIM). However, this case study of a specific RHA with its theoretical framework represents a new way of investigating knowledge and adaption. This can provide us with a more in-depth understanding of factors that influence the use of coercion. In addition, knowledge can be gained regarding the impact coercion has on human rights and potential strategies for promoting the rights of patients.

3.1.2 Exploring the intersection of coercion and human rights

The use of coercion has, in the early 2000s, been explored in the light of human rights (Husum, 2011, p. 31). A closer look at this literature on how these two works in relation to one another, however, reveals several gaps and shortcomings. Since its proclamation in 1948, Norwegian laws have incorporated the UDHR. Today's Western culture is based on the core ideals of UDHR regarding individual freedom and integrity. Despite this, previous research revealed that psychiatric patients still claim that traditional medical health care violates their human rights (Valaand, 2007).

As has been previously reported in the literature, several studies also revealed that patients` perceptions of coercion during the admission process (when admitted to compulsory mental health care), do not correspond with their legal rights. There are key questions and notions that are still not discussed in the literature, and this implies that society's treatment of psychiatric patients does not yet reflect the stated ideal of equality for all people.

Blesvik et al. (2006) shed some light on the Norwegian devotion to human rights in relation to psychiatric patients in their study. It was revealed that psychiatrists need knowledge and understanding about the content of the human rights conventions. The data from Blesvik et al. (2006) identified the case for the Norwegian Government taking accountability in a way where international human rights commitments are not just legal requirements on paper but carry a meaning for those who need them. Perhaps this implies that patients are subjected to unnecessary and unjustified harm? If this is the case, it is important to study what psychiatrists emphasize in such cases to ensure that principles like autonomy and self-determination are upheld.

Previous research indicates that laws and quantitative statistical analysis alone do not adequately express the complexity of coercion (Engerdahl, Molewijk & Pedersen, 2016, p. 103), necessitating the need for studies that approach and explore the use of coercion in a different way, as done in this thesis where the focus is on extracting information directly from participating psychiatrists via interviews and qualitative analyses. Although attention has been given to this field in the media, politics, as well as in other professional contexts, this is so far lacking in the scientific literature. Therefore, there is a strong desire to expand efforts in connection to preventing, uncovering, and safeguarding human rights in relation to coercion used in different mental health care treatments.

Consequently, in order to establish clear ethical guidelines that control the use of coercion within the Norwegian psychiatry services, research has to be done regarding what psychiatrists emphasize during their decision-making process.

3.2 Ethical aspects

The literature has mostly concluded that the use of coercion has proven ethically difficult. One explanation for this was given by Husum et al. (2018) who stated that this was due to a greater emphasis in recent years on human rights, respect for the right to self-determination and user participation (Husum et al., 2018). Additionally, there is less evidence to support the notion that coercion benefits the treatment of patients who suffer from various mental disorders (Husum et al., 2017). However, previous research shows that patients who have been hospitalized and subjected to coercion, have to a certain degree understood the necessity of coercive interventions (Haw et al., 2011; O`Donouge et al., 2010).

Since these findings show two conflicting sides of coercive practices, I now take a different approach by investigating it from a perspective that endeavors to unravel the complexities on psychiatrists' emphasis on the use of coercion from an ethical perspective. Ethical considerations play a pivotal role in the decision-making process as psychiatrists are required to balance their professional obligations, rights of the patients, and also secure a safe environment for the surrounding society.

Thus, the use of coercive practices in mental health care poses not merely an empirical question, but also ethical questions (Husum, 2011, p. 94). According to Husum (2011), in addition to addressing the quality of psychiatric treatment, reducing coercion to the absolute minimum is a human rights issue. Furthermore, reducing the use of coercion during hospitalization in mental health care should be of high priority, and human rights should be considered in the treatment of people with mental difficulties (Husum, 2011, p. 99). A discussion of ethical aspects is a relevant and an important supplement to empirical studies on mental health care, as it is to health care in general. To safeguard the human rights of patients, professionals in mental health care services need education about human rights (Husum, 2011). Can coercive practices have adverse effects on patients' safety? If so, it is important to study the reasons behind the choices of psychiatrists to ensure that this is not the case.

Regardless of the criticisms, there may need to be a change in the Norwegian mental health care system. In support of this, a PhD study found that human rights are frequently violated within the mental health care system without the patients or the control commission being aware of this (Storvik, 2017). In seven out of eight specific areas, this PhD study revealed contrasts between the legal and clinical practice. For instance, there was no clear distinction between coercion and seclusion. This could perhaps indicate that the patient's legal protection is at risk. According to the Norwegian National Human Rights Institution (NIM), Norway has alarmingly high rates of discrimination against vulnerable groups of individuals and a dearth of research and data on the subject (Norwegian National Human Rights Institution, 2023).

A moral problem is presented by the fact that patients frequently view coercion as unpleasant and burdensome. Results from previous studies also show that patients who were forcibly admitted, feel disrespected when they are being admitted (Holmboe et al., 2017; Norvoll & Husum, 2011). Additionally, some patients state the feeling of not having the right to self-determination and not being heard regarding their own treatment (Oloffson & Jacobsson, 2001). Are supervisory authorities truly guardians of the patient`s fundamental rights and interests? Are health personnel using coercion on a patient well trained in upholding fundamental human rights principles and ethical standards in a variety of coercive circumstances? This represents a gap in the literature concerning the intersection of human rights and healthcare. More accurately, there may be a dearth of research examining the reliability of supervisory authorities in protecting the rights of patients and also the level of preparedness of healthcare personnel to handle human rights- and ethical issues in relation to the use of coercion.

3.2.1 Patients' and psychiatrists' moral and ethical perception on coercion

In 2018, German researchers interviewed and administrated surveys to a sample of 213 patients who had received coercion as a treatment method while they were hospitalized (Krieger et al., 2018, p. 478). The results revealed that the patients' sentiments towards the numerous forceful interventions they had experienced varied (Krieger et al., 2018). Based on their results Krieger et al. (2018) suggested that psychiatrists should try to involve themselves as much as possible and be clinically reasonable in the treatment process (e.g., with shared decision-making), which may ameliorate fear, prevent trauma, and foster adherence.

In a 2013 Norwegian study, Larsen and Terkelsen carried out a comparison of how patients and medical practitioners felt about the use of coercion (Larsen & Terkelsen, 2014). According to their findings, patients frequently felt inferior. Interestingly, the staff felt a sense of shame for their part when the patients' dignity was violated. Other studies have found that in situations where coercion was involved, patients tended to experience a feeling of being incapacitated and humiliated (Tingleff et al., 2017; Verbeke et al., 2019). The consensus among psychiatrists is, however, that coercion is ethically justified when it results in better treatment or better protection for the patients, and thus, outweighs any negative effects coercion will have on the patient's autonomy and integrity (Hem et al., 2018; Wynn, 2006).

The Staff Attitude to Coercion Scale (SACS) questionnaire was designed in 2008 by a Norwegian research team, which was tested and concluded to be a feasible tool to use in mental health wards that practiced coercion. SACS was developed to measure and compare how psychiatrists within the mental health field felt about the use of coercion (Husum et al., 2008). Raveesh et al. (2016) then used SACS to study the opinions of psychiatrists towards the use of coercion. The results from the study indicated that the participants generally agreed that coercion was strongly linked to protection and injury prevention and that it was required, but not as a treatment. The psychiatrists who participated in this study all agreed that it was important to be protected when confronted with danger arising from the patient.

A 2018 German and Swiss study also used SACS and found that positive attitudes towards informal coercion were negatively correlated with adequate use of coercion (Elmer et al., 2018). Those who regarded coercion as offensive had a higher degree of appropriate coercive use. Those who considered coercion as treatment, on the other hand, had a lower degree of appropriate use of coercion. Nevertheless, is seems that the use of coercion can be both offensive and burdensome for the patient. According to Lorem et al. (2015), exposure to coercion and the subsequent loss of autonomy can impact the patients' treatment experience. In addition, this exposure can also result in a less favorable effect on the treatment outcome and introduce complexities in future clinical effects. The emphasis on patient autonomy within mental health care has played an important part of legislative growth in Norway.

However, studies indicate that healthcare professionals are not yet following this approach (Lydersen, 2022). Given that the employees have a clearer perception of patients' experiences of being subjected to coercion, this will possibly help to strengthen the patients' relationship and trust in the Norwegian healthcare system (Lydersen, 2022).

3.3 Summary of research gaps

In this section, the identified research gaps are summarized. The first gap relates to the need for a greater analysis of when coercion is used in mental health care and the importance of human rights. Earlier studies on coercion and human rights show conflicting results of how these work in relation to one another. Various legal frameworks regulate the use of coercion within Norwegian mental health care and there is a blossoming of the need to develop a legal framework that complies with human rights laws. This that can be facilitated through an understanding of what psychiatrists emphasize in these situations. The second gap relates to the ethical dilemmas that arise during these decision-processes. It is important to understand the ethical implications and how they influence psychiatrists in order to comprehend the underlying considerations that drive them into using coercion on patients. Such an approach can help to ensure that the dignity and rights of patients are secured. This can also provide essential insight into the underlying values and beliefs that guide their practice. This knowledge can later aid in the development of guidelines and policies that prioritize ethical principles.

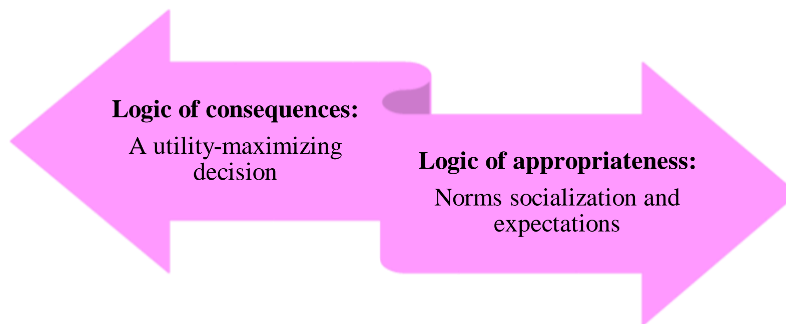
Some evidence for the ways in which coercion and human rights are balanced is provided by earlier studies of professional's points of view. While they can be caused by a multitude of different factors, by incorporating how psychiatrists' reason before making a decision we can get a clearer understanding of potential causes. The relatively recent viewpoints on patients' human rights emphasize the moral issues and worries on the use of coercion in mental health care. Since there are various ideologies and points of view in this area, studying this further is important to advance knowledge to this specific topic. While the above studies provide us with valuable information, my suggested approach is scarcely reflected in the literature on this topic. This is to say, few scholars have conducted research on this topic having a case of psychiatrists from a specific health region in Norway within a theoretical framework of political science. In summary, it is important to understand the human rights principles and ethical considerations that psychiatrists make when considering whether to use coercion in order to advance legal and moral standards and at the same time safeguard the patients' safety and dignity.

Chapter 4: Theoretical Framework

The following chapter provides an overview of the theoretical framework serving as a foundation for the analysis that follows. The previous section provided an overview of literature relevant for introducing research gaps in our understanding of how legal aspects, human rights principles, and ethical aspects shape the outcome of psychiatrists' decisions on the utilization of coercion on patients. In this chapter, I will develop the theoretical framework for this thesis, building on theories and perspectives of decision-making. The theoretical framework applied in this context draws on two key theories: rational choice and social constructivism. Within this framework, four expectations will be introduced – two derived from rational choice and two that are rooted in social constructivism. These four expectations will further guide the research process by providing specified predictions that later will be examined empirically. This will help describe the political, legal, social, and cultural complexity at hand and its complications.

A specific justification is necessary for developing a new understanding of a subject, such as the decision-making process regarding what can explain psychiatrists' way of thinking when deciding about coercive practices. Within the political science field, a diversity of different theories and perspectives exist, all of which are founded on specific scientific theoretical positions. In line with both theories, the psychiatrist's setting will be interpreted and understood in order to be given meaning. Both of these two theories are connected to different logics of action. The first one (rational choice) is associated with the logic of consequences and is linked to the desired result of choices. The latter (social constructivism) is connected to the logic of appropriateness and values the role of internal and social norms. Moreover, these two logics represent two specific approaches in understanding human behavior and decision-making. Additionally, these two theories appear to be moving in opposite directions because they emphasize various aspect of human behavior (*Figure 4)*. Based on the results from this current study psychiatrists navigates a complex terrain of legal frameworks and norms. Human rights serve as the core of such legal and ethical frameworks that shape psychiatrists' decision-making regarding coercive practices.

Figure 4



An illustration of how rational choice and social constructivism operate in different directions.

4.1 The background of rational choice theory

The rational choice theory was first introduced as a so-called *exchange theory* (Aakvaag, 2008, p. 98) and for this reason I will present a brief explanation of this theory. Two American sociologists; Peter M. Blau and George C. Homans developed the *exchange theory*. These two pioneers were the first to introduce the idea of actors who maximized utility instead of being constrained by norms (Aakvaag, 2008, p. 98).

In the early 1960s, Blau and Homans used exchange theory to study the modern society. In doing so, they formed an exchange-theoretic alternative to the current functionalist consensus by allowing utility and rational actors to take the place of norm-governed actors and self-reproducing social systems as the foundation for sociological theory (Aakvaag, 2008, p. 99). So, according to exchange theory, we should begin by assuming that society is made up of self-interested rational actors who trade material and immaterial goods among themselves in accordance with a reciprocity principle (what is a reasonable relationship between performance and counter-performance) (Aakvaag, 2008, p. 100).

Even though exchange theory remains a crucial cornerstone of rational theory, in the 1970s, the attention within the tradition shifted more towards examining the characteristics of individual actors' rational choices as opposed to exchange processes (Aakvaag, 2008, p. 101). Two filtering processes can be used to describe human behavior; i) for simple factual, physical, political, cognitive, economic etc. grounds, many alternatives already become unsustainable – for instance – humans cannot break the law without expecting to face consequences, ii) given their desires and perceptions, the actors will make the decision based on the option that results in the best outcome. The term "best" in this context refers to what alternative actors consider the most efficient means to fulfill their desires (Aakvaag, 2008, p. 101-102).

4.1.1 Rational choice theory – considering each option

According to Elster (1986), rational choice theory relies on three specific aspects in the decision process to defend and explain behavior. First, we have the feasible set, meaning the collection of every course of action which is rationally thought to fulfill a spectrum of legal, physical, and economic limitations. The second is a set of rational thoughts regarding the situations' causal structure, which defines which action will lead to what results. The third and final set is about ranking the feasible options subjectively, typically based on a ranking of the outcomes on how likely it is that each option will lead to a particular result. To choose the highest-ranked component in the feasible set is the essence of acting rationally (Elster, 1986, p. 4).

The rational choice theory is based on a human model, in which individuals are maximizing utility and acting in accordance with a conscious means-ends calculation (Aakvaag, 2008, p. 97). Hence, the theory contends that individuals act instrumentally rationally (Aakvaag, 2008). That is, for each alternative we consider, we must consider what decision maximizes utility and choose the one that benefits the most in relation to the aims that have been set.

The realm of rational choice theory constitutes the logical underpinning of consequentialism (Risse, 2000). It views actors' interests and preferences as mainly fixed throughout the course of interaction. Further, within a rational choice approach, actors participate in strategic interactions based on their preexisting identities and interests. They attempt to achieve their preferences through key behavior (Risse, 2000). In this area of instrumental rationality, one's own utility are optimized and maximized through behavior.

4.1.2 Rational choice – motivation behind choices

According to rational choice theory, individuals act instrumentally rationally: We make consciously choices of action, opting for the option we believe will be the most helpful in achieving our goals. Desires, perceptions, and the actual choice itself make up the three primary components of the actor- and action knowledge of rational choice theory (Aakvaag, 2008, p. 102). A rational action calls for a rational desire. Furthermore, it is demonstrated by the capacity to rank various course of action options according to their desirability. Desires operate as a catalyst for action and are thus the main factor influencing human action.

It is common for individuals to have both rational and irrational desires for the future. The desire must be rational in order for a rational decision to be conceivable. There are some requirements that must be met for the desires not to be irrational.

In addition to the fact that the desires must be future-focused and show a minimum of stability and duration, the desires must be complete. A desire's completion suggest that ranking may be possible (Aakvaag, 2008, p. 103). Moreover, it is required that the desires are transitive, meaning for example that if I prefer to become a firefighter rather than becoming a plumber, and further I prefer to become a plumber rather than an electrician, this mean I would also prefer to become a firefighter rather than becoming an electrician. Furthermore, in addition to logically realizable (however, not necessarily rational), desires are also required to be autonomous. They had to have arisen in a controlled and deliberate manner, or in other words, the so-called "right" way (Aakvaag, 2008, p. 105).

The action must be in an optimizing relationship with the actor's perceptions, according to Aakvaag (2008) and an actor's perceptions are a reflection of the individual's worldview. An actor needs to have some understanding of the world, in particular the current situation's action alternatives and outcomes available in the current scenario, in order to be able to choose the alternative that will be the best possible means of realizing the desire (Aakvaag, 2008, p. 106). To be rational, a perception must be based on all the information that the actor is in possession of, and also, this information must be the reason why the actor has this perception. In order for perceptions to be classified as rational, the theory stipulates a variety of features. First, the perception needs to be based on available and sufficient information. Furthermore, one needs to obtain new information in order to act rational, in addition to basing on the knowledge already at hand (Aakvaag, 2008, 107).

Also, according to the theory, the information must be logically consistent (it must be reliable). One should avoid making generalizations based on the experiences of others and by this ensure that the perception is logically and correctly formed (Aakvaag, 2008, p. 108). Finally, perceptions must be unaffected by desires and preferences.

The presentation in Figure 5 explains how the decision, which initiates the action, must be rational. It is not enough that perceptions and desires are both rational. To accomplish this, the actor must first choose the best alternative and finally choose the alternative in the "right" way.

Figure 5

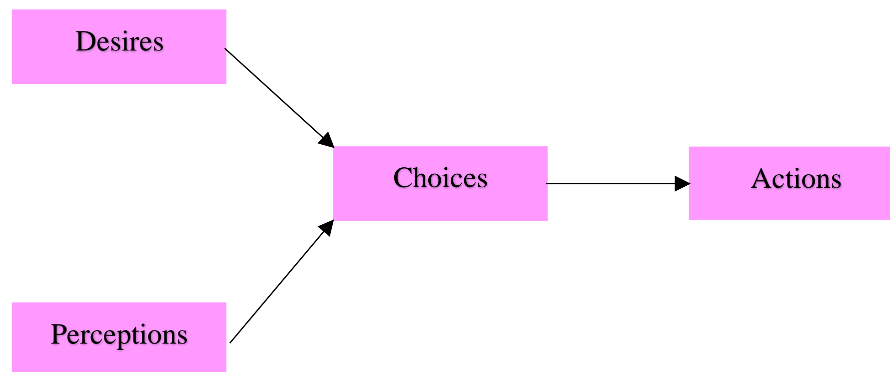


Illustration of the theory of rational choice (modified from Aakvaag, 2008, p. 102).

4.1.3 Uncertainty of choice

Despite being regarded as a well-developed theory, it is not without uncertainties (Aakvaag, 2008, p. 119-120). One does not fully understand all the probabilities of alternative choices of action. As a result, the best option is far less evident than what the theory may imply. Something than can work as a guide, however, is to choose the alternative, in the light of the actor, that appears to be the most effective way to achieve a specific goal (maximum-minimum rule). In the best-case scenario, it is also possible to select the decision that offers the greatest "profit". Moreover, there is no guarantee that the probabilities will be in line with reality.

4.1.4. Explaining psychiatrists' decisions through rational choice

To begin, my first expectation (E1) derived from the rational choice perspective is as follows: *Psychiatrists follow the law in fear of sanctions*. E1 predicts that psychiatrists are rational decision-makers who prioritize legal compliance when making decisions on coercion to maximize their own utility. This expectation also aligns with the assumption that psychiatrists choose according to what maximizes their own utility in social life.

With this, rational choice can provide an explanation as to how psychiatrists weigh the use of coercion based on their own self-interest. Utility in this context, is related to what consequences comes out of the psychiatrist's decision regarding the use of coercion, either in form of means or treatment.

Adhering to legal standards is of great importance to psychiatrists as they are obligated to follow certain laws and regulations that define their scope of practice on coercion. Non-compliance with the legal framework might lead to legal sanctions and repercussions, for instance loss of their medical license.

This meaning, compliance with legal standards can assist in reducing the risk of legal sanctions and thus psychiatrists make choices that align with established legal standards, even though these decisions are not necessarily something they personally agree with. Psychiatrists may base their choice of whether to use coercion by complying with legal standards and thus basing their decisions on something that aligns with their own self-interest. For example, a psychiatrists may choose to not use coercion even if they personally believe they should but emphasize the importance of legal compliance and minimizing the risk of a negative outcome.

The question of whether psychiatrists in such situations could only be interested in the legal effects of the legal framework itself rather than guidelines and rules presented by the hospital, or HOD, is an intriguing one to investigate. This might be because the weight of legal sanctions associated with a non-compliance to the law may weigh heavier than violating an internal guideline from the hospital or HOD. Viewing this from a rational choice perspective, the strength of the sanction may play an important factor in determining the psychiatrist's decision-behavior. Meaning, the weaker the sanction, psychiatrists may be less motivated to comply than if the repercussion was stronger.

Another expectation (E2) derived from the rational choice framework is as follows and predicts that: *Psychiatrists' commitment to human rights principles places emphasis on either patient care or welfare for the society depending on how utility-maximization concerns.* Thus, psychiatrists may struggle to balance such competing priorities. Even though rational choice assumes that psychiatrists base their decisions on the alternative that maximize their own utility, they might also express a desire to prioritize the rights and self-interest of a patient and or groups in society, rather than their own self-interest. For patients, right to treatment and the right to autonomy and self-determination can be closely linked to this. When providing patients with necessary treatments, psychiatrists do indeed fulfill their obligation to provide healthcare to patients. Comparable, by respecting patient's right to autonomy and self-determination, they also respect patients' independence and dignity, which might result to a more trusting psychiatrist-patient relationship. In addition, when considering the potential impact of the greater good of society, choices might result in better outcomes for the society as a whole. By maintaining such obligations, it fits well with the rational choice argument, seeing as this aligns with psychiatrists' professional responsibilities. When basing their choices on such outcomes, by emphasizing the care for patients and society, psychiatrists might also experience positive outcomes for themselves in the end, for instance seeing as they themselves can be considered part of the society.

4.2 Social constructivism theory – objectivity in parenthesis

The fundamental principle behind social constructivism is that all human cognition is socially constructed (Berger & Luckmann, 2000). Culture, in addition to the historical and modern environment of which a person is a part of, is what influences the level of knowledge. This also means that ethical aspects and norms are socially constructed. These two elements are essential components of social constructivism seeing as they guide how individuals behave and perceive in different social settings. The social environment affects what we think and who we are, and we "collectively" recreate this social environment through our actions, according to social constructivists. In this way, morality and ethical aspects are also socially constructed phenomena that are formed by cultural factors and social norms (Cottone, 2001, p. 39). Further, decision-makers are guided by these factors and norms in defining what the appropriate practice is. Such guidance emphasizes the significance of the social setting in the blossoming and maintenance of moral and ethical frameworks.

According to Gergen (1991, p. 168-169); "When individuals declare right and wrong in a given situation they are not only acting as local representatives for larger relationships in which they are enmeshed. Their relationship speaks through them". The social constructivist gathers information from those involved, evaluates the type of relationships that are present at the time, consults respected colleagues, as well as professional expert opinions (which would also include ethical codes), negotiates in times of need, and further responds in a way that allows for a reasonable consensus when concerns arise during critical moments of professional practice. Social constructivists emphasize a different rationality than rational choice: the "logic of appropriateness" (Risse, 2000). Further, norm-guided behavior reflects this perspective by centering on the social norms and institutions have in molding individuals' behaviors. Norm-guided behavior means that individuals' choices are influenced by expectations and norms from the social environment, and the influence of the individuals' own beliefs (Risse, 2000). This emphasize the importance of the social constructivist perspective and what way it is significant to consider social contexts and institutions when studying human behavior.

This study is partly grounded in the social constructivist theory that interactions within a context provide decision-making processes content and significance. Decision-making will be examined as something that is formed through interaction between individuals and within a context, in line with a social constructivist's perspective. Constructing refers to how we absorb knowledge, how we manage this knowledge, and lastly how we respond to having this knowledge.

Social constructivism's contribution is, according to Tjora (2020), defined by the idea of a "socially constructed reality". People's perceptions of what reality is are constantly influenced by the occurrences and situations they find themselves being in. Social constructivism is fundamentally based on the assumption that people are not independent from the environmental context, and that people's actions are influenced by the ideas' beliefs that make up their environment's ideational framework. According to social constructivism, people (collectively) "reconstruct" this environment through their actions and behavior. Put differently, moral and ethical aspects are not intrinsic or innate, but are formed through interactions between individuals and shaped by societal and cultural factors. According to Maturana (1988) "objectivity" is "in parentheses", where the limits of human interaction are indicated by parenthesis. Therefore, reality is perceived as socially constructed. Within the social context, this view is absolute.

Individuals form their moral beliefs and values through their interaction with other people and the surroundings. Social constructivism underlines the significance of comprehending the cultural and social settings whereby moral beliefs and values are constructed and proposes that these moral factors are neither static or universal, but they are rather subject to change and affected by social interactions. Theorists of social constructivism heavily weigh the importance of comprehending the cultural and social settings in which moral beliefs and values are formed and recognize the effect of social interactions on individual's moral framework.

4.2.1 Social constructivism - from function to use

Thus, according to social constructivism, reality develops via interpersonal interaction and agreement regarding what is real instead of being based on what is objective facts (Cottone, 2001, p. 39). The social constructivism model offers a theoretically unique decision-making approach because it suggests that social norms, cultural values, and other people's perspectives also have an impact during the decision-making process. This also meaning that our decisions are not straightforwardly the outcome of personal preferences or rational analysis.

This might appear in a variety of ways, such as by conforming to the standards of our community or embracing the norms and values of our culture. According to the social constructivism theory our perceptions of reality and how we view the world are not fully objective. Also, they are not completely unaffected by our own experiences. As opposed to that, social and cultural aspects have an impact on them.

4.2.2 Social constructivism – building knowledge

When applying this theory, it provides us with the opportunity to uncover implicit and underlying information as to how psychiatrists within Norwegian mental health care decide whether to apply coercion or not. Furthermore, this knowledge might prove valuable for raising attention in an effort to bring about change where this is needed. The fundamental concept behind this theory is that instead of being a duplicate of an objective reality, knowledge is a result of the mind choosing, making sense of and recreating occurrences. Put differently, knowledge is the outcome of interactions between subjective and environmental elements. Social interactions alter the knowledge that people acquire.

Further, individuals do not make decisions in a "vacuum", according to social constructivism. Rather, the decisions are shaped by the attitudes, expectations, and communities they are part of. Individuals' perceptions and what they deem to be desirable outcomes are influenced by these elements. For instance, a person who is raised in a low-income culture, may be more inclined to make decisions based on what is most fruitful financially, than someone from a culture that sets a high value on material goods.

Moving on from this backdrop, in order to achieve the goal of this study and provide an answer to the overreaching question of the thesis, this approach is apparent in the informant's answers, which are an expression of how they view the world in what way this is influenced by their interactions with others and the environment in which they live. The "why" and the "how" questions instead focus on the individuals' perspective of their current situation and how they choose to perceive it, rather than looking for universal truths. Put differently, the purpose is to comprehend in what way the informants construct their identification related to their surrounding environment and manage their sense of decision-making over whether or not to use coercion towards patients.

In conclusion, social constructivism offers a helpful framework for comprehending the intricate cultural and social influences that affect people's decision-making. We can better understand why people make the decisions they do by acknowledging the influence of cultural values and norms, in addition to the active role that individuals play in creating their own realties. This will be useful in our efforts to develop more inclusive and equitable decision-making procedures. "The mind becomes a form of social myth; the self-concept is removed from the head and placed within sphere of social discourse" (Gergen, 1985, p. 271).

Social constructivism also emphasizes the significance of power relations in decision-making. Those with more social and cultural sway have the ability to mold the conversation and the prevailing narratives that affect judgement. Hence, social constructivism places a strong emphasis on the necessity to take all perspectives and diversity into account when making decisions, and in this way, be certain of the fact that marginalized voices are heard, and at the same time also consider their points of view. A thorough understanding of a research area can be obtained from the social constructivism theory, which also makes it possible to view decision-making as a social negotiation process. The approach can provide insight into how choices are constructed in practice.

4.2.3 Understanding human rights through social constructivism

According to social constructivists, respect for human rights, in ways that limit and guide our behavior, can be routinized as normal. When stating that human rights are socially constructed is stating that actors build and re-create practices and ideas in respect for human rights in specific socio-historical settings and contexts (Stammers, 1999, p. 981). It is a way of comprehending human rights that does not require a reliance on the abstract or logic reasoning that surrounds them. Human rights as socially constructed norms may be internalized and guide individuals' comprehension of what is right and wrong. Individuals may therefore believe that this is the expected and appropriate behavior in societies where human rights are upheld. Individuals within this society may then be more inclined to uphold human rights without necessarily being aware of doing such. Moreover, individuals respect for such rights becomes ingrained within the social norms of a society, further guiding individuals to adhere to such norms even when they are not strictly enforced.

4.2.4 Explaining psychiatrists' decisions through social constructivism

Moreover, this theoretical framework offers a helpful lens through which to explore the intricate nature of moral and ethical considerations in light of decision-making. Instead of being solely determined by rational analysis and objective facts, the concept of decision-making is formed by social and cultural factors. The factors affect our perceptions and values and this further dictate how outcomes of decision-making. For instance, when psychiatrist make decision on whether to utilize coercion, they may be influenced by their moral beliefs about what feels "right" or "wrong". Similarly, they may also be influenced by social norms and values of what is defined as appropriate conduct when deciding on using coercion or not.

The idea that psychiatrists are driven by an inner sense of morality leads to my next expectation (E3): *Psychiatrists are driven by internal norms and how they morally feel about coercion.* This expectation predicts that psychiatrists' actions are motivated by personal beliefs and values. Regarding the morality aspect, a social constructivist believes that through processes of socialization processes, such as engaging in discussion with others and receiving reinforcement and feedback, psychiatrists internalize moral norms and values of their social and cultural environment. Further, these norms and values shape how they feel about the use of coercion.

The fourth expectation (E4) predicts that external social factors play an important role regarding decisions on coercion: *Psychiatrists are driven by external societal influence and expectations.* Whereas the former considers each person's internal values and beliefs, the latter places great emphasis on external factors such as social influence and expectations from the surroundings. In regard to the current study's topic, such surroundings are predicted be other surrounding health personnel, families of patients or the society as a whole – including the media and other important organizations.

Chapter 5: Methodology and Research Design

Often the research process begins with a question regarding the selected theme. This curiosity further prompts a search in the literature for both the most recent theory and other relevant studies (Dalen, 2011, p. 23). The main research question for this thesis is related to what legal and ethical considerations psychiatrists emphasize regarding the use of coercive practices. To address this, two sub-research questions have been developed: 1) *To what extent do psychiatrists prioritize their own self-interest versus either the interests of patient or society?* 2) *To what extent do psychiatrists rely on their personal ethics or wider community standards?* As described previously, the research employs a theoretical framework which combines two distinct perspectives on decision-making to develop four expectations. These expectations also pertain to the above outlined sub-research question, with two expectations corresponding to each sub-research question. These four expectations will be tested using data collected from semi-structured interviews with different psychiatrists.

This study employed a qualitative content analysis of the transcriptions from semi-structured interviews conducted with eight different professional psychiatrists. This chapter will explain the research design and justification for using a qualitative study approach. The planning and implementation phases will be discussed, alongside relevant case study background, ethical issues, and a summary of strengths and limitations. I also present the steps involved in the data collection and -analysis.

As highlighted in the literature review, much research on this topic has been quantitative in nature. My approach is different, and presumably the selected method is well-fitted when presenting a detailed empirical description. This will further prepare the ground for the analytical discussion in the following chapters.

An abductive approach was used to analyze the collected data from the different interviews. According to Alvesson & Sköldberg (2008), the selection of theory and the analysis of data are the outcomes of an abductive process that alternates between theory and data. This approach is both deductive and inductive, in that it entails an iterative procedure that alternates between theoretical ideas and empirical findings. Gaining understanding of a phenomenon is the ultimate aim of an abductive approach (Conaty, 2021, p. 17).

5.1 A single case study design – Why psychiatrists? Why South-Eastern Norway RHA?

Gerring (2017, p. 28) defined a case study as "an intensive study of a single case or a small number of cases which draws on observational data and promises to shed light on a larger population of cases". A case study places a lot of emphasis on one particular case (Elman, Gerring & Mahoney, 2016, p. 375). As stated previously, a "qualitative lens" is applied to examine the topic for this master thesis. The selection of case was purposive instead of randomized (Seawright & Gerring, 2008, p. 295). A central question to ask is thus; *what is this a case of?* Concerning Norwegian mental health care, this is a case study of psychiatrists' decision-making processes on coercion within the South-Eastern Norway RHA.

Even though there are other healthcare personnel with the authorization to use coercion on patients, psychiatrists are chosen due to their central role within mental health care, and because they are often the primary decision-maker when it comes to the use of coercive practices. In addition, they also have a unique expertise in how to handle patients who suffer from mental illnesses. Also, psychiatrists are likely to have more experience in handling the complexity of ethical and legal issues at hand, and therefore they serve as the most suitable study population for the current thesis.

There are multiple reasons as to why it would be interesting to do a single case study of the South-Eastern Norway RHA. When studying one single RHA it enables a more detailed study of the psychiatrists' decision-making within this region. It also allows us to identify certain strengths and weaknesses regarding the practices of coercion within this specific RHA. Furthermore, we might gain a more in-depth understanding of how these services are delivered. For example, this RHA has comparatively higher use of coercion compared to the other three RHAs in Norway (as described and illustrated in Chapter 2).

Compared to the other three RHAs, the South-Eastern Norway RHA is the largest (Regjeringen, n.d.), and therefore a thorough examination of this RHA might provide valuable and important insight into the views of psychiatrists concerning coercive practices. Seeing as this RHA has a high use of coercion and has a high population, psychiatrists here will truly have access to a larger pool of cases to draw upon when discussing the topic of this thesis.

Also, this RHA is a relatively diverse region, in particular related to demography with a mixture of rural and urban areas where people of all walks of life reside. Therefore, by studying this particular RHA, one can explore how contextual factors, for instance the availability of resources and the currency of specific mental health diseases might influence the utilization of coercion. Other factors, such as social and local cultural norms, can also be explored. In sum, this can offer insight into how such coercive practices are impacted by wider environmental and social factors. Furthermore, this RHA covers a strategically important part of the country, with Oslo being the Capital and an important center for health care policy and its related decision-making.

5.1.1 Exploratory case study

This particular case study can be referred to as an exploratory case study. An exploratory case study is applied to identify an initial understanding of the phenomenon in question (Chopard & Przybylski, 2013, p. 1). The emphasis is on discovery in order to have an empirically supported introduction to the structure, context and dynamics of the topic. Such a case study is beneficial for formulating feasible expectations. Also, exploratory case studies are helpful in identifying research questions to be addressed (Chopard & Przybylski, 2013, p. 1). Therefore, exploratory case studies are often well-suited where the overall aim is to collect a thorough, in-depth description of a social phenomenon. Even though exploratory case studies usually aim at generating new knowledge without preconceived expectations, researchers can possibly develop certain expectations that guide their exploration.

5.1.2 Advantages and limitations of a single case study

The tradition of case studies continues to survive within all social science disciplines (Elman, Gerring & Mahoney, 2016, p. 376). Good case studies contain key characteristics, one of them being that they tell us something compelling and purposeful about the particular case that is being examined (Halperin & Heath, 2020, p. 234). This enables a thorough understanding of the single case and may provide insights that may have been difficult or impossible with a larger sample size.

Disadvantages of this approach is that it limits the scope of research since the findings are restricted to one person or a specific subgroup of people. In other words, it may be challenging to generalize findings (Achen & Snidal, 1989, p. 146). Additional limitations consist of, without being restricted to, biased case selection in addition to researcher bias (Leuffen, 2007; Flyvbjerg, 2006).

Biased case selection means that the case selected may not be representative for the general population as a whole. Moreover, a single case study may exhibit a researcher bias towards verification, which connotes a tendency to support the researcher's preexisting ideas (Flyvbjerg, 2006, p. 4). In order to address a lack of generalizability, one strategy is to utilize purposive sampling to choose cases that represent the population of interest. The researcher can also be transparent about such limitations of the study and the degree to which the results are generalizable. It should also be made clear which observations would support the suggested theoretical relationships and which would undermine them.

5.2 Data collection and informants

The data was collected through semi-structured interviews with informants during a one-month period. In addition to being identified as psychiatrists employed within the South-Eastern Norway RHA, the informants can also be referred to as so-called experts. The reason being that these informants are identified as people with specialized knowledge relating to a certain issue (Halperin & Heath, 2020, p. 324). Also, there is variation among the psychiatrists in terms of gender (3 women and 5 men) and age, and the year they completed their specialization. Prior to entering the research area, it was important to secure permission to contact potential informants (Dalen, 2011, p. 31). An important step in the data collection process was to have the research project approved by the Norwegian Agency for Shared Services in Education and Research (SIKT), in order to collect, store and share data. In line with SIKT's requirements, I created an information letter for my informants and a consent form (see *Appendix 4*). All the informants who participated in this study are held anonymous through the entire research project and will not be recognizable.

This study intentionally avoided using secondary data such as various documents because the overall research question of the current study sought to collect data that was best achieved through semi-structured interviews. Also, documentation that could be relevant for this study are often not available due to the fact that such information (regarding the use of coercion within psychiatric facilities) are often confidential due to its sensitivity.

5.2.1 Sampling strategy

The question of whom to interview and how to determine the group of potential informants is a central issue. Two distinct steps were applied to identify the informants. The first is known as purposive sampling where informants are chosen based on different criteria that show that they are appropriate for the research topic (Dalen, 2011, s. 45).

Purposive sampling, also known as judgement sampling, is a type of non-random sampling in which subjects of a population are chosen based on certain criteria deemed relevant to the analysis – for instance type of profession (Lynch, 2013, p. 41). In this study, informants were chosen because of their profession (psychiatrists) and what RHA they belonged to (South-Eastern Norway RHA).

Additionally, the following step involved conducting a so-called snowball sampling, also referred to as respondent-driven sampling, which is an approach for gradually adding respondents to a sample using suggestions from previous informants (Halperin & Heath, 2020, p. 300). This sample-building strategy makes it easier to reach respondents. Snowball sampling has the benefit of exposing the interviewer to informative sources they may not otherwise had access to (Bleich & Pekkanen, 2013, p. 91). Nevertheless, it was crucial that I was conscious of the risk of "getting stuck" within the same network. To limit this risk, I explicitly asked already recruited informants to put me in contact with potential informants working at different psychiatric departments within my chosen RHA. Moreover, it is more likely that an informant will recommend others who hold the same viewpoint. To avoid this, I stopped recruiting informants when the so-called "saturation point" was reached. This meant that the informants now stopped contributing new information (Bleich & Pekkanen, 2013, p. 91).

5.3 Semi-structured interviews

In a research interview, the researcher aims to clarify the research topic and the research questions (Dalen, 2011, p. 26). Due to this study's case design and the nature of the research questions, I used semi-structured interviews. Such interviews focus on a few predetermined themes that the researcher has chosen in advance. I conducted a total number of eight interviews, a number of interviews common for semi-structured interviews (Halperin & Heath, 2020, p. 313).

5.3.1. Interview guide

The most crucial topics this study will address are covered by an interview guide that incorporates key themes and questions (*See Appendix 1*) (Dalen, 2011, p. 26). The interview guide consisted of six questions with a number of sub-questions. In order for such a brief interview protocol to be successful, I had to make it clear what kind of data I wished to obtain and also be prepared to ask more detailed questions in situations where the answers to the general questions were inadequate.

In semi-structured interviews, the interviewer combines structured questions (to elicit factual material) and unstructured questions (to probe into the informant's experience) (Halperin & Heath, 2020, p. 313). Preparing an interview guide can be challenging, since the guide must be able to break down the major concerns of the study into smaller, more manageable themes and questions.

In order to limit such challenges the interview guide was structured according to the so-called "funnel principle", which works as a helping tool when creating an interview guide (Dalen, 2011, p. 26). I began by asking questions that were peripheral to the main, and possibly the most emotionally charged subjects, that needed explaining. For instance, during my interviews with different psychiatrists about their perspective on human rights within the field of coercion, I avoided starting the interview by asking questions like; "what is it like to physically use coercion on a patient against the patients' will?". Instead, the opening question was of a kind that the informant found comfortable (Dalen, 2011, p. 27). In time, the questions concentrated more on the major issues, before it was necessary to widen the "funnel" towards the end, so that the questions once more pertained to more general topics (Dalen, 2011, p. 27).

One of the most useful types of question to ask during an interview with an expert informant is a so-called "grand tour question". With a grand tour question, the informant is asked to verbally guide the interviewer through an area that they have knowledge about (Leech et al., 2013, p. 215-216). In my interview, I asked if the informants could tell me about an ordinary day at their workplace. This type of question, which perhaps is best used in studies were only a small number of interviews are conducted, has the advantage of providing the researcher with information about what typically occurs. The use of general prompts, like for instance "is there anything else" was encouraged, because it prevented me from speaking *for* the informant.

5.3.2 Conducting the interviews

For an interview to be used in a research context it is essential to listen and give the informant enough time to tell and elaborate. Some of the questions were modified after the conduction of the first interview. Pauses can be innovative in that they offer the subject of the interview time to reflect on a question that has been asked (Dalen, 2011, p. 33). Given how crucial it is to preserve the informants' own statements, it is advised to employ a recording equipment when conducting qualitative interviews (Dalen, 2011, p. 28), with the consent from the informants.

The principles of survey research require that interviewers constantly ask the exact same questions in the exact same order (but also, in some situations, ask the questions in randomized order). Further, it requires that the questions are asked in the same way – this is a rule that is designed to be breached in expert interviews. My goal was to make the interview more like a conversation than a survey, with the hope of extracting more honest answers. I then, instead of asking questions that were directly taken from the interview guide, asked them in my own words. Additionally, it meant that I would not ask the informants questions from the guide if the informants had already answered this previously. By doing so, it might look as if I was not paying attention to what the informant was telling me, which possibly could have interfered with our conversation. On the other hand, in situations like these it was possible to go back to an earlier response and adjust the specific questions. For example, "You told me that X makes these decisions." "Is there anyone else who also participates in this process?"

5.4 Strategy for processing and analyzing the data

Following the completion of the interviews the organization and maintenance of the collected data material began. In qualitative studies the analysis process begins early, in fact, even during the interview stage where the researcher monitors and observes throughout the process (Dalen, 2011, p. 56). After having conducted all eight interviews I began transcribing using the Microsoft Word software program. The interviews were all conducted in Norwegian. "Filler words" without meaning were removed from the transcription in order to make it more readable as they were not of any relevance to the study.

With the use of the analysis program NVivo researchers can analyze and organize a wide range of data including, but not limited to, documents, images, transcriptions etc. (Edhlund & McDougall, 2016, p. 12). With the help from NVivo I coded and categorized the transcriptions from the different interviews.

In order to create a clear understanding of the full data set NVivo made it simpler to systematize codes and arrange them into several categories. Using NVivo thus made it possible to see every statement that were categorized or coded as the same. In this way it was possible to see which statements from the different conducted interviews corresponded to each other. Eventually I ended up with having both categories and sub-categories of the codes that corresponded to two main categories (Logic of Consequences and Logic of Appropriateness).

When coding and analyzing the collected data it seemed appropriate to use an abductive approach. By doing this, I had the ability to both recognize the emerging themes that were connected to the selected theoretical framework and to also search for emerging themes throughout the analysis. Hence, I was informed by the theory and concepts, while maintaining an open mind to any new emerging challenges and issues that surfaced during the interviews.

In this study, four expectations (E1-E4) were developed prior to coding the data (introduced in Chapter 4):

E1: Psychiatrists follow the law in fear of sanctions.

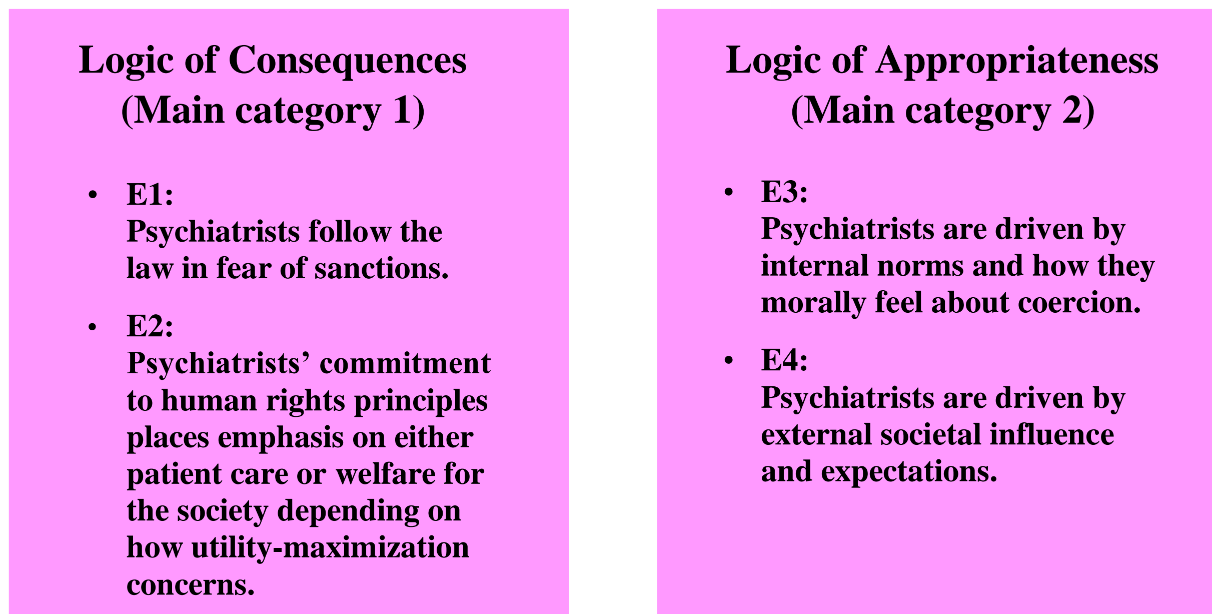
E2: Psychiatrists' commitment to human rights principles places emphasis on either patient care or welfare for the society depending on how utility-maximization concerns.

E3: Psychiatrists are driven by internal norms and how they morally feel about coercion.

E4: Psychiatrists are driven by external societal influence and expectations.

These four expectations provided a direction for recognizing and coding meaningful data into the two main categories: 1) Logic of Consequences and 2) Logic of Appropriateness (see *Figure 6*). These two main categories are founded on the theoretical framework of this study, the first one connected to rational choice theory and the latter related to social constructivism. This way of categorizing deemed most relevant for the overall research question and underlying sub-research questions.

Figure 6

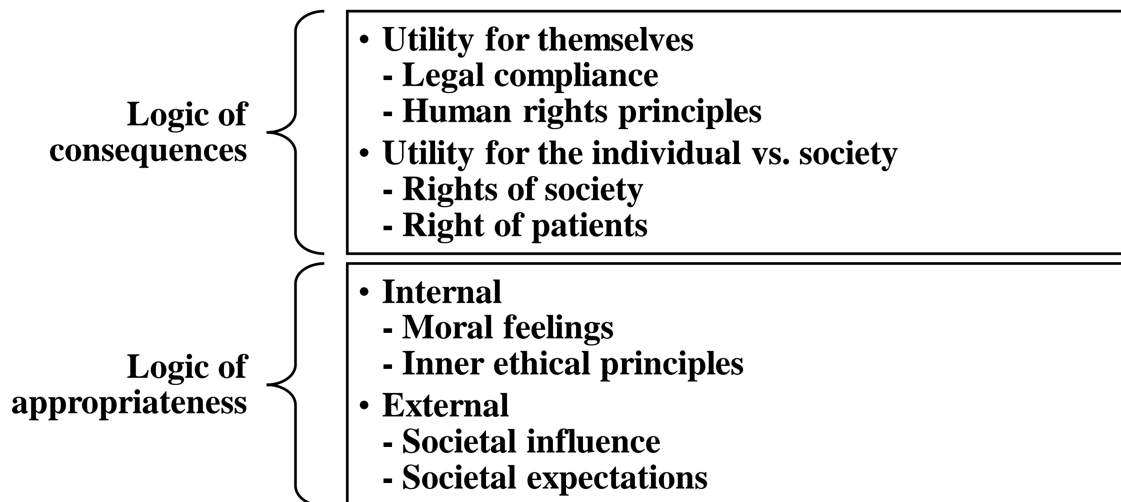


This figure illustrates how the four expectations are divided into the two different theoretical frameworks. Logic of Consequences belongs to the rational choice perspective, while Logic of Appropriateness rests on the perspective of social constructivism.

It is, however, important to note that these four expectations could belong under both theoretical frameworks. For instance, E1 and E2 could also fall inn under *Main category 2* as they explore the construction and interpretation of social norms, such as the expectation that psychiatrists should uphold human rights principles of the patient versus groups in society. In the same way, E3 and E4 could both belong to *Main category 1* since both internal and external factors reflect a focus on maximizing utility. Nevertheless, I believe that the division above provides the strongest expectations from the theories and will also help gain a deeper understanding of the reasons behind their behavior. I made this decision with the aim to present a more clear-cut understanding of the decision-making process that occurs when psychiatrists evaluate whether to use coercion on a patient, and further how they are influenced by elements that fall under two chosen political science theories.

I made different sub-categories (followed by underlying categories) as markers when I coded my data in NVivo. For example, if I was coding data related to E1, I would be looking for language statements that stressed adherence to the law such as "avoiding loss of license" (see *Figure 7*). Analyzing the empirical findings meant examining patterns that emerged within each of the two categories and comparing the results (both between the two main categories, but also within each main category).

Figure 7



An outline as to how the categories were organized in NVivo. The two main categories: Logic of Consequences and Logic of Appropriateness, each had two connecting sub-categories, each of which had its own underlying categories.

A more detailed overlook at how the coding was done in NVivo can be provided upon request.

5.5 Validity and reliability

According to Halperin & Heath (2020), validity is the extent to which data actually reflect the phenomenon that we are trying to measure. Concerning the analysis of interview data "…validity refers to whether the conclusions being drawn from the data are credible, defensible, warranted, and whether they can withstand alternative explanations" (Halperin & Heath, 2020, p. 495). Further distinctions are made between *external* and *internal* validity. *Internal* validity refers to the accuracy of the analysis (Halperin & Heath, 2020, p. 168). In the hope of maximizing such internal validity, conducting interviews with experts (within psychiatry) would give less biased and more objective information. By remaining as impartial, objective and analytical while examining the answers to my questions, I was able to further address this issue at hand. *External* validity is the ability to generalize to other similar situations (Halperin & Heath, 2020, p. 489). Since this current study primarily highlights the decision-making processes of psychiatrists within one Norwegian RHA its generalizability to another context is limited.

Reliability refers to if the same findings can be consistently achieved on repeated occasions (Halperin & Heath, 2020, p. 191). Reliability issues are resolved by the researcher by outlining the methodological framework, research design and research advancement. Since social concepts are dynamic and will differ in the following studies, this is essential for qualitative research. In qualitative research, as this current study, reliability is challenging to attain as it relies on the researchers' subjective beliefs and preconceptions, which also affect the interpretation and gathering of data. For this current study one prominent challenge related to reliability is the interpreting content analysis of the conducted semi-structured interviews. This challenge rises a need to consider the interviewers and informants' background in the process of interpretation.

As stated previously, all informants are made anonymous. One of the reasons being ethically strict guidelines from SIKT. Because of this, transcripts form all the eight interviews are not available in the Appendix, and therefore future research will not be able to replicate this current study completely. However, the interview guide is attached (*see Appendix 1*). This guide can still contribute to the reliability due to its clear layout of questions used during the interviews. Even though I acknowledged previously that there were instances where I deviated from the interview guide, I tried to ensure through all the interviews that the questions that were asked were related to the research topic and covered the theme of the original question. This can strengthen the thesis reliability, seeing as it should be easier for another researcher to replicate the interview.

An accurate record of the interview is important, otherwise the validity and reliability of the results may be questioned. In order to avoid any measurement errors that may occur and possibly reduce this thesis' reliability and validity, I carefully considered what was to be implemented when selecting informants and creating the interview guide. It is critical that the questions in the interview guide measure what one is interested in examining in order to strengthen the study's validity. The risk of the interview being too flexible is that the validity may be somewhat compromised if the questions do not contribute to measure the phenomena me as an interviewer is trying to measure, but instead measures other phenomena that are unrelated to the study.

The accuracy and validity of this research might be improved because of the homogeneous sample, meaning only one RHA was examined. The four different Norwegian RHAs might have various rules, regulations and practices relating to coercive practices and the surrounding decision-making, which might lead to variability and thus make the research study more complicated.

The final question of the interview guide: “At the very end, is there anything you would like to add?” helped when ending the interview, because it could strengthen the validity of the study further, as one will not miss out on any explorative data. Loss of validity of the interview itself must be balanced against loss of reliability across the interviews. The quality of the replies is likely to decline if the interviewer repeatedly asks the same questions in the same manner while ignoring the informant’s past responses, leading to less accurate – and therefore less valid – answers.

5.5.1 Strength and weaknesses

Results from this study can provide in depth-knowledge to its readers. However, I must point out that because this study only offers insight into the psychiatrists in question it makes it difficult to generalize the understandings and descriptions that surface in this study to other psychiatrists out of this context. Importantly, human knowledge is not absolute and varies across time and place. Knowledge is therefore always part of a context.

It can be debated whether the transfer value in this study also will apply to other professions with the authority to make compulsory decisions (such as psychology specialists), given that the study is restricted to informants who are psychiatrists. According to Mehmetoglu (2004), although findings from qualitative studies frequently pertain to a particular context, the findings should still apply to other settings that have settings with comparable or identical circumstances.

Despite this, the results from this study will have the greatest transfer value for other psychiatrists within the explored RHA. If I had chosen a quantitative approach with more informants and a survey it could have provided more generalizable data. However, the deep understanding of the informant’s experiences would then be missing. This study thus put emphasis on the unique experiences and perspectives of each participant.

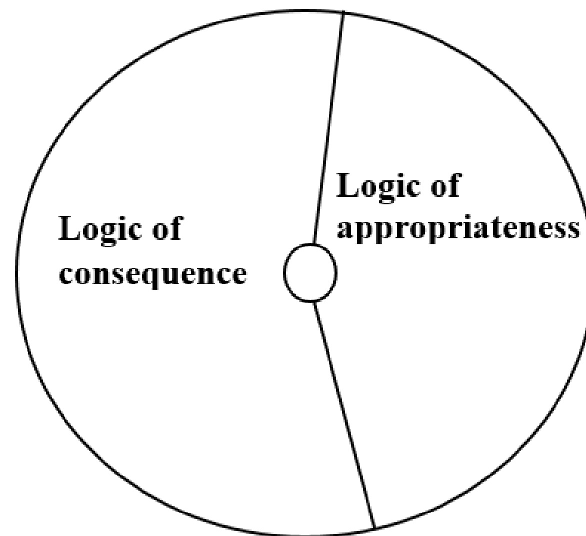
Therefore, I pursued analytical generalization in this qualitative case study, rather than statistical generalization. This particular case study provides no foundation for generalization, except for the eight informants this study is based on. However, it is possible to make arguments on a general basis by pointing to my findings derived from this study.

Chapter 6: Empirical Findings

The following chapter presents results from this current study. The data was collected through eight semi-structured interviews with different psychiatrists that were all from the same health region: South-Eastern Norway RHA. The transcriptions from the interviews were coded into two different main categories in NVivo (Logic of Consequences and Logic of Appropriateness). Both main categories had underlying sub-categories which further had their own underlying categories. Overall, both main categories were linked to this study's main research question: *What legal and ethical considerations do psychiatrists emphasize when deciding to use coercion within Norwegian psychiatric care?* Furthermore, they were also related to the two sub-research questions: i) *To what extent do psychiatrists prioritize their own self-interest versus either the interests of patients or society?* ii) *To what extent do psychiatrists rely on their personal ethics or wider community standards?*

The quoted statements are minor extracts from the different interviews, and these are divided in, and placed within the "suitable" main category. Regarding findings where there was a large degree of agreement among the different informants it was deemed unnecessary to repeat statements with the same content. However, it was emphasized in the presentation of the results that there appeared to be consensus regarding this subject. As all the interviews were conducted in Norwegian, I have included the original statements but have supplemented these with my English translation in parentheses. The diagram below (*Figure 8*) illustrates the distribution of the dataset that has been coded into the two main categories. The results suggests that informants from the current study placed heavier weight on the logic of consequences rather than the logic of appropriateness. The results from *Figure 8* also suggests an interaction between these two perspectives.

Figure 8



The figure (modified from NVivo) gives an illustration of the data distribution between the Logic of Consequences and the Logic of Appropriateness. More of the informants assigned a greater emphasis on the Logic of Consequences rather than the Logic of Appropriateness as visualized by the greater area occupied by the former.

6.1 Utility of whom: the logic of consequences

The following results point to a focus on the maximizing of utility as shown by the data collected through the interviews. These results suggest a high emphasis on the maximizing of utility, suggesting that psychiatrists decision-making processes are motivated by a desire to maximize their own utility, or the utility of patients versus groups within the society.

6.1.1 Utility for psychiatrists themselves

Drawing on the experiences shared by the participating psychiatrists on their approach towards coercion the consequences of possible alternatives proved highly valued. One of the elements examined by this study was whether psychiatrists prioritize their own fulfillment of favorable outcomes and maximizing utility when faced with decisions on whether to utilize coercion on patients. Several informants underscored the relevance of legal compliance when faced with such decisions. The data was analyzed in NVivo via coding to identify any references to this particular topic.

Due to potential negative consequences many of the psychiatrists felt compelled to comply with the legal framework and that this was something they highly valued. They also expressed their fear of legal repercussions such as possible loss of their medical license. Thus, these possible outcomes led to their emphasis on legal compliance:

«En bør gjøre det, sjekk loven og se hva den sier».
(One ought to do that, check the law and see what it says).

«…de ønsker jo at pasienten bare skal være her, men det kan ikke jeg gjøre
for loven tillater ikke det».
(…they want the patient to just be here, but I cannot do that
because the law does not allow it).

«… også er det jo loven som er nærmest oss ikke sant. Når jeg kjører bil så er det jo
veitrafikkloven som regulerer meg».
(...also, the law is the closest thing to us right. When I drive a car, the Road Traffic Act
regulates me).

When asked about their experiences on working with the jurisdiction, one of the most prominent findings among the informants was how much knowledge they all had regarding the legal framework. During almost every single interview, informants frequently cited laws and regulations in the context of coercive practices:

«Så har du noe som heter § 4-4, som er et behandlingsvedtak».
(Then you have something called § 4-4, which is a legal decision on treatment).

This did not apply to other rules or guidelines provided by the hospitals or HOD. They rarely referred to such rules or guidelines, nor did they discuss the possible consequences off not following these.

Occasionally, informants also provided responses as if the law made the decisions and not themselves. Instead of framing their responses in terms of their own decision-making, they referred to the law, revealing the central position of the legal framework in this regard:

«Loven vil ikke at det skal være for mange som tar de avgjørelsene,

men loven skjønner at …»

(The law does not want too many people to make those decisions,
but the law understands that…).

Each of my eight informants voiced their conviction that all the laws they were obligated to follow are rooted in human rights principles. Thus, they all believed that by adhering to the law out of fear of possible sanctions or legal repercussions their decision would also align with the human rights principles of patients and groups within society. The psychiatrists unwavering conviction in the alignment of the legal framework with human rights principles was so strong that they did not express a need to discuss them explicitly. Moreover, they pointed out that because of the legal frameworks preexisting incorporation of such principles, conversations on human rights were infrequent within their place of work:

«… jeg tenker aldri på menneskerettighetene. Jeg tror ikke noen gjør det».

(… I never think about human rights. I don't think anyone does).

«Altså, mitt inntrykk er at menneskerettighetene ligger i bunn av hele psykisk helsevernloven».
(So, my impression is that human rights create the foundation of the entire Mental Health Care Act).

When questioned about their viewpoints regarding the judicial system in Norway and how this operates in real life, the responses reflected contradicting opinions. A minority answered this question by referring to the legal framework as something like a helping hand, and so abiding to these regulations was thus not difficult:

«Lovverket har vært mer til hjelp enn til heft».
(The legislation has been more of a help than a burden).

However, even though findings revealed that informants emphasized possible outcomes of a decision, they also expressed opinions on the fact that the judicial system did not always correspond with their professional medical considerations. In line with this, findings showed that even though the informants often decided to comply with the law due to the fear of breaking legal practices and possible sanctions, most of the informants held conflicting views on this matter. Even though most of them followed the law and avoided negative outcomes by doing such, they did not always firmly agree that doing so took care of the patients' well-being. Meaning, seeing as they considered human rights as already included within the legal framework, on paper, by complying with the law, this automatically ensured the protection of human rights principles. Even so, the psychiatrists sometimes felt conflicted between this legal framework and their own medical opinion. This discrepancy led to scenarios in which they chose not to use coercion, even if their medical expertise suggested the opposite. They viewed themselves bound by the legislation:

«… men de fleste mennesker skriver ut pasientene med hendene for øynene og fingrene krysset. Man kan bare håpe at det går bra».
(… but most people discharge patients while covering their eyes and crossing their fingers. One can only hope it ends well).

One of the informants even went so far as describing this issue by stating:

«Så det psykiatrien gjør nå, er at den tar syke folk som ligger på tvers i gatene og legger dem sidelengs slik at trafikken kan fortsette som normalt. Retten til å gå til grunne er godt lovfestet i Norge».
(So, what psychiatry now does, is that it takes sick people who are lying across the streets and place them lengthwise so that the traffic can continue as normal. The right to perish is well established by the legal framework in Norway).

In this context, common for most informants was the opposition to the capacity-based criterion that was added to the Norwegian Mental Health Care Act in 2017. The results indicated that there are far too many incidents where patients are evaluated as competent enough to consent when they instead should have been involuntary admitted to mental health care. Almost all of the informants provided examples of incidents where a patient was evaluated as competent enough to consent, but shortly after showed signs of severe mental illness, and in the worst cases – did something that could have been avoided had this person been involuntarily hospitalized. Examples of such incidents were deaths of other people who became an accidental target for a serious illness or the destruction of one's own life:

«Det er nok noen del pasienter som blir vurdert samtykkekompetente og som da klarer å bli veldig syk og ødelegger sitt eget liv».
(There are probably several patients who are assessed as competent to consent and who then manage to become very ill and destroy their own lives).

Ultimately, their decision on whether to use coercion might reflect a desire to act in the best interest of themselves. If they did utilize coercion without a legal justification, they could face possible consequences like loss of their medical license or some form of disciplinary action.

6.1.2 Utility for the patient vs. groups in society

Even though the informants put great emphasis on maximizing utility for themselves, the data also disclosed their acknowledgement of the understanding that their profession carries with it a duty to protect and advocate for the human rights of patients. This was in both the sense of respecting aspects like patient's autonomy and self-determination, but also their right to medical treatment:

«… retten til autonomi og selvbestemmelse er så stor hele tiden at vi noen ganger kvier oss litt for å bryte denne rettigheten».

(… the right to autonomy and self-determination is so great all the time that we may sometimes be too reluctant to violate this right…).

«… fordi noen ganger glemmer vi at det faktisk er en menneskerett å motta medisinsk behandling».

(… because sometimes we forget that it is indeed a human right to receive medical treatment).

Interestingly, the results suggested that the psychiatrists attributed significant emphasis on upholding patients' autonomy and self-determination. By respecting such human rights principles, the patient would have the opportunity to regain dignity, something that would be in the patient's self-interest. That is why during the decision process, some informants felt it was important to create platforms of possible opportunities where the patient could decide for himself or herself, before psychiatrists evaluated the use of coercive practices.

The need of providing proper medical care was brought up in relation to the right to medical treatment, and if coercion (in this case as a form of treatment) was deemed the solution, this was something they took into consideration. The use of coercion would sometimes be most favorable and maximize utility for the patient in need. The assertions pertaining to this matter included statements based on the idea that if patients were allowed to abstain from medication and, for instance, walk around in the neighborhood naked, this would constitute a deprivation of needed medical treatment and a breach of the patients right to such treatment. Moreover, related to this, some of the informants pointed out that seeing as they are all bound by a medical oath to provide patient care, a responsibility they hold in the highest respect. Nevertheless, the results indicated that psychiatrists might struggle to determine which of these rights (the right to autonomy and right to medical treatment) are more important:

«… så, på en måte er det en menneskerettighet å kunne bestemme for seg selv, mens det også er en menneskerettighet å få den medisinske hjelpen du trenger».

(… so, in a way it is a human right to be able to decide for oneself, while it is also a human right to get the medical help that you need).

Furthermore, the study examined in what way psychiatrists weigh the maximizing of utility for groups in society. As one of the informants highlighted when asked about their viewpoints on human rights in context to this:

«… som en grunnleggende rett som har noe med frihet å gjøre, ta egne valg, selvstendighet, men som også har en avgrensning. Det er grenser for hva man kan påberope seg som en menneskerett i forhold til å plage andre eller skade andre. Det er en rettighet, men det er også en rettighet med en begrensning».
(…as a fundamental right which has something to do with freedom, making one's own choices, independence, but which also has a limitation. There are limits to what one can claim as a human right in relation to bothering others or harming others. It is a right, but it is also a right with a limitation).

In this context, this informant stated that human rights are various rights we possess, but that they also include the right to not injure others or be injured by others, for instance being exposed to the violence of a severe mentally ill patient.

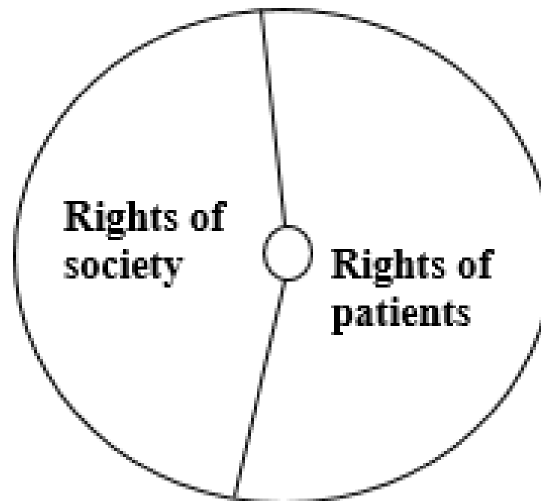
Every single informant mentioned, at one point during the interview that they frequently chose to use coercion when they viewed this as being in the best interest of groups in society. They further explained this by referring to multiple incidents where they all had made decisions based on that would be in the society's best interest:

«Jeg tenker nok litt mer på de sosiale konsekvensene».
(I might think a little more about the social consequences).

«Selvfølgelig tenker vi på sikkerhet, vi har et samfunnsvern ansvar».
(Of course, we think about safety, we have a responsibility to protect society).

Taken together, even though the value of societal consequences was frequently mentioned during the interviews, the possible utility for the patient were to a greater extent emphasized than the utility of groups in society. *Figure 9* provides an illustration of how the distribution appeared in NVivo. It is apparent that slightly more emphasis was placed on the patient's utility than on that of groups in the society. The patients' needs come first and are weighted the most.

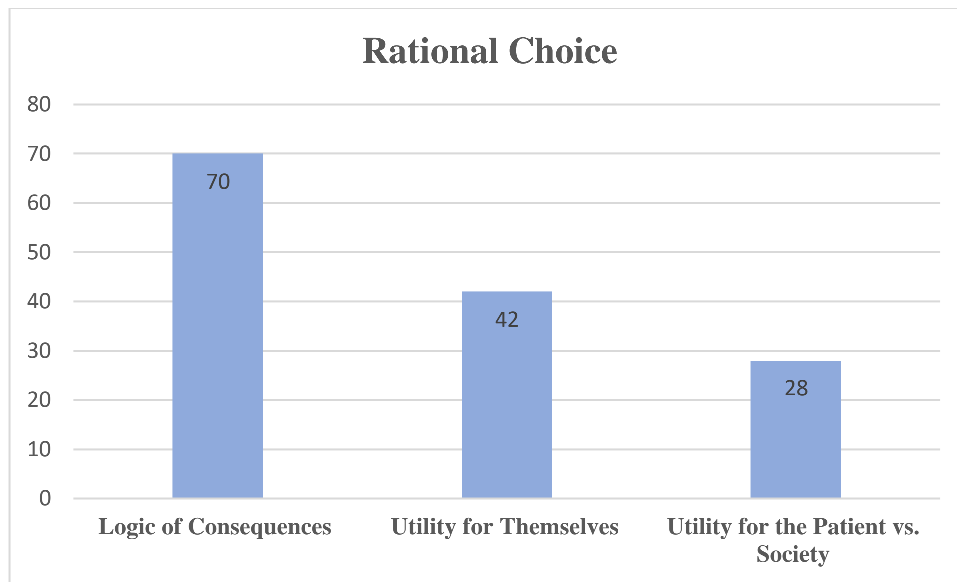
Figure 9



The diagram modified from NVivo illustrates how psychiatrists weigh the rights of patients versus the rights of groups in the society when determining whether to use coercion. As illustrated, a significantly greater emphasis was placed on patients – divided between the right to treatment and right to autonomy and self-determination.

Overall, the results from the coding references extracted from NVivo to study the relative distribution of coding references across Main category 1 *(Figure 10)* illustrates how "Utility for Themselves" had more coding references than "Utility for the Patient vs. Society", indicating that this sub-category (Utility for Themselves) was a more commonly discussed sub-category among the data. These results might imply that psychiatrists weigh their own utility to a larger degree than the utility of their patients versus groups in society. This means that this sub-category may be more relevant to the informants and held a larger importance in their considerations.

Figure 10



The figure presents the number of coding references for Main category 1 (Logic of Consequences) and its two sub-categories. Main Category 1 is a combination of these two sub-categories.

6.2 Logic of appropriateness: inner or outer norms

The results presented below demonstrate how the psychiatrists weighed the role of internal and external ethical aspects. Furthermore, these findings present how their decisions are driven by elements such as internal or external constructed norms, moral feelings or societal influence and expectations.

6.2.1 Internal morals and feelings

The informants tended to consider that using coercion constituted some form of *care* when asked how they morally felt about utilizing such practices:

«Det første jeg tenker på når det kommer til tvang, det er omsorg».

(The first thing that comes to mind when I think about coercion is care).

The responses suggested that most of them viewed coercion as something that could improve a situation, either by making someone better, or preventing harm to the patient or others. Therefore, they felt a moral responsibility to use coercion, either in form of treatment or to prevent a dangerous situation. My findings indicated that even while they occasionally felt strongly that their actions might be contrary to the desires of others, the informants maintained that these decisions were preferable to the alternatives. Furthermore, several findings confirmed that the informants felt it was challenging to do this in a morally or ethically justifiable way:

«Det er ikke det man ønsker, å bruke tvang. Og vi prøver jo å unngå det så langt vi kan».
(It is not what we desire, to use coercion. And we do try to avoid it as much as we can).

The data also provided information about the various internal norms linked to their behavior towards coercion. For example, the findings revealed that internal norms play an important role in explaining the psychiatrists' behavior. It is apparent that their moral foundation was based on the justification of whether using coercion in a set situation was right or wrong:

«Det skal være tvang der det trengs og absolutt ikke der det ikke trengs».
(There should be coercion where this is necessary, and absolutely not where this is not necessary).

Interestingly, the informants had different beliefs and values in this context. Internal norms are not universal and the results from the study suggested that these internal norms varied among the informants. For instance, one stated:

«Jeg tenker på autonomi, jeg tenker på frihetsfølelse …».
(I think of autonomy, I think of feelings of freedom…).

This statement implies that psychiatrists might weigh the respect for patient's autonomy and dignity and as a result go to great lengths before deciding to use coercion. However, other informants put significantly more weight on the safety of patients and groups in society, and that coercion was necessary to prevent them from hurting themselves or others:

«Jeg tenker at pasienten kan skade andre, ødelegge for seg selv …».
(I think that the patients could injure others, destroy themselves…).

Nevertheless, these decisions are not something that come easy to them, regardless of the internal norm or the moral feeling they may be motivated by. Findings related to this suggested that when making these decisions to act against someone's will, such as using coercion on a patient, they frequently expressed feelings of emotional distress. Some also felt a sense of helplessness in situations where they were unable to provide the patient with the care they needed without resorting to coercion:

«Jeg synes ofte det er tappende, fordi jeg har en hverdag hvor pasientene ofte er veldig sinte på meg».
(I often find it draining, because I have an everyday life where the patients are often very angry with me).

To sum up, these data discovered that some psychiatrists struggle to find a balance between the opposing demands of their professional obligations and personal values. They expressed experiences of internal conflicts and moral distress during these decisions. Internal conflicts between a psychiatrist's internal norms, ethical considerations and moral feelings may arise when coercion is used. These findings thus highlight the difficulty of ethical reasoning on the use of coercion.

6.2.1 External influence and expectations

This study aimed to find out whether external factors such as societal influence or expectations weighed in on the decision-making process of the participating psychiatrists. Several psychiatrists used the term "bedside-culture" to explain the potential impact of their social environment when making coercive decisions. They further explained how this bedside-culture recognizes that social environments can play a significant role in shaping decisions:

«Det er veldig preget av sykepleierne som jobber der, hvilken tradisjon og kultur de har for at vi skal prøve andre ting før vi bruker tvang.»

(It is very much influenced by the nurses who work there, what tradition and culture they have for trying other things before we use coercion).

In other words, the "culture" of the different psychiatric departments influences the outcome of the decision. The psychiatrists provided an explanation for this by stating that it sets expectations for people to follow such norms and adjust accordingly. Coercive practices were less employed when informants were sounded by other staff members with long experiences and who because of this felt more secure. In such situations, de-escalating techniques were prioritized:

«… de med erfaring har helt klart en fordel hvis man er godt trent på de-eskalerende teknikker».
(… those with experience clearly have an advantage if one is well trained in de-escalating techniques).

However, one of the psychiatrists indicated how this can cause people to cling on to such de-escalating techniques for much too long when asked if this could result in other outcomes. The same informant then expressed frustration over episodes where it proved necessary to intervene sooner, but this was prevented due to various social norms created within the facility:

«… se noen som venter veldig lenge og det kan bli vanskelig for andre – hvor man kanskje kunne grepet inn tidligere …».
(… see someone who waits a very long time, and it can be difficult for others – where you could have intervened earlier …).

Contrary to this, when inquired on their encounters with other psychiatrists, for instance about those who had recently received their specialization in psychiatry, they expressed apprehension regarding the possibility that newly trained psychiatrists would easily resort to coercive measures as a result of their limited exposure to clinical practice. Put differently, having less experience might result in the use of coercion where other less invasive means would have been preferable.

The results also revealed other existing norms formed through the social environment, for instance the expectation on preventing injuries towards staff. Informants referred to several situations where both nurses and other care personnel had suffered lifelong injuries. By being concerned with this, norms were constructed and expressed through the more frequent use of coercion, and that this was better versus a nurse suffering e.g., from a serious head injury. Furthermore, one of the informants also underlined how difficult it can be to change such cultures and social norms. The informant elucidated that the construction of such expectations through social interactions are thus difficult to change:

«… slik kultur sitter i veggene i lang, lang tid. Du må nesten erstatte alle for at man skal starte å tenke annerledes. Det er veldig lett å bli sosialisert inn i en spesifikk måte å tenke på».
(… such a culture sits in the walls for a long, long time. You must replace almost everyone to start thinking differently. It is easy to be socialized into a certain way of thinking).

The educational and training backgrounds of the psychiatrists were found to be diverse and that collaborating with colleagues who were educated and trained in different geographical places frequently exerted an influence on the decision-making. For instance, when informants were surrounded by other psychiatrists who had received their training in places where there was a high threshold for utilizing coercion and more focus on de-escalating techniques, the use of coercion decreased.

Similarly, informants who were surrounded by others who had trained in places were coercion was highly valued and had proven to be necessary in most situations carried out an expectation to resort more quickly to coercion.

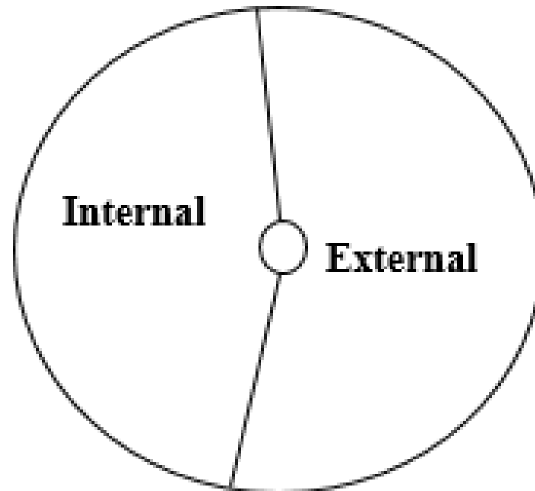
The media also influence the informants when making coercive decisions. Findings discovered that the media serves as a significant agent of socialization that influence and affect how the informants perceive and approach their work, specifically regarding the use of coercion. How the media portrays mental illness may affect the beliefs and values of the informants leading them to possibly overemphasize the utilization of coercion. According to the informants, the media present a dilemma as they may advocate for coercion in some scenarios, while promoting for less invasive interventions in others:

«… det går litt begge veier. Vi snakket jo om Kongsberg i sted der det var en episode med pil og bue. Der ropes det på en måte etter mer tvang … I andre sammenhenger så ropes det etter mindre, og problemet er å skille det ene fra det andre, det er det som er dilemmaet …».

(… it goes both ways. We talked about Kongsberg before where there was episode with a bow and arrow. There, in a way, there is a call for more coercion… In other contexts, there is a call for less, and the problem is to distinguish one from the other, that is the dilemma…).

Extracted results from NVivo (see *Figure 11*) revealed that external driven factors weigh slightly more heavily on the informant’s decision process such as societal influence from the working environment, contra internal norms and moral feelings. However, there was not much of a difference between these two, which suggests that they both have some sort of impact on the informants.

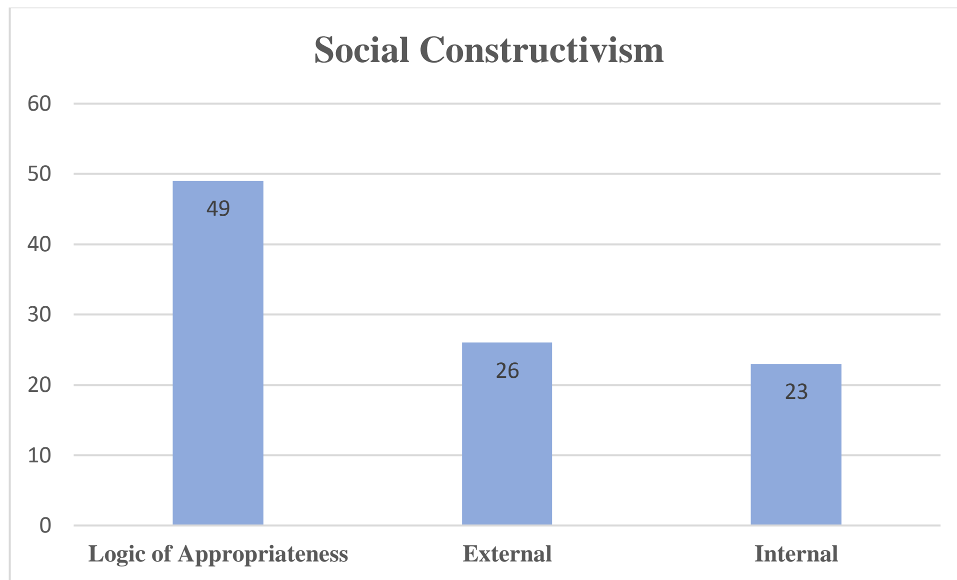
Figure 11



The diagram modified from NVivo gives an overlook of the distribution between internal and external norms' emphasis on the decision-making process on coercion. The diagram displays a slightly greater emphasis on external influence compared to internal factors among the informants.

In summary, the findings discovered that coding references arguing "External" factors are slightly higher than for "Internal". Still, as illustrated in *Figure 12,* "External" had marginally more coding references than "Internal". This implies that they are relatively similar in terms of the amount of coding references received.

Figure 12



The figure presents the number of coding references for Main category 2 (Logic of Appropriateness) and its two sub-categories. Main Category 2 is a combination of these two sub-categories.

6.3 Summary of the results

The findings in this thesis are both in line with the rational way of thinking and also the outcome of social interactions with others when the informants make decisions about whether or not to employ coercion on patients. Furthermore, these results underpin the four expectations of this current study. Even though the results of the organized data indicate that psychiatrists place slightly more emphasis on consequences when making decisions on coercion, other socially constructed elements take part in guiding their decision-making. These elements are often shaped by wider societal influences as well as social expectations and psychiatrists' personal beliefs and values towards coercion.

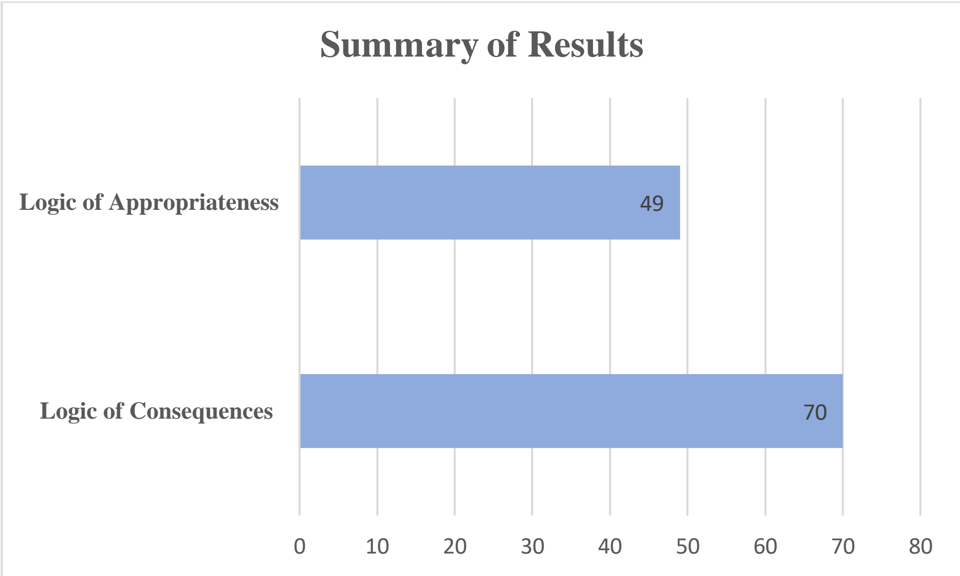
In sum, there are arguments in favor of making choices based on what maximizes most utility, but there are also arguments that indicate the influence socially constructed factors can have on the informants. Thus, there is no clear answer to what they base their decisions on, but that there are conflicting elements as also stated by one of the participating psychiatrists:

«Vi blir dømt om vi gjør det, og vi blir dømt om vi ikke gjør det».

(We are damned if we do and damned if we don't).

This means that regardless of what the outcomes of their decisions were, informants expressed being second-guessed. Taken together, as presented in *Figure 13,* the Logic of Consequences has a higher amount of coding references than the Logic of Appropriateness. However, the difference between these two main categories is not particularly noteworthy, suggesting that the arguments from both perspectives were frequently represented.

Figure 13



The figure illustrates the distribution of coding references and demonstrates the balance between the two main categories.

Chapter 7: Analysis & Discussion

Within the Norwegian mental health care system results from this current study have revealed that there are numerous justifications as to what psychiatrists weigh when they decide on the prospect of implementing coercion on patients. During the analysis it was discovered that both predictions based on rational choice and social constructivism within psychiatrists' decision-making regarding the use of coercive practices are intricately interconnected and have complex interrelationships. In addition, the analysis identified the concept of human rights as a broad set of ideas that manifests themselves in different areas, and as this current study revealed, in the field of coercion within psychiatric facilities. Thus, the broad and encompassing nature of human rights as a background might prove challenging for psychiatrists during their decision-making regarding the use of coercive practices. As this analysis suggest, psychiatrists must make decisions that balance legal and ethical frameworks and the ideals of human rights as they travel through this intricate terrain. Thus, such decision-making requires a thorough understanding of such elements. Indeed, previous chapters account for how psychiatrists must navigate themselves through a complex terrain that considers different aspects of decision-making. Among these, which are carefully explained and explored in this current study, are the principles of utility, which are weighed against the potentially socially constructed norms of coercive interventions. When exploring considerations regarding the use of coercion, this study has focused on whether the potential utility maximizing of decisions outweigh the emphasis on ethical and appropriate considerations.

As explained previously, when deciding on whether to utilize coercion based on a rational choice argument psychiatrists make decisions based on a strategic calculation aimed at maximizing utility, either for themselves or the patient versus groups within society. This can involve weighing the potential risks of legal sanctions by not complying to the judicial- and human rights principles. It can also include emphasizing the patients right to medical treatment or their right to self-determination, or lastly, safeguarding the society at large from harmful situations. Nevertheless, this study revealed that other perspectives also have an impact in how psychiatrists balance off different elements in their decision-making process.

Seeing this through a social constructivist point of view, we see that the use of coercion is likewise shaped by broader importance of social norms and values, including moral and ethical concepts.

By examining the four expectations (E1-E4) and their (possible) align with data gathered through the conducted semi-structured interviews we can gain a better understanding of the complexity revolving this issue. This analysis will discuss the overall research question as well as the two underlying sub-research questions to also develop a deeper understanding of the underlying theoretical frameworks that shape their decision process. The four expectations generated from the two theoretical frameworks are not contradictory and can serve as conceptual lenses to highlight various facets of decision-making on the use of coercion.

7.1 Logic of consequences

A rational choice perspective would suggest that the maximizing of utility could serve as an explanation as to how psychiatrists make decisions regarding the use of coercion. The incentives for the psychiatrists to maximize utility can be broken down and placed within two different expectations: Psychiatrists follow the law in fear of sanctions (E1) or psychiatrists' commitment to human rights principles places emphasis on either patient care or welfare for the society depending on how utility-maximization concerns (E2).

Seeing as the overall research question for this study touches base with legal and ethical aspects concerning both patients and groups within society it is important to consider the role of human rights in this context. Through the psychiatrists' accounts, human rights principles are integrated into both the legal and normative landscape concerning coercion. This further suggests that such rights operate as a core component of such landscapes, instead of functioning as a peripheral concern.

The current study's findings discovered that psychiatrists viewed human rights as inherent to legal regulations. They therefore believed that by upholding their legal obligations they also defended such rights. However, while the current study explored this shared perspective among the informants that adhering to the law was in their best interests, it also revealed an uncertainty in such decision-making processes, especially when legal requirements conflicted with their own professional medical viewpoint. Further this highlights a possible tension between the legal framework and the professional understanding of human rights principles, highlighting the challenges of upholding such principles in practice.

7.1.1 Understanding psychiatrists' self interest

Strategic regulatory compliance and beneficial outcomes for the psychiatrists themselves may serve as one reason as to why findings revealed that decisions on the use of coercion can be understood through the lens of rational choice. This theory suggests that psychiatrists make determinations on the employment of coercion based on their self-interests, weighing the consequences of each existing option. Seeing as rational choice captures the logic of consequences this perspective proposes that psychiatrists may make their decisions based on maximizing their own utility and the most beneficial outcome for themselves.

Thus, empirical findings from this study suggests that psychiatrists make decisions grounded in which option they perceive as leading to the desired outcome for themselves. References to my first expectation (E1) was voiced by several informants when asked about the importance and meaning of the legal framework attached to Norwegian mental health care. This can explain why many of them to a high degree emphasized the obligation to follow the law in fear of possible negative repercussions. As the psychiatrists seek to make decisions evaluated and established on their effectiveness in achieving a desired outcome and these are not valued or chosen due to their intrinsic worth leads us to the question "what's in it for me"?

The present study provides empirical findings to support the aforementioned argument, which is demonstrated through gathering and analysis of data used in the current study. Furthermore, one may be able to shed further light on the underlying mechanisms causing the observed phenomena by looking at the informants' evaluations among a wide range of behaviors and interactions that show instrumental rationality. As stated previously, it is interesting to investigate whether psychiatrists regarding the use of coercion emphasize the sanctions of not just the law, but rules and guidelines formed by hospitals and HOD. Meaning, that the weaker the sanction, the less important it is for the informants to evaluate and emphasis these in decision-making processes. Results from the current study show that psychiatrists do not place much consideration on the different rules given by hospitals and HOD. Findings revealed that this does not have essential significance when the repercussions for not following them are not strong enough. Further, this can be discussed and possibly demonstrate that the efficiency of such rules and regulations may rely not solely on what they contain but also on the seriousness of the repercussions connected to them.

As stated, the informants expressed their opinions on how the legislation is built upon human rights principles. When choosing legal compliance in fear of a potential negative outcome, results indicate that psychiatrists do not emphasize the aspect of human rights to a large degree. When choosing to follow legal regulations, even if this is for their own self-interest, they do not care much about the possible breach of human rights. Put differently, by following the law they stated believing that they automatically also comply with human rights. Nevertheless, this can result in a narrow interpretation of human rights and further limit their practical application when making decisions on coercion. A more comprehensive understanding of human rights requires the informants to view rights as for example autonomy and self-determination as more central and independent concepts. Following the legal framework without considering the broader implications of human rights might result in complex situations. Even though the people who formed the law underline that it is founded on human rights principles, the legal regulations may not always fully reflect human rights. As a result, maximizing their own utility can lead to situations where the right to autonomy and self-determination are at risk. Their belief that human rights are automatically incorporated into the law may result in a failure to critically evaluate the implications of legal regulations for human rights.

7.1.2 Understanding psychiatrists' uncertainty

Even though the psychiatrists considered human rights principles as an automatic inclusion within the legal framework, some of their responses on the concern for both patients and society's rights suggest otherwise. The current study's findings explored how although psychiatrists shared the belief that adherence to the law also guaranteed the upholding of human rights of patients and society, they also expressed a concern for such rights. This further indicates a possible conflict between their professional duty to legal compliance and their medical duty that sometimes might require a deviation from the legal framework to act in the best interest of the patient or individuals in society. If "best-interest" in this sense refers to the upholding of rights such as patients right to medical treatment or society's right to be protected against harm, this might suggest that human rights are not fully integrated into the legal framework after all. The fact that psychiatrists stated that they at times deviate from the law in order to, for instance, respect patients right to autonomy highlights the intricate interplay between legal compliance and human rights.

Concerning these decision processes, results from this study give insight as to why there may be a perceived utility in adhering to the law's requirements to safeguard themselves from potential legal sanctions. Nonetheless, in spite of this perceived utility, they may still experience uncertainty surrounding their choices. This process is complex seeing as they feel an obligation both towards the legal framework in fear of sanctions, but they also feel an obligation to their professional medical opinion. The amendment to the Mental Health Care Act in 2017 regarding patients' capacity to consent to treatment, where one of the goals was to underscore the importance of patients right to autonomy added more legal obligations for psychiatrists when determining on the utilization of coercion. The capacity to consent criteria requires that psychiatrists carefully assess the patient's ability to take part in discussing different treatment options. Results from the current study revealed that the majority of the psychiatrists who participated believed that this new amendment portrays a rather strict framework seeing as these new requirements entail a significant threshold for a patient to be evaluated as lacking the capacity to consent. This meaning, the participating psychiatrists have mixed feelings between their legal requirements and their professional medical judgement, giving rise to uncertainty regarding the decisions they make on coercion.

Still, by following the "maximum-minimum rule", the findings revealed that in such situations they still chose the outcome with the highest maximum possible payoff and the lowest possible minimum loss or risk. This elucidates the reason behind the psychiatrist's inclination to opt for decisions that avoid legal sanctions. They carefully adhere to legal requirements when assessing a patient's capacity to consent. They do so even in situations where their professional opinion argues that the strict criteria used to assess the capacity to consent may not yield the most preferable outcome for the patient or promote the patient's rights. Decisions such as these are rational choice grounded seeing as the informants weigh the potential benefits of legal compliance versus the potential drawbacks of non-compliance. Unfortunately, also stated by most of my informants, these are decisions that can result in patients being denied necessary coercive interventions. Furthermore, adhering to such legal requirements that contradicts their professional opinion, they may experience a feeling of choosing legal compliance over patient-welfare. Moreover, loss of trust in the doctor-patient relationship may occur and this may have a negative impact on patient after-effect. In summary, this calls for attention to balance legal requirements, human rights, and professional medical judgement.

7.1.3 Patient care vs. society's well-being

Psychiatrists often face difficult decisions about when to use coercion, balancing the need to consider their own self-interest with the self-interest of patient versus groups in the society. Concern for the patients right to medical treatment and support for patient autonomy are two factors which emerged through the interviews, which can explain why findings suggests that this induced their provision to care for the patient. This implies that there are instances where psychiatrists also base their decisions on their perception of the patient's self-interest. In cases where a patient's condition poses severe illness the psychiatrists reported that in some situations they might conclude that the benefits of- and right to medical treatment outweigh any potential negative consequences that may arise from this decision. Even though it may be perceived as contradictory to use coercion if the patient is unable to consent to treatment, it is, according to the current results, evident to recognize that the patient still has the right to medical treatment and the psychiatrists have taken an oath to provide care for their patients. Their ultimate goal is to promote the patients right to receive the medical treatment deemed necessary for their well-being.

The results of the present study further revealed that the informants viewed the patients right to decide for themselves as something they cherished highly. For the informants, this also included the right to refuse treatment, even in situations where this might lead to even more illness. At the heart of these decisions, as accounted for by my informants, is the commitment to uphold the patients right to self-determination and autonomy. The psychiatrists expressed that by taking into account these principles they are able to ensure the upholding of these rights even in the most complex and challenging situations.

Even though the informants placed a great emphasize on the importance of patients right to medical treatment, the findings from the current study proposes that they emphasized the right to self-determination and autonomy to a slightly higher degree. Even if this might contradict the psychiatrist's own perception of what is in the patient's best interest (regarding treatment), the right patients has to decide for themselves is perceived by the informants as an essential principle that must be respected. The latter still mean that they are guided by rational decision-making principles and choose based on what is in the best interest of the patient. By emphasizing the importance of human rights such as the right to receive medical treatment as well as the right to self-determination and autonomy, psychiatrists can help to promote a more effective approach towards care and promoting a more heavily respect towards the patients free will to decide for oneself.

The data gathered in the present study indicates that psychiatrists might in some situations consider the wider consequences of their decision to use coercion in the larger context of providing care for groups within the society. From a utility maximizing perspective, this can possibly explain why psychiatrists might weigh the use of coercion highly in scenarios where it will result in a positive gain for individuals in society, regardless of the outcome this might have for the patient who is exposed to coercion in some form. As highlighted by my informants, if a patient poses as a danger to society and coercion is perceived as the best alternative to prevent this from happening, the consequence of utilizing coercion will be in the greater good for groups in society. The reasons behind such decisions, well established in the data results, is the informant's duty to protect and take care of society, as a whole, not just the patient in questioning.

The study underscores the delicate balance that psychiatrists must strike between what is in their patient's best interest and the needs of the wider society when considering the use of coercion. While informants emphasized the importance of the right to have one's autonomy and medical treatment respected, there are occurrences of situations where the greater good of society outweighs the individuals' desires and preferences. The findings of the study support my expectation (E2) that psychiatrists' places more emphasize on rights concerning the patient over societal considerations when they are faced with the decision to use coercion. This could suggest that psychiatrists who are more likely to prioritize the rights of patients over society are also more likely to perceive coercion as a last resort. Still, acting in the best interest of patients or society can often be achieved simultaneously. When deciding to uphold rights of patients and act according to their best interests, this might also lead to what is in the best interest of the society, and vice versa.

In brief, the study demonstrates a slightly more support for E1, meaning that psychiatrists tend to put their own self-interest first when deciding whether to use coercion. By doing so they maximize their own utility and avoid negative outcomes as for instance legal repercussions. However, the study also provides validation for the idea that psychiatrists do consider the welfare of patients and society on certain occasions (E2), even though there is a slightly more emphasis on E1.

These finding serves to address the first sub-research question of the extent to which psychiatrists prioritize their self-interest: *To what extent do psychiatrists prioritize their own self-interest versus either the interests of patients or society?* Further, this underscores the importance of critically examining the motivations of psychiatrists.

However, even though the results argue that psychiatrists are more likely to prioritize their own utility, they do not completely disregard the well-beings of patients and society as a whole. Put differently, it implies that their own self-interests can sometimes take precedence over their professional duties and opinions. The overall challenge in this case is to promote a balance between professional and personal interests and at the same time upheld ethical standards and ensuring decent outcomes for all.

7.2 Logic of appropriateness

A social constructivism perspective on decision-making would argue that it is not solely based on individual preferences or objective information. They are rather shaped by cultural and social factors, like for instance norms and values. It is possible to categorize this within two expectations: psychiatrists are driven by internal norms and how they morally feel about coercion (E3), or psychiatrists are driven by external societal influence and expectations (E4). From an ethical perspective, such social constructivist predictions on decision-making among psychiatrists highlights the importance of studying norms, values, and beliefs that underpin their decisions. This sheds a light on the need to consider not only legal elements, but also ethical considerations like the power dynamics and cultural norms that may influence the decision-making. By recognizing the social and cultural context of decision-making psychiatrists can aim to make a more ethically informed decision, which may lead to improved treatment outcomes and respect for human rights.

7.2.1 Internal moral compass

From a social constructivist standpoint, how psychiatrists morally fell about coercion and its implications can have a significant impact on what they emphasize when they determine the necessity of using coercion on a patient. This reasoning acknowledges that psychiatrists' inner moral sentiments and ethics are not predominated or fixed. Instead, they are influenced by the intricate interaction of social, cultural, and personal elements which are constructed over time. My third expectation (E3) anticipated that psychiatrists were driven by inner norms such as internalized beliefs and values regarding the use of coercion on patients, and how they morally felt about coercion when deciding whether to utilize it, for instance what they viewed as right and wrong. It can be argued that E3 holds some degree of validity, meaning that the psychiatrists are partly influenced by their internal norms and moral convictions.

As presented in the above results, psychiatrists internalize moral standards and values of their cultural and social context through socialization procedures. Further, neither the informants' internal norms or moral feelings can be analyzed and discussed without including social factors due to their role in shaping individuals' internal norms and moral values. Therefore, the social context is important when gaining knowledge about the complexities of an individual's internal moral compass.

Some psychiatrists stated strong feelings concerning the fact that their actions might be contradictory to the wishes of patients, but that coercion was better than the alternative, and some of them even stated that this was an attempt to *care* for the patient. We can further discuss this finding by suggesting that these informants might have internalized moral beliefs and values regarding coercion. Results suggests that the use of coercion is given priority in the name of caring for the patient in question, wishing for them to get better or prevent them from hurting themselves or others. However, such emphasize on coercive practices may come at the expense of rights such as autonomy. Put differently, some psychiatrists reflected a wish to provide the best care for their patients, even if this meant that they would override the patients wish or preference.

"Objectivity in parenthesis" refers to the phenomena that objective knowledge is impossible seeing as knowledge is influenced by one's own personal interpretations and experiences as well as being constructed via interactions with others. Argumentation through the lenses of this mindset would suggest that psychiatrists must recognize that their own biases and beliefs may influence their decisions and might find themselves considering other options. This viewpoint highlights the necessity of psychiatrist being conscious of their own prejudices and the social norms that shape their thinking. Factors like these are proven to be deep-rooted and reflect wider cultural and social behavior. The moral considerations and feelings refer to the informant's sense of what is right and what is wrong, while inner norms refer more to what is assumed the correct behavior.

A consistent result retrieved from the data was that the informants felt it was challenging to use coercion in a morally or ethically justifiable way. This is something that reflects the influence of socialization processes on their moral values and beliefs. This sheds light on the necessity for a thorough and critical approach towards coercive practices. Further, such findings suggest a need to carefully consider the appropriateness for coercive practices, given the complexity of ethical and moral issues within the psychiatric facilities.

The discovery that the moral foundation of the psychiatrists is founded on the justification of whether utilizing coercion in a specific context is morally acceptable or unacceptable indicate that their moral beliefs and values are influenced by their internal norms, as this might differ among the psychiatrists. Moreover, this difference in internal norms among the psychiatrists can possible mean that they have various definitions of what is constituted as right or wrong in certain situations, something that can be a reflection of cultural and social norms. Therefore, it is important to ensure that these internal norms are aligned with social norms, and further that moral and ethical aspect are appropriately balanced and contextualized in decision-making regarding coercive practices. Psychiatrists are moral individuals that make decisions based on moral principles that have profound implications, which emphasizes the importance of morality in the practice of psychiatry.

7.2.2 External drivers

Psychiatrists, like all other professions, are not immune to the influencing of social norms or their social environment surrounding then. These are factors that may influence how they approach medical treatment and mold their beliefs, thinking and practices. A social constructivist perspective argues that where and how psychiatrists are educated and trained can affect how individuals perceive and approach certain issues related to coercion. Seeing as the educational institutions and hospitals where they underwent their specialization differ among my informants, it was possible that the results would reveal differences between them concerning the use of coercion. Those informants who were educated and trained in Norway would have been exposed to a certain set of treatment methods and cultural norms that are unique to the Norwegian mental health care system. This meaning, they might also feel more pressured to follow Norwegian institutional and cultural standards. However, individuals who have completed their medical education and training abroad may have been exposed to other procedures. These might also be more likely to adapt behaviors from different cultural environments. However, the results indicate that the educational training or background of the participating psychiatrists did not significantly affect the results, meaning that they mainly agreed upon different issues related to the use of coercion and the complexity of all affecting factors.

However, the study revealed that the influence of present colleagues (who might have received education and training elsewhere) and other social- and cultural norms within the psychiatric facility itself emerged as important factors that influenced the informants' decision-making process on the utilization of coercion. First, the study's outcome demonstrates how the phenomena of the Norwegian expression *sengekultur* (bedside-culture) forms social and cultural norms within psychiatric facilities. Bedside-culture refers to practices and values that govern the interactions and behaviors within the psychiatric departments. A social constructivist perspective emphasizes that the environment within the specific facility may influence the way psychiatrists perceive and respond to patient behavior and may affect the course of treatment they choose to pursue, and that this might ultimately influence their decision into choosing the treatment that is regarded as most "appropriate". The different norms and values embedded in this culture has the tendency to shape psychiatrist's weighing regarding decisions on use of coercion. Colleagues' opinions and perspectives tends to impact my informants decision-making process seeing as they might conform to group norms and seek validation. For instance, if the informant was part of a medical environment who highly valued patient autonomy and empowerment, the informant would be more lenient to avoid coercion and focus on the use of de-escalating techniques and other voluntarily options. Conversely, if this group of medical staff prioritized safety and risk management, they might weigh the use of coercion heavily as means of preventing harm.

The societal influence and expectations may also arise from the society outside the psychiatric facility. The media is indeed a powerful tool for constructing and reinforcing social norms and expectations related to the use of all different types of medical actions that involves the use of coercion in some form. How the media portray mental illness can at times be stigmatizing and strengthen negative stereotypes. Additionally, this can potentially play a role towards how society, as well as psychiatrists, weigh the use of coercion in the conflicting dilemma between the rights of the patient and society. Take for instance an example where the media continuously portrays individuals suffering from severe mental diseases as threatening or unstable. Here, psychiatrists may feel more inclined to utilize coercion in order to maintain safety for the individuals within society. In addition, media coverage of high-profile cases involving dangerous individuals diagnosed with mental diseases might also make them feel pressured to frequently use coercive practices.

Despite this, when the media publishes reports from large institutions like the UN where coercion is mentioned in the context of human rights violations, psychiatrist might find themselves caring more for the rights of patients and think twice before determining to use such practices.

This means, in sum, that the fourth and last expectation (E4) posits that psychiatrists are driven by external and societal influence and expectations. This expectation is supported by the current study that has shed a light on which societal expectations and influences that may mold the decision-making process of psychiatrists on determining the utilization of coercion. For instance, findings revealed that my informants were more likely to make decisions based on the culture within their working-environment. Although findings suggest that moral convictions and internal norms, as stated in E3, play a role to some degree, social and cultural factors cannot be disregarded. The findings discovered a stronger emphasize on external- and social norms (E4) than on the internal norms and moral convictions as captured in E3.

Overall psychiatrists emphasize to a higher degree societal expectations over their own inner moral beliefs, regarding the second sub-research question: *To what extent do psychiatrists rely on their personal ethics or wider community standards?* This highlights the complex interplay between the surrounding professional expectations and their personal feelings within psychiatric practice on coercion. Indeed, psychiatrists practice as part of a larger social context that can shape both their values and beliefs. This might potentially lead them to a misalignment between their professional environment and personal convictions. In this case, the challenge will consist of navigating these tensions while still ensuring that patients receive adequate mental health care and maintaining moral standards.

7.4 Summary

As this current analysis and discussion have demonstrated, when examining psychiatrists' decision-making on the use of coercive practices arguments aligning with the theory of rational choice and arguments from a social constructivist's standpoint provide insight. In relation to this, the current study has revealed how important it is to recognize the importance of human rights principles within the legal framework and social life.

Human rights principles are ingrained in both the Norwegian legal and ethical framework that governs the employment of coercion within psychiatric facilities, such as this study focusing on the South-Eastern Norway RHA has revealed. It is expected that all psychiatrists follow such regulations to ensure that these rights always are protected.

This decision-making navigates psychiatrists through a challenging terrain consisting of both the legal framework and normative considerations. From a rational choice standpoint, psychiatrists might be motivated to follow such principles for their own utility, or the utility of the patient versus groups within the society. Similarly, normative considerations have an important role in the decision-making process seeing as these might influence how psychiatrists view and implement both legal and ethical standards.

As pointed out previously, psychiatrists occasionally struggle with balancing legal adherence with their own professional medical opinion and ethical considerations, which highlights the challenge of upholding human rights in practice. It further indicates that human rights are not a simple abstract set of ideas and principles but is interconnected with day-to-day decision-making within psychiatric facilities in the evaluation processes where psychiatrists evaluate whether or not to employ coercion on patients.

In sum, this indicates that the psychiatrist's complex decision-making on the utilization of coercive practices is closely related to the broader context of human rights as a collection of principles and norms that direct the social and political environment. Both theoretical aspects acknowledges that the concept of human rights provides a frame in legal regulations and social behavior. These rights offer a set of normative principles that influence psychiatrists' decision-making, as well as their interactions within society. These principles are frequently portrayed within the legal framework and social norms. This means that human rights can provide both a legal and ethical foundation, influencing both arguments based on rational choice and social constructivism.

The combination of the two theoretical perspectives with human rights as a frame can help ensure that such decisions are developed with utmost consideration and respect for the well-being and rights of those individuals that are involved, either in form of a patient or as a member of society. As this study demonstrates, human rights might not necessarily portray a black-and-white proposition and that different situations might have various interpretations and implementations of such principles.

Further, as findings show, there may be inconsistencies between various human rights tenets, for instance the right to make decisions over one's own life and the right to be protected from harm. Human rights can easily be perceived as being broad and encompassing seeing as it includes various ideas and ideals that are intertwined with the functioning society, more specifically in context to the current study, within the use of coercive practices.

Chapter 8: Concluding Remarks

This thesis has examined the following research question:

What legal and ethical considerations do psychiatrists emphasize when deciding to use coercion within Norwegian psychiatric care?

The preceding chapters introduced the topic together with background knowledge, presented previous research and established a theoretical framework with four expectations to address the research question (with its two underlying sub-research questions). Further, I have outlined the research design, and finally, after presenting my empirical findings, analyzed and discussed the results.

Chapter 3 highlighted previous research on the current topic. I found that previous research on the understanding of human rights principles and ethical considerations regarding psychiatrists emphasizing in the decision-making process on the use of coercion was not fully complete. I identified research gaps relating to the need for qualitative research for more analysis of when coercion is used in mental health care and the importance of human rights, and the ethical dilemmas that arise during this decision-process.

The following chapter first outlined the theoretical framework for explaining why I believe the perspectives on rational choice and social constructivism on decision-making can help gain a more nuanced understanding of psychiatrists' weighting between different considerations when choosing. The theoretical framework incorporated four different expectations, where all four were used to predict and explain a social phenomenon. By probing all four expectations, I assessed the relative strengths and weaknesses of each expectation. To empirically examine these four expectations data was collected through semi-structured interviews as part of a single case study that was presented in chapter 5. The next chapter presented my findings, both in form of statements from participating informants, but also through diagrams modified from NVivo, and different bar charts to get a more detailed overview of my findings. Chapter 7 entailed an analysis that combined the examination and interpretation of findings, and a broader discussion of their wider significance to be able to offer a more comprehensive understanding.

8.1 Main findings and implications

The current study's analysis has led to the following conclusion: the decision-making process on the use of coercive practices in the field of psychiatry is not solely based on arguments concerning the logic of consequences or the logic of appropriateness. Instead, psychiatrists weigh a complex interplay of several elements, including legal compliance, adherence to human rights, and normative considerations when deciding on whether to use coercive practices on patients. Further, this demonstrates the complexity of human rights principles and the challenges psychiatrists face in their effort to navigate and uphold such principles. The thesis identified human rights as a broad set of ideas that manifest themselves within diverse settings, including the decision-making processes regarding the use of coercion.

The decision-making perspectives of rational choice and social constructivism are frequently compared as if they were two separate and opposing ideas (as illustrated in chapter 4). Still, results from the current study revealed that these two are in fact interrelated and not mutually exclusive. In addition, logic of consequences and logic of appropriateness intersect with human rights. These rights manifest themselves in legal and ethical frameworks.

From a rational choice perspective, psychiatrists make decisions based on maximizing their own utility (expectation 1 - E1), or the utility of patients versus groups in society (E2). As the findings suggest, psychiatrists follow legal regulations for their own benefit while viewing human rights as already incorporated in such frameworks. In the context of human rights, when considering the best interest of the patient versus society, psychiatrists might consider the benefits of respecting human rights, for instance a patient's right to treatment or the society's right to be safeguarded from harm. From a social constructivism point of view, human rights are seen as socially constructed ideas and not as objective principles. In context to decision-making, this means that human rights are not only legal principles, but also internal (E3) and social norms (E4) that form how psychiatrists behave.

It appears that psychiatrists, to a certain extent, emphasize their own self-interest to a slightly higher degree then the best interest of patients versus society, mainly influenced by the fear of being sanctioned when deciding on whether to use coercion. However, additional conclusions made from this study revealed that psychiatrists who succumb to making such decisions based on the maximizing of their own utility might encounter uncertainties as they try to navigate the delicate balance between legal compliance and their professional medical opinion.

Even though psychiatrists perceive human rights as enshrined within the legal framework, the psychiatrists expressed ambivalence in their attempt to uphold these rights, for instance in situations where a patient's medical needs conflicted with such rights. In situations where they chose to not use coercive practices because of legal requirements, they sometimes believed that such treatment should have been given, nonetheless. Related to this, their focus is mainly on adhering to the law itself, as opposed to other rules or guidelines that posits less invasive repercussions, such as guidelines presented from the Ministry of Health and Care Services HOD.

Compared to E1 and E2 based on logic of consequences, which together are weighed to a slightly higher degree than the logic of appropriateness (E3 and E4), it is important to note that psychiatrists still place a high value on normative considerations. These considerations are firstly made up of internalized moral beliefs and values such as how they feel about utilizing coercive practices, wherein various opinions emerged regarding what is deemed morally incorrect or correct. Secondly, the impact of the influence of colleagues, the wider community, and social norms is also accentuated in terms of conforming to perceived appropriate behaviors within their surroundings. In other words, the appropriate decision-making for psychiatrists in terms of coercive practices must be comprehended in light of the cultural and social context in which they operate. By considering such elements, it is possible to obtain a more comprehensive knowledge of the ethical aspects and complexities inherent in the use of coercive practices within Norwegian Mental Health Care.

The interplay between rational choice and social constructivism suggests that psychiatrists are not simply driven by self-interest and legal compliance, respect of patients and society's human rights, moral beliefs or social norms, but rather by a complex interplay between these different factors. These findings reveal that psychiatrists do not solely weigh their own self-interest or patients versus society's human rights, but also consider the broader societal implications of their decisions. Psychiatrist's decision-making on the use of coercive practices is more inclined to be more intricate and nuanced than a simple dichotomy between maximizing utility and internal- and external norms. Findings from the current study imply that psychiatrists face more intricate decision-process on the use of coercive practices, as opposed to a simple choice between rational choice arguments or arguments of social constructivism. Further implications of such findings indicate the need for psychiatrists to understand the complexity of such decision-making.

There also evolves a potential for conflicting interests and values to arise during the decision-process, highlighting the need for clear ethical guidelines and communication between all parties involved.

Furthermore, the implication of integrating rational and social factors, including human rights considerations in the development of decision-making frameworks or models for psychiatrists and other health personnel within the use of coercion, should be examined. This approach would facilitate a more nuanced understanding, informed decision-making process, and promote the safeguarding of human rights for patients and society. This further implies that such guidelines should consider the various factors and perspectives that psychiatrists emphasize when making decisions about coercive practices, also including rational choice and social constructivism. By doing so, new prescriptive guidelines and policies can provide effective navigation to psychiatrists and other health care personnel in such complex decision-making processes.

It is important to acknowledge that human rights are not just abstract ideas, but are principles deeply related to everyday life and the operation of society. Findings imply how crucial it is to understand the way in which such rights affect psychiatrists' decision-making process and to further strive towards how psychiatrists are better able to secure the protection and promotion of human rights when deciding whether to use coercive practices. Further, this is something that can be transferred to all spheres of society. Even so, overcoming the depth and intricacy of human rights might be difficult, even for individuals, such as psychiatrists, who are committed to preserve them.

The incorporation of human rights within the use of coercive practices in the South-Eastern RHA reflects the recognition that Norwegian Health Care is not solely a medical issue, but also a social and political one. This might imply the necessity of approaches that considers the social and political context of mental illness and the wider implications of coercion as a psychiatric treatment or a mean to prevent harm. The weighing of legal and ethical aspects on the use of coercion when individuals and society's right are at odds by psychiatrists, is intricately linked to the broader conceptualization of human rights as an important component within the contemporary legal and ethical framework. This current study concludes that human rights play an important role as guiding principles in striking a balance between legal standards and ethical considerations.

8.2 Reflections on further research

In this section, I outline avenues for further research. Firstly, the decision-making by psychiatrists on coercive practices might be better understood by expanding the sample size and include a more diverse range of healthcare personnel who are authorized to make decisions about coercion to provide greater breadth and depth and also enhance generalizability.

Secondly, as this study is a single case study of one out of four RHAs in Norway, future research might consider conducting an in-depth analysis of the remaining three RHAs. This will also form a suitable foundation for future comparative research to discover differences and similarities between these four RHAs. In such case studies, further studies could potentially deliberate on using focus groups as one way of interviewing allowing psychiatrists within the same RHA (and possibly across RHAs) to interact with each other and generate new ideas. By conducting focus groups instead of semi-structured interviews, this is also an efficient use of time, especially if one aims to compare all four RHAs. The effectiveness of present decision-making practices should be examined, along with potential areas for improvement.

Thirdly, to enhance the quality of causal data, it is advisable for future research to do a longitudinal study to track changes within the use of coercive practice over time in Norway, especially in light of recent amendments made to the Norwegian Mental Health Care Act. Such a study can explore this development and create an understanding of how different elements have influenced over time.

Moreover, by including perspectives of other health personnel working within psychiatric facilities this will create a more comprehensive understanding of the mental health services in its entirety. In addition, future research might also consider might incorporating other "counterparts", meaning organizations who have previously expressed concern about coercion within Norwegian psychiatry is a breach of human rights. It is important to acknowledge that there is more than one side to a story.

Finally, in future studies examining the normative side of psychiatrists decision-making process on the use of coercive practices, it would be interesting to identify the exact norms governing such practices. Through such research an insight in the understanding of the lineage and evolution of such norms within the field of mental health care might be discovered.

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Appendix 1: Original interview guide in Norwegian

Bakgrunn:

1) **Kan du fortelle meg om bakgrunnen din?**
   a) I hvilket årstall fullførte du spesialiseringen din i psykiatri?
   b) Hvor studerte du medisin/ fullførte spesialiseringen din?
   c) Hvorfor ville du bli psykiater?

Arbeidsplassen din:

2) **Hvordan ville du beskrevet arbeidsplassen din?**
   a) Avdeling; poliklinikk/døgnavdeling? Åpen/lukket? Aldersgruppe?
   b) Kan du fortelle meg om en helt vanlig dag på arbeidsplassen din?
   c) Hva slags pasienter behandler du vanligvis? Alder/kjønn?

3) **Hvilke tvangs- midler og behandlinger anvendes på din arbeidsplass?**
   a) Hva brukes mest/minst?
   b) Hvilke situasjoner krever iverksetting av tvang, enten som behandling eller for å forhindre fare?
   c) Er det noen spesielle kjennetegn ved de pasientene som er mest utsatt for tvang?
   d) Er det noen spesielle kjennetegn ved de ansatte som bruker mest tvang?

Personlige syn:

4) **Hva er dine synspunkter om …**
   a) begrepet «tvang»?
   b) begrepet «menneskerettigheter»?
   c) norsk og internasjonal lovgivning om tvang?
   d) balanseringen av hensynet til lover opp mot tvang?
   e) balanseringen av menneskerettighetsperspektivet opp mot mulige sosiale konsekvenser?
   f) om lovverket som gjelder tvang er med på å bevare menneskerettigheter?

5) Etter en endring i psykisk helsevernloven i 2017 er det nå pålagt å vurdere pasienters evne til å samtykke til behandling, og bruk av tvangsbehandling kan kun benyttes dersom pasientene mangler samtykkekompetanse, med mindre det foreligger en overhengende fare for pasientens liv eller andres liv. Hva er dine tanker om dette?

6) Er det noe du vil tilføye helt til slutt?

Appendix 2: Interview guide translated into English

Background:

1) **Can you tell me about your background?**
   a) In what year did you complete your specialization in psychiatry?
   b) Where did you take your medical degree/ complete your specialization?
   c) Why did you want to become a psychiatrist?

Your place of work:

2) **How will you describe your place of work?**
   a) Department; polyclinic/inpatient ward? Closed/open? Age group?
   b) Can you walk me through an ordinary day at your place of work?
   c) What kind of patients do you usually treat? Age/gender?

3) **What means of coercion are used at your place of work?**
   a) What is used least/most?
   b) What types of situations require coercion, either in form of treatment or to prevent danger?
   c) Are there any special characteristics of the patients who are most exposed to coercive measures?
   d) Are there any special characteristics among the staff who use coercive measures the most?

Personal views:

4) **What are your viewpoints on…**
   a) the term "coercion"?
   b) the term "human rights"?
   c) the Norwegian and international legislation on coercion?
   d) the balance of laws against coercion?
   e) balancing the human rights perspective against possible social consequences?
   f) coercion as one of your work tasks?
   g) whether the legislation one the use of coercion helps to preserve human rights?

5) Following an amendment in the Mental Health Care Act in 2017, it is now required to assess patients' capacity to consent to treatment, and use of involuntary treatment can only be used if the patients lack the capacity to consent, unless there is an imminent danger to the patient's life or the life of others. What are your thoughts regarding this?

6) At the very end, is there anything you would like to add?

Appendix 3: Approval from SIKT

Meldeskjema / Masteroppgave (Tittel vil omhandle hensynet til menneskerettigheter i ... / Vurdering

Vurdering av behandling av personopplysninger

Referansenummer	Vurderingstype	Dato
675782	Automatisk	24.02.2023

Prosjekttittel
Masteroppgave (Tittel vil omhandle hensynet til menneskerettigheter i tvungent psykisk helsevern i Norge).

Behandlingsansvarlig institusjon
Universitetet i Oslo / Det samfunnsvitenskapelige fakultet / Institutt for statsvitenskap

Prosjektansvarlig
Jonathan Kuyper

Student
Hanna Iversen

Prosjektperiode
01.01.2023 - 01.09.2023

Kategorier personopplysninger
Alminnelige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 01.09.2023.

Meldeskjema

Grunnlag for automatisk vurdering
Meldeskjemaet har fått en automatisk vurdering. Det vil si at vurderingen er foretatt maskinelt, basert på informasjonen som er fylt inn i meldeskjemaet. Kun behandling av personopplysninger med lav personvernulempe og risiko får automatisk vurdering. Sentrale kriterier er:

- De registrerte er over 15 år
- Behandlingen omfatter ikke særlige kategorier personopplysninger;
  - Rasemessig eller etnisk opprinnelse
  - Politisk, religiøs eller filosofisk overbevisning
  - Fagforeningsmedlemskap
  - Genetiske data
  - Biometriske data for å entydig identifisere et individ
  - Helseopplysninger
  - Seksuelle forhold eller seksuell orientering
- Behandlingen omfatter ikke opplysninger om straffedommer og lovovertredelser
- Personopplysningene skal ikke behandles utenfor EU/EØS-området, og ingen som befinner seg utenfor EU/EØS skal ha tilgang til personopplysningene
- De registrerte mottar informasjon på forhånd om behandlingen av personopplysningene.

Informasjon til de registrerte (utvalgene) om behandlingen må inneholde

- Den behandlingsansvarliges identitet og kontaktopplysninger
- Kontaktopplysninger til personvernombudet (hvis relevant)
- Formålet med behandlingen av personopplysningene
- Det vitenskapelige formålet (formålet med studien)
- Det lovlige grunnlaget for behandlingen av personopplysningene
- Hvilke personopplysninger som vil bli behandlet, og hvordan de samles inn, eller hvor de hentes fra
- Hvem som vil få tilgang til personopplysningene (kategorier mottakere)
- Hvor lenge personopplysningene vil bli behandlet

Vi anbefaler å bruke vår mal til informasjonsskriv.

Informasjonssikkerhet
Du må behandle personopplysningene i tråd med retningslinjene for informasjonssikkerhet og lagringsguider ved behandlingsansvarlig institusjon. Institusjonen er ansvarlig for at vilkårene for personvernforordningen artikkel 5.1. d) riktighet, 5. 1. f) integritet og konfidensialitet, og 32 sikkerhet er oppfylt.

Appendix 4: Information and consent letter

Vil du delta i forskningsprosjektet om beslutningsprosessen ved bruk av tvang i norsk psykiatri?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å innhente opplysninger som gjelder profesjonelles syn på bruken av tvang innenfor norsk psykiatri og hensynet til menneskerettigheter. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål

Følgende forskningsprosjekt er en masterstudie i statsvitenskap ved Universitetet i Oslo.

Formålet med dette prosjektet er å innhente opplysninger som gjelder profesjonelles syn på bruken av tvang innenfor norsk psykiatri og hensynet til menneskerettigheter.

Som ledd i datainnsamlingen til denne masteroppgaven ønsker jeg å få frem hvordan de som avgjør om tvang skal benyttes (profesjonelle), balanserer menneskerettighetsperspektivet (pasientens rettigheter) opp mot mulige sosiale konsekvenser. Tvang i psykiatrien har lenge vært et omdiskutert tema og har ofte involvert utsagn fra ulike pasienter.
Jeg er ikke ute etter å finne ut om tvang i psykisk helsevern bryter med menneskerettigheter, eller avgjøre om hva som er det beste alternativet, men er istedenfor opptatt å belyse synspunktene til de som faktisk arbeider med tvang innenfor norsk psykiatri.

Den innsamlede dataen vil kun bli benyttet til denne masteroppgaven.

Hvem er ansvarlig for forskningsprosjektet?
Det er Universitetet i Oslo som er ansvarlig for prosjektet.

Hvorfor får du spørsmål om å delta?
Utvalget i denne undersøkelsen er trukket gjennom to ulike steg. Det første steget kalles for *målrettet utvelging* og her er informantene trukket ut på grunnlag av kriterier som tilsier at vedkommende er passende til undersøkelsen. Videre, har neste steg vært å foreta et såkalt *snøballutvalg*. Denne utvalgsstrategien går ut på at man forhører seg med informanter som allerede deltar i undersøkelsen kan anbefale andre informanter de tror vil være relevante. Personopplysninger er i disse tilfellene innhentet fra internett eller mottatt fra deltagende informanter (altså de som da har henvist videre).

Hva innebærer det for deg å delta?

Jeg vil innhente opplysninger om deg/ dine synspunkt i forhold til oppgavens tematikk gjennom et intervju. Dette vil være opplysninger knyttet opp mot ditt syn på tvang i norsk psykiatri og hensynet til menneskerettigheter. Opplysningene vil bli innhentet gjennom et intervju, der informantens svar enten vil bli skrevet ned eller tatt opp på diktafon.

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Alle dine personopplysninger vil da bli slettet. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil kun bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.
De som vil ha tilgang til dine opplysninger ved Universitetet i Oslo, vil være studenten som gjennomfører prosjektet (Hanna Iversen) og hennes veileder ved universitetet (Jonathan Kuyper).
Navnet og kontaktopplysningene dine vil jeg erstatte med en kode som lagres på egen navneliste adskilt fra øvrige data, og datamaterialet vil være kryptert.

Det vil ikke være mulig å gjenkjenne informanten i denne oppgaven.

Hva skjer med personopplysningene dine når forskningsprosjektet avsluttes?

Prosjektet vil etter planen avsluttes 23.05.23 – men jeg ønsker å bevare retten til å bruke informasjonen fra intervjuet til 23.11.23, dersom en uforutsett hendelse skulle resultere i at innlevering av masteroppgaven må utsettes. Ved innlevering av masteroppgaven vil lydfil med intervju slettes. Når prosjektet er ferdig, vil datamaterialet med ditt gjennomførte intervju anonymiseres.

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra Universitet i Oslo har Sikt – Kunnskapssektorens tjenesteleverandør vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke opplysninger vi behandler om deg, og å få utlevert en kopi av opplysningene
- å få rettet opplysninger om deg som er feil eller misvisende
- å få slettet personopplysninger om deg
- å sende klage til Datatilsynet om behandlingen av dine personopplysninger

Hvis du har spørsmål til studien, eller ønsker å vite mer om eller benytte deg av dine rettigheter, ta kontakt med:

- Prosjektansvarlig: Masterstudent: Hanna Iversen (iversenhanna@hotmail.com).
- Universitetet i Oslo: Veileder: Jonathan Kuyper (j.w.kuyper@stv.uio.no)
- Personvernombud ved Universitetet i Oslo: Roger Markgraf-Bye (personvernombud@uio.no)

Hvis du har spørsmål knyttet til vurderingen som er gjort av personverntjenestene fra Sikt, kan du ta kontakt via:

- Epost: personverntjenester@sikt.no eller telefon: 73 98 40 40.

Med vennlig hilsen

Hanna Iversen

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet *[sett inn tittel]*, og har fått anledning til å stille spørsmål. Jeg samtykker til:

☐ å delta i intervju.
☐ at lydopptak gjennomføres av intervjuet.

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet

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(Signert av prosjektdeltaker, dato)