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Coercion in a locked psychiatric ward: Perspectives of patients and staff

**Inger B. Larsen and Toril B. Terkelsen**

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## Abstract

**Background:** In spite of a national strategy for reducing coercion in the mental health services, Norway, still has a high rate of involuntary treatment compared to other European countries. It is therefore crucial to study various parties involved in involuntary treatment in order to reduce coercion.

**Research question:** How do patients and staff in a Norwegian locked psychiatric ward experience coercion?

**Research design:** Participant observation and interviews.

**Participants:** 12 patients and 22 employees participated in the study.

**Ethical considerations:** The study is accepted by the National Committee for Medical Health Research Ethics.

**Findings:** The participants experienced coercion in different ways. Patients often felt inferior, while many of the staff felt guilty of violating patients' dignity, although they ascribed responsibility for their actions to the "system". The main themes are 1) corrections and house rules, 2) coercion is perceived as necessary, 3) the significance of material surroundings and 4) being treated as a human being.

**Discussion:** The discussion draws upon the concepts of vulnerability, guilty conscience and ethical sensitivity, related to the staffs' divergent views on coercion.

**Conclusion:** Especially among staff there are divergent views of coercion. Professionals being physically and emotionally close to the patient are more likely to understand him/her as a unique person with individual needs. If patients are kept at a distance, professionals as a group change to understand patients as members of a group with common needs and common restrictions.

**Keywords:** Locked psychiatric ward, forced treatment, coercion, seclusion, experiences of staff and patients, vulnerability, ethical sensitivity

## Introduction

In Norwegian psychiatry, the use of coercion is regulated by law (1) and can be explained in two categories: coercion applied in the best interest of the patient and coercion motivated by the concern for others. The criteria for the legal use of coercion are dangerousness on one hand and the need for treatment on the other. If a person is considered dangerous to himself or others, use of forced medication, seclusion or Swedish belts are allowed in shorter periods, not for the reason of treatment, but to calm down the situation. The treatment criterion allows the use of long term forced medication on people with severe psychosis.

In spite of a national strategy for reducing coercion in the mental health services, Norway, according to a white paper, still has a high rate of involuntary treatment compared to other European countries (2). This white paper criticizes force in the civil mental health services and declares the need for coercion-free alternatives. To be able to reduce coercive practices and emphasize an experience-based service, the National Centre of Experienced-Based Knowledge in Norway promotes the need for new knowledge (3). This means taking the patients' own experiences into account, including them as equal human beings, and seeing beyond a concept of knowledge based merely on objectivity (3-5).

Husum, Bjørngaard (6) illuminate the differences between areas and hospitals within countries in the use of coercion. Some professionals considered it offensive, some as care and security and some as treatment (6). The same pattern seems to apply to patients. Katsakou, Rose (7) found that some patients viewed their involuntary hospitalization positively, whereas others believed it was wrong. According to Wynn, Kvalvik (8) physical or pharmacological restraints or seclusion may certainly weaken the alliance between patients and staff and may lead to more violence and injuries. In order to develop strategies to strengthen alliances and reduce the use of coercion in psychiatry, Landeweer,

Abma (9) describe how social processes might play an important role in moral deliberations. By bringing in new perspectives in the dialogue with the patients, moral development can be fostered. “When people look at the situation in a new light, new intuitions are triggered,” they underline. Eriksen, Sundfør (10) consider as moral practices reciprocity, personal involvement and recognition of each other as human beings. They emphasize these as fundamental for relationships between patients and professionals. It is crucial to understand people’s problems as meaningful reactions to their life stories (11).

This brief literature review gives a few examples of differences in staff and patient attitudes related to coercion, show how forced treatment might weaken the alliance between staff and patients, and suggests dialogue and reciprocity as practices to reduce coercion. As far as we can see, earlier studies have focused either on staff or patient experiences of coercion. This study presents various parties involved in involuntary treatment and discusses findings, using the concepts of vulnerability, guilty conscience and ethical sensitivity. The research question is:

*How do patients and staff in a Norwegian locked psychiatric ward experience coercion?*

The current article is based on fieldwork in a locked psychiatric ward in Norway where the use of coercion was the object of the study. The findings have guided us to understand coercion as the way in which it was observed and talked about by patients and staff.<sup>1</sup> It means involuntary commitment, medication,<sup>2</sup> seclusion, Swedish belts, and house rules and restrictions which were perceived as coercion by patients and/or staff.

## **Methods**

### *The setting*

The ward, which has the capacity to treat nine patients at a time, is situated in a medium-sized Norwegian town. Both the exterior and the interior are carefully planned, with the idea that tasteful

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<sup>1</sup> One of the authors, Terkelsen, who carried out the fieldwork, is referred to as T or “the researcher” hereafter.

<sup>2</sup> For more extensive data about forced medication, see Terkelsen and Larsen (12).

surroundings signal respect and a non-stigmatizing atmosphere. All the patients have single rooms with a private bathroom. However, the front door is locked and the two courtyards, although nicely laid out with plants, are enclosed by high walls. All staff carry security alarms.

Between the front door and the entrance to the main ward, there is a seclusion area capable of keeping two persons secluded from the rest of the ward as well as from each other. This area is stripped of everything apart from the most basic necessities, such as beds, tables, cupboards and chairs. The Swedish belts were kept here, but out of patients' sight when not in use.

### *The data collection*

Ethnographic fieldwork was carried out as outlined by Miles and Huberman (12) and Madden (13). Data were collected through participant observation and conversations/interviews with staff and patients throughout a period of four months in 2010. By studying how people behaved in their natural surroundings, it was possible to get close to their experiences and actions (14).

The ward was visited 48 times, on the average three times a week from two to seven hours, including daytime, evenings and two nights. The researcher (T) observed at close hand how and where people were interacting and what they were talking about. Spontaneous conversations often arose in these situations. Additionally, 18 planned one-to-one formal interviews with staff were carried out. Quotes from the employees are based upon one-to-one spontaneous conversations or interviews, while quotes from patients mostly come from one-to-one spontaneous conversations after T had spent time getting to know them. It was difficult to plan formal interviews with patients, because their condition often changed rapidly. T found it ethically right to make contact with the patients in a careful manner by mingling with them in a natural, spontaneous way, though always being open about her role as a researcher.

### *The participants*

Altogether 12 patients, nine men and three women, participated in the study. Not all were formally involuntarily admitted. Some perceived themselves as involuntary patients although they had agreed to

admission because: “If I had refused, they would’ve forced me anyway”. The same patients were not present throughout the research period, as some left and new ones came. They had different diagnoses, such as schizophrenia, bipolar disorders, personality disorders and substance-induced psychosis. The youngest patient was 17 years old, the eldest 53. Altogether 22 employees, 14 men and 8 women aged between their mid-twenties and early sixties agreed to participate. Some were trained nurses with or without specialization in psychiatric nursing, while others were social health workers. These fully trained people were all called milieu therapists. Two psychiatrists also took part in the study, as well as a few employees on short-term contracts without formal training. Because of confidentiality we will not differentiate between the staff in the presentation, but just call them “staff” or “employee” (E).

### *The analysis*

The field notes and interviews consisted of 200 pages of text. First, in order to gain an overall impression, all the texts were examined carefully. All the situations, episodes and utterances relating to the subject were identified. By using a phenomenological approach, questions were posed to the text on how patients were describing their experiences and feelings of being subjected to forced treatment, and how the staff experienced this. Secondly, we aimed at detecting patterns, themes, repetitions, contrasts and paradoxes in the material (15). The process of condensation made it possible to obtain knowledge of how patients and staff experienced coercion. They were all in various ways concerned with corrections and house rules as much as involuntary admission and seclusion. We also observed differences in how coercion was experienced in relation to the material surroundings in the ward. We noticed that particular surroundings supported coercive practices. Additionally, everybody had opinions about how to avoid coercive interventions, and since this is an important goal in Norwegian policy, we decided to focus on this as well. The result was identified in four themes: 1) corrections and house rules, 2) coercion is perceived as necessary, 3) significance of material surroundings and 4) being treated as a human being.

### *The ethical considerations*

The National Committee for Medical and Health Research Ethics in Norway accepted the project. Only participants giving informed voluntary consent are included. One may argue that it is problematic to ask people who are involuntarily committed to take part in a study, because of vulnerability or “lack of mental capacity” (16). However, the researcher, together with the staff, found the patients fully competent to talk about their experiences when being interviewed. Furthermore, it was important that they did not feel obligated to participate. If the atmosphere was relaxed and the participants felt secure, it was natural for them to take part in different activities, or ask for a chat. If not, T retreated. Regarding confidentiality, all participants are anonymous, and names are invented.

### *The validity of the study*

Participants’ experiences are depicted using their own descriptions of various situations. In this regard, definite settings involving coercion are revealed. Nevertheless, T chose situations or persons to interview, a potential bias to be aware of. Moreover, a field researcher is not able to guarantee that her presence will not influence participants’ behaviour or narratives. However, taking the duration of the fieldwork into consideration, it seemed that the participants became familiar with the situation, even more so because people were coming and going all the time, for instance students and employees on short-term contracts. Another possible bias is the translation from Norwegian into English. As Norwegian authors we risk choosing words and sentences which the participants themselves would not recognise.

### **Patients’ and employees’ experiences of coercion**

The field notes show that patients and staff were concerned about corrections and house rules. Some found them humiliating and difficult to understand. For both groups it was easier to understand the patients’ need for involuntary hospitalisation and sometimes the necessity for being secluded. The staff used the material surroundings, such as specific rooms and equipment, as an important part of the coercive treatment. Thus physical surroundings supported or reduced coercive interventions.

### *Corrections and house rules*

Corrections and house rules were meant to help patients gain control over their quite often chaotic lives. They were told that such restrictions would help them in the recovery process. However, when rules were applied rigidly instead of flexibly, many patients perceived corrections as provocative, making them feel inferior. “The staff should not act as guardians,” one of them said. James (P), for example, was critical of those he characterized as “provocative men”, although he believed that in his case coercion was necessary. Andrew (P) said something similar. He talked about “the sergeant” in a negative way. These employees were described as using a military style, denying cigarettes and coffee.

Jenny (P) was walking restlessly up and down in the seclusion area. She had a diagnosis of hypomania, which was the reason for putting her in seclusion. She was very frustrated and said angrily:

The first offense was on arrival when Jack ( E) stood in front of me in the hallway, arms crossed, explaining the rules. He looked as if he was working as a doorman outside a disco [...] He explained the rules here in a top-down manner.

Mona (P) was admitted voluntarily with the diagnosis of schizophrenia, although she felt she was not there of her own free will. She said ten years of experience as a patient had taught her to be compliant with psychiatric treatment:

It’s of no use to protest, you just have to do what they say. I have nothing good to say about psychiatry, but I have met a lot of nice people here. They have been human, giving me freedom. We need rules, but flexibility is important.

Some employees thought that small, insulting corrections in daily life may feel more humiliating than straightforward coercion:

You have to be a little generous and responsive. You should avoid correcting small things, such as asking people to take their feet off the table. Here the staff is very different – some believe it is absolutely necessary to point out things like that (Elisabeth [E]).



William (E) felt that the patients' dignity was violated:

It's better to loosen ties, than blindly follow the rules. Not commanding people to their rooms at eleven. Or giving them only one cigarette an hour [...]. Another thing, you're refusing to let people who want cold water after ten o'clock at night have it, because the kitchen is closed. You don't need to correct people all the time.

Daniela (E) was also critical. She commented:

We shouldn't humiliate people by correcting them all the time or believe that we know everything. What we should ask ourselves is how our mothers would like to be treated.

These professionals believed such humiliations were wrong, and blamed the "system" and the routines. However, a large number of the staff had a different view. Gary (E) said it was necessary to correct more. To him house rules were vital and patients ought to learn about them immediately on arrival. Hence, attitudes differed. Patients and some professionals wanted flexibility, while some professionals wanted strictness and authority.

### *Coercion is perceived as necessary*

Patients and staff had opinions about involuntary admission and compulsory treatments, like medication and seclusion. Some patients found this kind of coercion necessary and almost everybody among the staff was likely to agree about coercion as a necessity for the patients.

T and a young patient, James, were sitting in the smoking area, talking about how it felt to be locked in the ward against one's will. James was sometimes very confused, and after drinking alcohol he often ran into big problems. He said: "The conclusion is that I needed the coercion I was exposed to. I was really confused when I arrived. I don't cope with everything, I must admit. Some things are out of my control." When asked if the seclusion was necessary, he continued:

It was necessary, it was. But it wasn't good. [...] I understand why they have to remove everything in there. They could have considered letting me have something to do there. I even had to fight to get pen and paper.

Several patients admitted that seclusion was right for a short period, when things became very chaotic. However, they complained that it lasted too long. Peter (P) said: "After a while it only makes you feel worse."

Both James (P) and Andrew (P) said they needed coercion but were not comfortable with the methods. Andrew explained: "If it's possible to understand their use of coercion, it's acceptable."

Some patients said they were "voluntarily admitted by coercion". Terry (P), for instance, felt he really needed help, and taking medicines was the price to pay: "I was not psychotic, but the doctors said I was. It implied accepting involuntary admission voluntarily, so they could force me to take antipsychotic medication."

All staff agreed that coercion sometimes was necessary. The fear of violence and things getting out of control was one explanation. Daniela (E) put it this way: "There are a lot of disagreements here, but when it comes to the big questions, we agree." "Big questions" referred to involuntary admission, restraints and forced medication. T did not observe any patient becoming violent during the fieldwork; however, awareness of threats and violence was embedded in comments by the staff:

There isn't much violence here, but I'm afraid of Peter. He threatened to kill me, said he knew different ways of killing me [...]. The other patients were terrified. It's a goal that people can live in freedom, but sometimes it goes too far. There's a trade-off between dilemmas (Pauline [E]).

Another reason for using coercion, according to the staff, was that it was for the benefit of the patient. Forced seclusion was handled primarily as part of the treatment, not as protection against violence. Therefore, many employees did not judge this as coercion, but as treatment. Jan (E), for instance, believed that seclusion was a very effective treatment for "the patients who [...] have enough with

their internal chaos.” However, not all of the staff agreed. William (E) argued that patients sometimes were put in the seclusion area not for treatment but just because of a previous “history”: “We keep a patient in the seclusion area just because it should not be nice to be here. He was acting up at home and is supposed to stay here two or three days [...]” For Jan, seclusion was part of the treatment. For William, on the other hand, seclusion meant punishment.

Some of the staff members were critical of the coercive practices in the ward. Pauline (E) said: “I think it’s too strict here. Differences are not accepted.” Later on she continued:

The staff doesn’t bother whether patients are coerced or not. They trust the doctors and do their work, preferably as gently as possible, but nevertheless loyally. [...] The doctors are almost never present. They stay in their offices and make decisions.

Being the one who applied coercion on the doctor’s orders could also be a burden. A remark from Sally (E) was characteristic of many of the staff: “Physical coercion, like forced medication, for instance, is absolutely the worst thing I do. Some patients believe I poison them. I feel like a perpetrator, it gives me a bad conscience. But I blame the system.” It seemed that being loyal to the system removed feelings of guilt and shame.

### *Significance of material surroundings*

Maria (P) told how the hospital building made her feel small. She commented: “They are copying the medical model in psychiatry. It is painful to me. [...] You feel worse being close to doctors and the hospital. But I like the interior here.” Despite the welcoming surroundings, the interior and rooms inside the ward also symbolized restrictions. At first glance, a place to sit together where two corridors met seemed really nice. On sunny days, the sunshine came flowing through the large windows. Staff and patients would often sit here together, chatting and drinking coffee. This part of the ward was meant to be “normal” and social. However, it was also a vantage point for the staff, because they could keep control in all directions.

Another place for controlling, discussing and administering things going on in the ward was the meeting room. It was used to discuss and plan the patients' treatment without the patients present. "The big questions", for instance, forced medication, prolonged involuntary commitment, or use of the seclusion area, were answered here. A medical frame of reference dominated. Mental health illnesses were mainly considered as psychiatric diseases. The following commentary about a patient who was diagnosed with schizophrenia was characteristic: "Seclusion, order and stability in blood serum is crucial for this patient". The staff was convinced that medication was obligatory, if necessary with coercion, to obtain "stability in blood serum". Thus, the meeting room represented a medical understanding of mental health problems.

The seclusion area was often used, explained by the staff as "if you are chaotic inside you need an orderly outside." Jenny (P) was secluded, and complained: "This is like a fusion of a kindergarten, a madhouse and a prison." In the stripped room, she was controlled by employees obeying the house rules, she said. The room itself and the staff signaled to her that she was not a human being with a free will. Jenny used material metaphors to describe her experience of the ward and the rules which appeared unintelligible for her. She called her own room a "seclusion cell". To further illustrate her frustration, she called the protected courtyard a "prison exercise yard".

As for the Swedish belts, the staff was aware of the power it symbolized. William (E) said that once the bed with belts was placed in the seclusion area even before an angry patient arrived. "It should never have been done", he said. "You can imagine how terrified the patient was when the first thing he saw was *that* bed. It made the whole situation worse." Andrew (P) said that being put in restraints was the worst: "Hell is the right word. When you don't understand why, it's like going through a real Hell. [...] It means restraints may trigger paranoia, although you know that the staff wants the best for you."

Another material way of controlling patients' behavior was rules designed particularly for one individual patient, written on a piece of paper and stuck to a table in the staffroom inside the ward. All the staff were supposed to be loyal in making the patient comply. One example is rules for Helen (P) who was furious at being locked up in the ward:

1. If you need to talk about private matters, you have to do it in your room together with your contact.
2. You are not allowed to have private conversations in the public areas.
3. You have the possibility to go out together with the staff.
4. You are obliged to take a shower and change your clothes on Friday and Monday.
5. The staff will serve you food during mealtimes.
6. You are not allowed to take food from the buffet yourself.
7. If you are not able to stick to the guidelines, the staff will tell you to go to your room.

Hence, the hospital building, the rooms, the interior and written instructions were intended for the benefit of patients, described as part of the treatment and a way of helping them to control themselves. However, many patients experienced this as insulting. Both the lack of physical things, like in the stripped seclusion area, and the presence of them, like high walls or security alarms, may indicate an understanding of the patients as unordinary. On one hand such material surroundings may promote coercion because patients become aggressive or “feel worse” when being in a building which reminds them of their illness. On the other hand, according to the staff, these things may prevent coercion because they support control and safety.

### ***Being treated as a human being***

Jenny (P) burst out, when she met John, who was an employee without formal health education: “Oh there, you old grand-dad. Good to see you!” He stroked her cheek, which she liked. Jenny continued: “Isn’t it terrible? There are just a few people I can talk with and none of them are health professionals. John’s able to talk to ordinary people. He takes care of me. I feel touched when people are good to me.”

When the patients talked about their favorite employees, they described them as somebody who treated the patients as “ordinary people”, “as human beings” and “not as a diagnosis”. Jenny (P) was critical of the ones who understood her as a diagnosis:

Most of all they are concerned about my head. They want to give me medication for hypomania, but [...] I'm not concerned about the diagnosis. My opinion is that we are complex [...] body and soul, but here the only thing that counts is the head.

She did not feel that they understood her and continued: "being tired is not the same as being insane."

Many patients were critical of the psychiatric descriptions of their problems because it made them feel unordinary. Some said that medication itself increased the feeling of not being normal. It affected their way of thinking, moving and talking. They suggested that it would be more useful if the staff treated them as ordinary, complex people with problems, for instance lack of rest and sleep. Some among the staff agreed:

I struggle [...] with myself using force in situations involving "doing things our way".

Sometimes I wonder if we make people more ill than they really are. Maybe we just don't accept normal things. Perhaps we should not correct so much. We should let people live the life they want (Irene [E]).

Others also pointed out the importance of doing "ordinary" things with patients in ordinary settings. Elisabeth (E) put it this way: "It's very important to be present in the environment to avert aggression. Normal presence and normal chat make people more normal."

The researcher observed how angry patients were comforted and calmed down. Peter (E) represented what you might call a favorite employee from the patients' point of view. He had a way of making people relax:

It's important to know something about the person, things that interest them, and then you can use this while talking to them. Caring by giving something to eat and drink can help. [...] You can hug a person, and it works. Often I give them a friendly nudge. Then they feel included.

To be treated on equal terms with the same needs as all human beings seemed to help.

## Discussion

As the findings reveal, there were divergent views and reactions on the use of coercion, particularly among the staff. Some of the staff had guilty feelings when using coercion, while others seemed to feel a kind of guilt if they did not use it.

The ones who felt guilty when using coercion wanted “to loosen ties rather than blindly follow the rules”. At the same time they thought it was impossible to avoid force and blamed the “system”. Blaming the system seemed to ease the burden they felt.

In contrast, the ones who defended coercion felt a kind of guilt when not being consistent. They thought that staff should be stricter and understood, for example, use of house rules and seclusion as important treatment activities rather than an oppressive practice.

On one hand, when the staff was gathered they agreed, at least on “the big questions” like forced medication and seclusion. Being together seemed to create a common “professional outside” supported by knowledge from medical psychiatry. On the other hand a more private, “vulnerable inside” occurred in the one- to- one interviews, exemplified with this quote: “I struggle [...] with myself using force in situations involving ‘doing things our way’.” When showing the “vulnerable inside” they criticized their colleagues, the practices of the ward and medical psychiatry in general.

We will now explore and discuss the reasons for these divergent views and reactions with the concepts of vulnerability, guilty conscience and ethical sensitivity.

### *Vulnerability and guilty conscience*

Vulnerability is about fragility, of being at risk of something and being dependent on others (17). It involves the risk of getting hurt, or hurting others. No doubt patients in this study were indeed vulnerable and dependent on others. They were also at risk of being secluded or given medication against their own will. Corrections and house rules seemed to increase dependency and vulnerability.

However, the professionals were also vulnerable, as revealed by their telling about guilty consciences. The majority of the employees felt dependent on an unchangeable system which they believed to be necessary, although some also felt like perpetrators. In this context, two studies are interesting.

Dahlquist, Söderberg (18) aimed at illuminating how psychiatric therapists were involved in ethical dilemmas which affected their consciences in a challenging way. They found that the therapists faced feelings of inadequacy, powerlessness, shame and a feeling of not being good enough when encountering such dilemmas. Only in sharing these feelings with co-workers could they endure them.

Another study goes in a different direction. Lind, Kaltiala-Heino (19) found that only a few nurses working in a psychiatric acute ward felt that coercion was ethically problematic. How does it happen

that in one study the therapists felt guilt and shame, while in another only a few had problematic feelings? It might be that both phenomena co-exist, as we interpret the findings in our study. Could it be that perceptions of coercion vary, not only between individuals, but also on the basis of being in a group and being alone? Our data reveal that some employees felt guilty, but “blamed the system”. The feelings of guilt occurred when they were close to the individual patient and his pain. At the same time they were relieved by the fact that someone higher up in the system carried the weight of responsibility. The staff as a whole functioned as supportive of the legitimacy and necessity of the coercive actions. They stuck together, comforting and protecting themselves as a group, agreeing that coercion was necessary. In these situations feelings of guilt were about lack of treatment and about what would happen to patients and to society if they did not use force. The material surroundings, such as buildings, walls and seclusion areas supported and legitimated coercion and protected the professional against their feelings of vulnerability. The expectancy of loyalty, for instance in the case of the rules written for Helen, is characteristic. However, it is understandable that the staff were loyal to each other. They were also vulnerable, as seen by the fact that they were sometimes seriously threatened by patients. Reciprocal support seemed to ease the personal burden of a guilty conscience. On the other hand this kind of community may hide their ethical sensitivity and moral perception of how seriously the patients experienced coercion.

### *Ethical sensitivity*

Weaver, Morse (20) made an extensive literature review about ethical sensitivity, and found that “Moral perception involves awakening and particularizing which allow the professional to perceive client and situational needs” (p. 609), meaning that an employee is able to see the other as a unique subject, and is aware that something ethically important is at stake. Theories of moral perception belong to the humanities and not to natural science. Our findings reveal that patients did not want to be treated as a diagnosis. This kind of objectification was hurtful, provoking and made them feel vulnerable. They felt they were not treated as “a human being”, as Jenny put it. To be cared for as normal people, in ordinary settings, was underlined as important by all of them. In contrast, a statement from an employee: “stability in plasma serum and seclusion is needed” indicates a perception of abnormality and a medical way of thinking.

Even when patients felt hurt, the “guardians” among the staff continued to treat them in a way the patients perceived as disrespectful. The “listeners”, however, who cared for patients as normal people, seemed to act in a more empathic way, indicating differences in ethical capacities between members of the staff. Moreover, it seemed that use of coercion on a regular basis could endanger the moral perception of the staff. The staff explained, for instance, seclusion as treatment. A remedial action made for the patient’s benefit may appear more ethically acceptable, than for instance, a procedure to calm down a situation. A way of justifying use of coercion was to tell oneself as a professional that in



the long run it is to the patient's profit. If the policy of the ward is to explain coercive interventions as treatment, the ethical issues are concealed, and the threshold for using coercion is lowered.

## Concluding remarks

Among staff there are different reasons for divergent views of coercion. Professionals who are physically and emotionally close to the patient are more likely to understand him/her as a unique person needing individual care, meaning sometimes to "loosen ties" and sometimes not. This indicates a kind of "one to one vulnerability" which entails a guilty conscience when a patient is treated as a medical case and not as an individual. Contrarily, if patients are kept at a distance they change from being treated as individuals with particular needs to members of a group with common needs and common restrictions. Consequently, professionals as a group stick to what might be called another kind of ethical sensitivity. It is a frame of reference where medical psychiatry defines the "right" answer for how to treat the same category of patients in the same way in order to help them and in order to protect society. This is not in line with the idea of taking the individual patients' own experiences into account by including them as equal human beings.

## References

1. Norge. Psykisk helsevernloven og psykisk helsevernforskriften med kommentarer. Oslo: Helsedirektoratet; 2012. 176 s. p.
2. Paulsrud K. Økt selvbestemmelse og rettssikkerhet: balansegangen mellom selvbestemmelsesrett og omsorgsansvar i psykisk helsevern : utredning fra utvalg oppnevnt ved kongelig resolusjon 28. mai 2010 : avgitt til Helse- og omsorgsdepartementet 17. juni 2011. Oslo: Departementenes servicesenter, Informasjonsforvaltning; 2011. 407 s. : ill. ; 30 cm p.
3. Ekeland T-J. Ny kunnskap - ny praksis, et nytt psykisk helsevern. Skien: Nasjonalt senter for erfaringskompetanse innen psykisk helse; 2011. 31 s. p.
4. Terkelsen T, Blystad A, Hydle I. Transforming Extraordinary Experiences Into the Concept of Schizophrenia: A Case Study of a Norwegian Psychiatric Unit. *Ethical Human Psychology and Psychiatry*. //;7(3):229-52.
5. Larsen IB, Andersen AJW. "Tvangstrøyer og ensomhet, blomstervaser og kjærlighet". Hvordan beskriver skandinaviske brukere av psykisk helsevern sine erfaringer med den hjelpen de ble tilbudt ? *Tidsskrift for psykisk helsearbeid* 2011;8(2).
6. Husum T, Bjørngaard J, Finset A, Ruud T. Staff attitudes and thoughts about the use of coercion in acute psychiatric wards. *Soc Psychiatry Psychiatr Epidemiol*. 2011 2011/09/01;46(9):893-901. English.
7. Katsakou C, Rose D, Amos T, Bowers L, McCabe R, Oliver D, et al. Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: a qualitative study. *Soc Psychiatry Psychiatr Epidemiol*. 2012 2012/07/01;47(7):1169-79. English.
8. Wynn R, Kvalvik A-M, Hynnekleiv T. Attitudes to coercion at two Norwegian psychiatric units. *Nordic Journal of Psychiatry*. 2011;65(2):133-7. PubMed PMID: 20735188.
9. Landeweer EG, Abma TA, Widdershoven GA. Moral margins concerning the use of coercion in psychiatry. *Nursing Ethics*. 2011 May 1, 2011;18(3):304-16.

10. Eriksen KÅ, Sundfør B, Karlsson B, Råholm M-B, Arman M. Recognition as a valued human being: Perspectives of mental health service users. *Nursing Ethics*. 2012 May 1, 2012;19(3):357-68.
11. Andersen AJW, Larsen IB. Hell on earth: Textual reflections on the experience of mental illness. *Journal of Mental Health*. 2012;21(2):174-81. PubMed PMID: 74978597.
12. Terkelsen TB, Larsen IB. Tvangsmedisinering som permanent unntakstilstand : erfaringer fra feltarbeid. *Tidsskrift for psykisk helsearbeid*. 2012;9(2):123-32.
13. Miles MB, Huberman AM. *Qualitative data analysis: an expanded sourcebook*. Thousand Oaks, Calif.: Sage; 1994. XIV, 338 s. : ill. p.
13. Madden R. *Being ethnographic: a guide to the theory and practice of ethnography*. London: Sage; 2010. IX, 197 s. p.
14. Terkelsen TL, I.B. Tvangsmedisinering som permanent unntakstilstand: erfaringer fra feltarbeid. *Tidsskrift for psykisk helsearbeid*. 2012;9(2):9. Norwegian.
15. Kvale S, Brinkmann S. *Interviews : learning the craft of qualitative research interviewing*. Los Angeles, Calif.: Sage; 2009. XVIII, 354 s. : ill. p.
16. Szmukler G, Appelbaum PS. Treatment pressures, leverage, coercion, and compulsion in mental health care. *Journal of Mental Health*. 2008;17(3):233-44.
17. Martinsen K, Kjær TA. *Løgstrup og sykepleien*. Oslo: Akribe; 2012. 198 s. p.
18. Dahlqvist V, SÖDerberg A, Norberg A. Facing inadequacy and being good enough: psychiatric care providers' narratives about experiencing and coping with troubled conscience. *Journal of Psychiatric and Mental Health Nursing*. 2009;16(3):242-7.
19. Lind M, Kaltiala-Heino R, Suominen T, Leino-Kilpi H, VäLimÄKi M. Nurses' ethical perceptions about coercion. *Journal of Psychiatric and Mental Health Nursing*. 2004;11(4):379-85.
20. Weaver K, Morse J, Mitcham C. Ethical sensitivity in professional practice: concept analysis. *Journal of Advanced Nursing*. 2008;62(5):607-18.