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Memona Rehman

Should Dignity be Compromised?

- Contextualizing the Relation Between Coercive Treatment and Dignity, from the Perspective of Persons with Experience from Norwegian Mental Health Care Facilities.

University College of Southeast Norway
Faculty of Law and Social Sciences
PO Box 235
NO- 3603 Kongsberg, Norway

http://www.usn.no

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Abstract

Research reveals that there is a lack of studies done from the perspective of people with experience from mental health care facilities, regarding their perception of coercive treatment. International legislation justifies human rights through the concept of human dignity, which lays a foundation for its' relevance in this study. International organisations also advocate for reducing the enforcement of coercive treatment in mental health care facilities. This research project examines the possible impact coercive treatment may have on the dignity of persons in mental health care treatment, seen from their own perspective. The study explores relevant academic literature on the topic of coercion and develop an understanding of dignity through selected elements of Kantian- inspired theories. The relation between coercive treatment and dignity is further discussed to answer the research questions. By illustrating the situation of persons, through their own perspective, the study aims to give them a voice in decision making regarding the coercive treatment that are enforced upon them.

Keywords: dignity, human rights, coercive treatment.

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"Love and compassion are necessities, not luxuries. Without them humanity cannot survive."
— Dalai Lama

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Chapter 1: Introduction

1.1 A Glimpse of the Context: Gaustad Psychiatric Hospital

"I shower once a week. They help me out with washing my hair. I stand completely naked with someone watching. I stand as straight as I dare. I ask the social worker if I look fat. She says my question gives her goosebumps". The woman in her 30s, was a patient at Gaustad psychiatric hospital. Due to chronic self- injury, she weighed below 40 kg. During three months in confinement she wrote 250 e-mails to the newspaper VG, describing her situation (Åsebø, Norman, & Amundsen, 2012).

The woman in treatment, clarifies that she has "something" which cannot be healed, and that she constantly feels an urge to die. Within the last two years, she has been kept in mechanical restraints for the majority of the day and night. Even while writing, her arms are strapped down to belts, and she is not allowed to visit the bathroom or shower by herself. The woman states that her life is not worth living anymore. She further describes the feeling of being in hospital for the pure purpose of storage, and her lawyer claims that her health- related condition was substantially better when she was admitted, compared to two years later (Åsebø, Norman, & Amundsen, 2012).

March 2015, the woman in treatment took her case to Borgarting Supreme Court to be let off from the compulsory mental health care, after already losing the case in Court. In the courtroom, her arms were strapped down in a cross, and the water jug was removed from the table in front of her. Her lawyer claimed that the use of mechanical restraints, was in defiance of *United Nations' Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (UNCAT) and the *Convention on the Rights of People with Disabilities* (CRPD). He also claimed that the hospital was violating her right to a private life. The enforcement of restraints was claimed to be characterised as torture, but her case was lost in the Supreme Court as well (Åsebø, Norman, & Amundsen, 2012).

In 2016, VG exposed that there was a lack of control and overview from Norwegian authorities regarding the use of coercion in psychiatric hospitals. The newspaper also documented coherence between use of restraints and available staff. The previous year, over 640 incidents were considered illegal according to Norwegian lawyers. About 170 persons

were kept in mechanical restraints (i.e. belts), even after falling asleep. Over 220 protocols were lacking information about when the patients were released from the restraints, or why they were kept in restraints (Steiro & Skartveit , 2016).

In 2015, the ministry of health collected national numbers regarding coercive measures in psychiatric health care in Norway, concerning all adults in treatment above the age of 16. The statistics revealed inconsistencies among hospitals. Hospitals in western Norway, used coercive measures the most. The highest numbers were in Stavanger, against 10.1% of the persons. In Oslo University Hospital HF, 8.1 % of the patients received a legal decision on use of mechanical restraints during 2015. The hospitals in western Norway also indicated a larger use of both isolation (locked doors) and physically holding down the patients (Ministry of Health , 2015). Research done by National Centre for Suicide Research and Prevention (NSSF) reveals that from 2008 to 2015, 1910 persons in treatment of mental health care committed suicide. The persons were either in treatment of mental health care or had ended the treatment within the last year they lived. The numbers revealed were equal to more than one person every second day. Altogether, more women than men seem to seek psychiatric help. However, more men than women commit suicide after receiving professional help (Moland, 2018). Seeing that the numbers of suicides are undesirably high, what causes the persons to commit suicide is relevant to this research project. Why the mental health care was not able to save the persons from committing suicide, is also a relevant question.

Human dignity is introduced as the justification for human rights in several United Nations' documents, and among them the Universal Declaration of Human Rights (UDHR). According to UDHR, Article 1*: "All human beings are born free and equal in dignity and rights."* (UN General Assembly, 1948). The Article creates a foundation for the understanding of dignity, not only as important within an ethical framework, but just as important within the area of law. The article of the Universal Declaration relates human rights to the aspect of dignity; hence its' relevance for the area of study (Thune & Stavrum, 2012). Even though the international documents use dignity as their justification for human rights, there is a lack of defining what the concept of dignity means. In this research project the topic of dignity will therefore be explored through elements of Kantian- inspired theories. The theories are chosen based on its' seniority in the discourse of dignity, and its' relevance for further discussion.

1.2 Research Question and Research Objectives

As the literature presented implies, there is an existing discourse, concerning whether and to what extent coercive treatment influences persons in treatment, and whether it is compatible with human rights. This research will examine the existing discourse from their own perspective, to observe the subjective view of the situation, as inherent dignity is extremely personal. According to Bryman, the research questions, provides an explicit statement of what the researcher wants to know (Bryman, 2012). I will do my research on coercion and the influence of dignity; hence my research questions are as following:

- In what way do persons who have experienced coercive treatment in mental health care facilities in Norway perceive the coercive treatment and its relation to dignity?
- How can Kantian- inspired ethical understandings of dignity help to provide an expanded understanding of the persons experiences of coercive treatment in mental health care facilities in Norway?

The research questions lay a foundation for critical reflection of the coercive treatment based on the perspective of the persons with experience from mental health care facilities, as their knowledge about their own experiences is superior to any other perspective. It is nevertheless essential that forming a research question is a developing process; and that these research questions have been developed until the completion of the thesis (Hart, 2005).

The main purpose of the research is to illustrate the situation within coercive treatment from a subjective standpoint, develop an understanding from an ethical perspective, and illuminate how it may influence the lives of persons. This is done to empower the persons in treatment and give them a voice regarding their own situation. The previous section presents the relevant of this research project to the topic of human rights. Seen that the focus group is a marginalized group in society, it is also relevant for the topic of diversity, thus multiculturalism.

1.3 Historical Background

In this section, I will give a brief introduction of the historical background of psychiatric treatment in Norway. The purpose of the section is to explore the development of coercive

measures in Norwegian mental health care. Throughout history, mental disorders have been considered diseases, and mentally ill persons have been considered insane- even in old Norwegian legislation. According to the Norwegian medical jurist Paul Emanuel Winge (1857-1920), people in former times believed that the soul left the body temporarily. When the soul had left the body, its place was taken by one or more spirits, who could be either good and clean or bad and impure. If the body was taken by an impure or devilish spirit, the person was defined as insane. The body was then considered to be owned by this spirit, and not by the person itself. Hence, the actions taken in such a moment, were not regarded as dependent on their own will, but rather the spirit's will. The person was excused of any responsibility, thus both incapacitated (claimed legally incompetent) and given impunity. The aim of the mental health care treatment was therefore, to save the person from harming himself, or others (Lysnes, 1982).

The psychiatric revolution was initiated through capitalism from the 17th century. The 'insane' were looked upon as scapegoats in society and considered as outcasts in society. Institutions were established where these people were kept locked into small rooms, with lack of food, bad hygiene and no activities. The most restless patients were exposed to physical coercion such as whipping and bastinado (foot whipping). Other coercive measures were also enforced, such as: collars, masks, gagging in addition to mechanical restraints in various other forms. Some were chained naked to the walls, or strapped into chairs or logs, attached horizontally to the floor and the ankles were placed in two holes and chained. The most rebellious persons were locked into and isolated in cells in basements, with limited lighting, left alone with their hallucinations during the nights (Hermundstad, 1999).

Gaustad was the first mental asylum established in Norway in the 19th century. It was initially designed to accommodate 300 patients. Because of societal development, increased knowledge of neuropsychiatric illnesses, accessibility to alcohol and the perception of sickness, they increased to accommodate 640 patients (Hermundstad, 1999).

From the Middle Ages to the 20th century, blood cleansing methods were used to exchange sick blood into new and clear blood. This was done either by puncturing haemorrhoids, transfusion through veins in the arm or by placing leeches on different spots of the body (Hermundstad, 1999).

The use of hydrotherapy was another method used from early 19th century. Several psychiatrists believed that cold baths down to 20°C, cured the body and made it capable of resistance. Warm baths were used as late as mid-1900s. The temperature in the baths was normally between 35°C and 37°C degrees and the treatment would last from 15 minutes to 8 hours. Sometimes it could even last for 200 hours, equal to eight days. The persons would eat and sleep in the bath (Hermundstad, 1999).

Putting persons in comas by injecting huge amounts of insulin, or through the use of general anaesthetics was another method of therapy used until the end of the 20th century (Hermundstad, 1999). However, these methods of treatment were claimed illegal through national legislation in 1999. This proves that there has been a development in legislation as well. Current legislation regarding coercive treatment, will be illustrated in the next section.

1.4 Legal Framework

Since 1945 several conventions have dealt with the concept of human rights, considering mental health care and human dignity as one of their pillars. In this section, I present a selection of the rulings that address the topic directly. All actions of coercive treatment in mental health care facilities should be taken in accordance with legal regulations. There are several different levels of protection for the patients in treatment: international, regional and national. In the following section I develop an understanding of how the jurisdiction may have been implemented in mental health care facilities in Norway, and how challenging these rights can be in regards to jeopardizing the human dignity of the persons. As said by professor of law, Aharon Barak:

"Most central of all human rights is the right to dignity. It is the source from which all other human rights are derived. Dignity unites the other human rights into a whole" (Daly & Barack, 2012 p. 1)

The Convention on the Rights of Persons with Disabilities (CRPD)

The Convention on the Rights of Persons with Disabilities (CRPD) was ratified by Norway in 2013 and the treaty was signed in 2007 (UN General Assembly, 2007). In a possible situation

of disagreement between the jurisdiction, the CRPD will be prioritized before national legislation. According to Norway's initial report to the UN, Norwegian policies on the topic comply with the principles given in the Convention (Norwegian government , 2007).

Article 14 of CRPD regulates the liberty and security of people with disabilities. It states that disability should not be a reason to justify deprivation of liberty. The convention is kept under surveillance by the CRPD- committee, which has specified that the coercion in psychiatric hospitals is incompatible with the CRPD. However, the Supreme Court of Norway has expressed that there is no foundation to conclude that the convention forbids involuntary commitment and involuntary treatment of mentally ill people, as long as the practice is compatible with the criteria in the Mental Health Act (1999) (Norwegian government , 2007).

European Convention on Human Rights (ECHR) (Formally the Convention for the Protection of Human Rights and Fundamental Freedoms)

Norway ratified the European Convention on Human Rights (ECHR) in 1952. According to Article 3 of the Convention, *"no one shall be subjected to torture or to inhuman or degrading treatment or punishment"* (Council of Europe , 1950). There are no exceptions to this Article.

According to Article 5 in the convention*: "Everyone has the right to liberty and security of person."* (Council of Europe , 1950). However, the Article also opens for exceptions, concerning deprivation of liberty. Article 5 (1) permits lawful arrest or detention of a person. There are nevertheless disagreements on whether the coercion in psychiatric hospitals could be considered a lawful detention of the patients.

The Mental Health Act (1999)

According to the first paragraph of the Mental Health Act (1999), the aim of the Act is to make sure that the establishment and accomplishment of the psychiatric health care happens in justifiable and reasonable means. It addresses the importance of working in accordance to the human rights and fundamental legal principles and respecting the needs, self-determination and dignity of the individual person. The Act also states that one of its' aims is

to reduce and prevent the use of coercion (The Mental Health Act, 1999). Decisions that deal with involuntary treatment can be appealed to the county administrator.

According to §4-8 of the Act, there are four types of coercive measures that are legally accepted in the psychiatry, if a patient could otherwise cause harm to himself or others around him.

1. Mechanical restraints, refer to equipment used to restrict a person's freedom of movement, which among other things includes belts.
2. Momentary isolation includes that a person is locked into his or her room for a specific period of time.
3. Medications, such as injections, last from a short period of time to a maximum of one or two days.
4. Staff can physically hold down a person for a short period of time. There could be various numbers of people holding the person, depending on the necessity in the specific situation.

The coercive measures I refer to in this thesis will initially concern these four types of coercive measures, described in the Mental Health Act (Mental Health Act, 1999).

The Act additionally regulates the use of Electroconvulsive therapy (ECT), also known as electroshock therapy. According to the Act, it is illegal to perform ECT through involuntary treatment, thus not directly relevant for this research project. ECT is used to treat depression and should only be used after informed consent (Mental Health Act, 1999). However, the United Nations Human Rights Committee has criticized the use of ECT in Norwegian facilities. The Committee expresses worry regarding the circumstances surrounding the use of ECT in Norwegian mental health care facilities. The scope is claimed to be diffuse, there is a lack of a second opinion of the use, and the treatment is managed by guidelines rather than legislation. The Committee criticises Norway for using ECT as a coercive measure (Human Rights Committee, 2018).

In September 2017, an amendment was done to the Mental Health Act (1999). One of the most radical changes of the Act, included that all persons committed in mental health care institutions should have their competence of consent evaluated. Persons with mental health issues could after this amendment not be committed coercively if they were competent to consent. But persons who seem to be dangerous for their own life, or others' life or health,

can still be forced to observation, shelter or treatment even if they are competent to consent. A requirement of evaluation after ending treatment has been inducted regarding involuntary isolation, examination and involuntary treatment, examination of room and property, personal search, involuntary intoxication search and use of coercive measures (Fylkesmannen , 2017).

The Patient and Consumer Rights Act (1999)

In chapter 4A of the Act regarding Patient and Consumer Rights (1999) health care without consent is presented. The aim of the chapter is to reduce the use of coercion and to perform necessary health care to prevent health damage.

According to §4-8 of the Act, coercive measures should only be used upon the patient when it is considered unsociably necessary to prevent him in hurting himself or others, or to prevent considerable damage of buildings, clothes, furniture or other things. Coercive measures should only be enforced when more gentle measures have already been applied in vain or seemed insufficient. Furthermore, coercive measures should only be applied by the professional in charge, unless something else is specified (The Patient and Consumer Rights Act , 1999).

1.5 Outline

In the first chapter of my thesis, I briefly outline the context of interest and the issue that will be studied further. To develop an adequate foundation for further research, legal framework, definitions of importance and research questions are presented.

In chapter two, I explore and review existing academic literature concerning coercion, which provides a thorough understanding of coercive treatment.

The third chapter of the thesis, introduces a theoretical framework with selected elements of Kantian- inspired theories, to explore the concept of dignity. The two main philosophers applied are Immanuel Kant and Ronald Dworkin.

In chapter four, I present my methodology. The methodology explores my method of research, process of conducting interviews, and further work with the research.

In the fifth chapter, I present my findings and analysis, organised into appearing themes. This chapter lays a foundation for upcoming discussion.

In chapter six I develop a discussion, relating the literature, theory and findings to answer the research questions of the study.

In the last chapter I give my conclusions regarding the research project, through shortly summarizing the thesis.

1.6 Terminology

In this section I will briefly introduce the decisions related to defining keywords in this thesis. Other terms are defined more explicitly throughout the thesis. I believe these terms need to be illuminated in the introduction, as they are the important throughout the whole thesis.

Patients

Persons in treatment of mental health issues can be referred to as both patients and consumers. The word patient is commonly related to being admitted to a hospital. Nevertheless, the scope of mental health care and coercive treatment can be larger than solely in hospitals. For this particular research project, it is essential that the interview subjects have not been interviewed inside mental health care facilities. Even though the patients have been referred to as "consumers" by for instance World Health Organisation (World Health Organization, 2001), the concept of consumers is considered as vague and objectifying in addition to elucidating the power relations between the system and the patient.

In this thesis, I will be referring to the focus group merely as persons. This is a choice of term, deliberately done with the aim of clarifying the importance that they are just as humane and dignified as any other human being, hence they should simply be referred to as persons. Referring to the Convention on the rights of Persons with Disabilities, the term persons is particularly used when talking about the focus group.

The concept of dignity also seems to relate to the term 'persons'. I believe that this awareness of terms can contribute to normalize the diversity of humanity. Inspired by Ramey's

understanding of the concept, the coercive treatment may not only affect the human being's physical body, but both moral and spiritual aspects, hence the whole person (Ramey, 2012). The use of the term also implements the fact that human dignity should apply to all persons and not just a selected group. However, the term patient will occur in chapter two, as the terminology used in the particular literature is applied in the chapter.

Dignity

Dignity, can be perceived in various ways and is also defined through different perspectives in this research project. To develop an understanding of the concept, it is illustrated through Kantian- inspired theory, however the main perception given importance in this research is based on the definition of persons with experience from mental health care facilities. Hence their definition and understanding of dignity is considered just as correct as any other definition.

Coercive treatment

According to Oxford Dictionaries, coercion is the action of persuading someone to do something by using force or threats. Coercive treatment can be understood as a fairly vague concept, and there seems to be different subjective interpretations of the relevant jurisdiction, and culture within institutions. Therefore, I have defined both coercive treatment within a legal context, and the persons' subjective perception of it.

Chapter 2: Coercive Treatment

In the following chapter, I will present and review relevant academic literature to the topic of coercion. I wish to examine the understanding of coercion, as it is one of the key concepts in this research project. By doing so, I wish to detect potential deficiencies in understanding the concept and understanding the perspectives of persons in confinement. The persons are referred to by using various terms in the following section. The terms used in the particular literature is also used in this section, to keep the originality of the literature. To search for existing contributions, keywords such as: coercion, coercion and dignity, coercion in Norway,

coercive treatment in Norway have been applied. The searches are done both in English and Norwegian, as some research or literature from Norway may not be translated into English. Search engines such as Oria, Idunn, and ProQuest have been used. Furthermore, reference lists in discovered literature are used to look for additional literature.

2.1 Diversity in Understanding Coercion

The term coercion can be interpreted subjectively dependent of varying situations. There are also different understandings of the term in existing literature. Coercion can differ dependent on the context of the coercive actions. For instance, coercion can occur in private situations such as forced marriages or as in forced labour. This thesis however, focuses on all coercive actions enforced while in coercive treatment, as in particular mental health care.

2.1.1 Subjective Interpretations of Coercive Treatment

Examining the literature, it becomes evident that perceptions of coercion vary widely. This can lead to complexity in narrowing the specific understanding of coercion. Syse (2002) has found that coercion as it is perceived from the patient's perspective, does not necessarily correspond with the voluntary aspect given by the law. A patient can perceive voluntary admission as coercive, according to the author. Furthermore, patients admitted involuntarily can also give their consent to medical treatment, even if they're not considered to be aware of the benefits of admission (Syse, 2002)

The Act Relating to Social Services of 2009 (Social Services Act) §6A-2 (2) introduces the only definition of coercion that is not based on consent (The Act Relating to Social Services , 2009). This adds the criteria which asserts that the admission should not be forced or coerced because of radical intervention (Syse, 2002)

Syse (2002)- especially significant for this thesis project, explores that a different understanding can be adopted when looking at the experiences and perspectives of the patients. This can differ greatly from the other legal definitions. Hence, the importance of the perspective in this research project.

2.1.2 Types and Dimensions of Coercion

The huge variety in understandings of coercion, adds complexity in comprehending or exploring the concept. Pedersen and Nortvedt (2017) divide coercion into three types. Firstly, the formal coercion which has come to decision through a legal decision. Secondly, patients who are voluntary admitted to psychiatric hospitals, experience pressure and execution of power from the health personnel, according to several studies. Thirdly, there is experienced coercion, which refers to the patient's own understanding of being forced to treatment (Pedersen & Nortvedt , 2017). These are the same forms of coercion as mentioned in the Official Norwegian Report from 2011 (NOU 2011: 9).

Høyer and Dalgard (2002) however, indicate that the term coercion can fluctuate amongst several dimensions and is adopted both broadly and narrowly. Using a broad definition of the term, the authors claim that hospital admission can be perceived as coercive if it does not happen on the initiative or wish of the patients themselves. This broad definition is often adopted in recommendations of coercive action in psychiatric health care. On the contrary, if we use a narrower definition of the term, the coercion will only happen when the patient actively or explicitly resists it.

Through exploring literature that acknowledges the different forms and dimensions of coercion, it becomes significant that it is not only a term, but rather a concept which can be perceived through different dimensions. Hence, it can be comprehended as fairly vague if not clarified explicitly. The variety of understandings also elucidates the importance of communication with people who have experienced coercive treatment in mental health care facilities, to emphasise their experience as opposed to the formal definition of coercion. And to develop a balanced understanding based on their experiences and perceptions.

2.1.3 Professional Inconsistencies Regarding Coercion

Within health- and care services coercion is commonly used as a generic term of actions which involve that one or more employees perform an action the client does not wish to be a part of or resists. The actions can, for instance, include pressure and use of physical coercion. If a person is exposed to threats or too much pressure, for instance threatening the patient that

he or she will be involuntarily medicated if the patient doesn't take the medication voluntarily, this is also included as coercion. Independent from the intention behind using coercion, it will always be an intervention in the mental or physical integrity of the patient, which raises important and difficult ethical and legal questions (Thune & Stavrum, 2012). Similar to Syse (2002), Thune and Stavrum (2012) also note that research reveals examples from psychiatric patients who experience extensive use of coercion even though they are legally admitted on a voluntary basis (Thune & Stavrum, 2012).

Earlier studies show that patients who was involuntary committed were subjected to coercion, and patients who were voluntarily committed were not. However, some recent studies show that some of the voluntarily admitted patients have been subjected to coercion, and on the contrary, some committed patients believe they are hospitalized in a voluntary basis. (Høyer , et al., 2002)

Høyer et.al (2002) argues that one of the reasons we lack empirical knowledge of coercion, is because it's poorly defined. The relation between the legal understanding of coercion and the defenders of coercion, is connected to paternalism. The coercion in psychiatric health care can both be the obvious physical power towards the patients and the more hidden forms of coercion that can be difficult to register. Studies of how patients perceive coercion also suggest that their experience is dependent on the extent they're included in decisions (Høyer & Dalgaard, 2002)

By exploring different perspectives of coercion, it becomes evident that despite different perceptions, majority agrees that coercion is a comprehensive term. There is also an agreement among several authors that there is a misconception between the formal and legal perspective of coercion versus how it is practised and understood by the patients. This leads us to the importance of how coercion is practised in treatment, which is explored in the next section.

2.2 Enforcement of Coercive Treatment in Psychiatric Institutions

The following section, explores literature regarding the practise of coercive treatment. By exploring the practise of coercive treatment, the research aims to illustrate possible gaps, that can reveal the reason why coercion is perceived as vague by several authors.

2.2.1 Disagreements Regarding the Necessity of Coercion

Some research examines the use of coercion in psychiatric confinement, in particular focusing on its use by medical professionals. Studies done by Lützen (1998), for instance show that nurses had their own goals for their patients, and to achieve these goals they used various types of subtle coercion. The nurses considered these goals and actions as being in the best interest of the patient. The study reveals that there is a need for more research concerning situations in clinics that include subtle coercion and nurse discretion. The authors claim that there should be an emphasis on how organizational factors contribute to the use of the coercion (Lützèn, 1998).

Raboch et.al (2010) have found that there is a lack of studies concerning involuntary treatment in mental health care. It is substantial to remark that there is a gap of twelve years between Lützèn's (1998) and Raboch's studies, and that there is still found a lack of research on the topic after these twelve years. Organizations and institutions have criticised the situation of coercive treatment in different psychiatric health care facilities and claim that several are lacking when it comes to care. On the other side, many agree that the use of restraint and isolation might be necessary (Raboch, et al., 2010).

Husum et. al (2010) *"investigates to what extent use of seclusion, restraints and involuntary medication for involuntary admitted patients in Norwegian acute psychiatric wards is associated with patient, staff and ward characteristics"* (Husum, Bjørngaard, Finset, & Ruud, 2010, p. 1). The authors claim that the use of coercion in treatment is questionable and that reducing the use of coercion should be a political aim. They continue to argue that an increased use of coercion, could influence the quality of the care, and also the human rights of the patients (Husum, Bjørngaard, Finset, & Ruud, 2010).

Scientific literature on coercion shows the desire to reduce aggression and violence, and prevent coercion in psychiatric hospitals, as it can be incriminating on both patients and staff. In the study, patients acknowledge that coercion could be necessary, but the experience is considered to be traumatising. It could be perceived as less traumatic if the patients know the staff, and there is physical contact and closeness present. The patients feel insecure as a result of coercion. In situations where the patients feel failure as a human being, the violence against

their integrity can cause feeling ignored, fearful, disgraced and frustrated (Thyrsting & Hall, 2008).

Syse (2006) however, focuses on the fact that there is an immense attention towards coercion being illegal. He mentions that there are exceptions, where the coercion is considered necessary and reasonable in situations. It is nevertheless important that actions are not taken without authority (Syse, 2006).

Falkanger claims that the most radical treatment a patient can be exposed to, is forced drugging with antipsychotics. Even if it is for the patient's best interest, also Falkanger agrees that it radically intervenes the personal integrity of the patient, and that it could cause harmful consequences (Falkanger , 2017). Some of the consequences are claimed to be increased death rates, particularly increased suicide rates, brain damages and motoric difficulties (Lund & Gøtzsche, 2016).

The literature reviewed in this section of the thesis, illustrates that there are disagreements on the necessity of coercive treatment. However, a great majority of the authors agree that the use of coercive measures should be reduced, as it can be harmful, even claimed to be illegal. By claiming that the coercive treatment should be reduced, the authors open up for a legal discussion concerning the situation of people with experience from mental health care facilities, and their awareness of the jurisdiction relevant to the situation.

2.2.2 Emphasising Converse Standpoints

Legal framework and relevant academic literature, makes it evident that Norway has declared a goal to reduce the use of coercion in national psychiatric healthcare. To reach the goal this research project finds it is essential to develop services based on the patients' own experiences with the coercion, and the standpoints of subjects who subsequently are displeased with and critical to the use of coercion.

There are mainly three points that need to be clarified to understand the contradictory perspectives of patients and staff regarding coercion. First of all, staff and patients often have a different view on how the staff should behave towards the patients whilst in treatment. Secondly, patients who have experienced coercion have a unique and subjective knowledge of the coercion. Lastly, the staff knows what they want to achieve with the coercion, and they

might find it hard to look away from this when considering and measuring the coercion (Nasjonalt senter for erfaringskompetanse innen psykisk helse, 2012).

To succeed in reducing coercion there is a need of knowledge about the practice. Studies show that competent patients are important to contribute to a variation in the occurrence of committed patients (Bergem, 2016). Kuosmanen et. al (2007) shares the same point of view as Bergem (2016). The authors claim that patients should be given increased power, through the policies. The mental health care facilities should be supportive, autonomous, expressive and practically oriented. The authors suggest that the patient's own views could give importance to some views on liberty that are not given significance in the clinical work yet (Kuosmanen, Hätönen, Malkavaara, Kylmä, & Välimäki, 2007).

From this section we can comprehend that there are disagreements regarding the necessity of coercion, in existing literature. However, several authors acknowledge that the use of coercion might be necessary, while some claim that the use of coercion can be an immense intervention. A variety of authors emphasise the importance of giving patients in mental health care a voice, when making decisions regarding the enforcement of coercive treatment. Thus, the importance and relevance to the topic of this thesis. Nevertheless, the facilities also have to comply with legal instructions.

2.3 Complying with International Recommendations on Coercion

As a country that has ratified a great range of international legislation, Norway attempts to assure the national law complies with international standards. Thus, the significance of how the understanding of coercion within international spectrum fluctuates. These variations or lack of a rigid understanding of coercion internationally, will have an implication on why Norwegian law might be understood as confusing. Furthermore, this will influence the experiences of the persons regarding coercion.

2.3.1 Nationally Initiated Actions Concerning Coercion

Literature reveals that by examining actions taken by the Norwegian government to improve circumstances concerning coercion, the government has been aware of the situation, and that

actions have been taken to improve it. Among the efforts, is the Paulsrud Committee presented in the following section.

In May 2010 the Norwegian government appointed a committee to elucidate and evaluate decisions about coercion in psychiatric health care. The committee aimed to reduce and enforce quality control on the enforcement of coercion. The committee was managed by the lawyer Kari Paulsrud, in addition to people with backgrounds of: law, health care, police and as patients or relatives (Ministry of Health and Care Services, 2010).

In 2011 the Paulsrud committee suggested amendment of the Mental Health Act (1999) and the Patients' Rights Act (1999). The aim of the modification was to strengthen the right of self- determination and legal protection of people with severe mental illnesses, as well as the society's responsibility to take care of the specific group. Part of the aim was also to prevent and reduce the use of coercion in the psychiatric health care (NOU 2011: 9).

According to Gabrielsen (2012), two aspects of the committee's recommendations were particularly central to the perspective of discrimination. Firstly, the emphasis on the patients' decision- making capacity, which is regulated by Patients' Rights Act (1999) and the Mental Health Act (1999). Secondly, the access to coercion in the treatment is considered differently in the Patient's Rights Act than the Mental Health Act and other legislation, by legalizing offensive intervention. Thus, it allows for coercion without the requirement of substantial health damage (Gabrielsen , 2012).

There is some criticism of the committee's suggestion. From the medical standpoint there is an objection to how it adopts a legal view of the situation. From the patients' point of view, on the contrary, they object to the fact that the committee did not do enough to reduce the occurrence of coercion (Gabrielsen , 2012).

The section presented, makes it evident that the work of the Paulsrud Committee was significant for the patients in mental health care facilities, as the Committee suggested an amendment of national legislation, for the best interest of the patients. These changes were considered and emphasised as important by the Norwegian government as well and the amendment of the law was accomplished. The actions prove the importance of such a committee and the involvement of different standpoints. Furthermore, the diverse background of the individuals in the Committee; including patients, is relevant to this research project.

The efforts prove that it is advantageous to include and listen to the persons who have experienced the coercion themselves.

2.3.2 Significant International Understandings of Coercion

Various international legal institutions address the notion of coercion in health circumstances. It is important to note that because of the controversy or changing ideas about the concept of coercion, the international law or treatment of international cases has changed over time.

In the World Health Report (2001) by the World Health Organization (WHO), several recommendations for actions to be taken within mental health care are presented. In their constitution health is defined as not only the absence of a disease or infirmity, but *"rather a state of complete physical, mental and social well- being"* (World Health Organization, 2001, p. 3). According to the WHO, this definition has attracted increased attention during the recent years.

WHO claims in their report that the model of mental health care has changed the past fifty years, by changing from *"institutionalization of individuals suffering from mental disorder to a community care approach backed by the availability of beds in general hospitals for acute cases"* (World Health Organization, 2001, p. 47). They claim that there has been a change regarding human rights for individuals with mental health disorders, as well as changes in interference techniques (World Health Organization, 2001).

The report refers to the persons as consumers and presents their role in mental health care by emphasising the importance of listening to their voices, and including professionals, family members, legislators and opinion leaders. It is important to look past the diagnoses and see the individual as a human being just like any other (World Health Organization, 2001).

Concerning the area of interest in this thesis project, WHO's definition of health, is perceived as somewhat vague. Their report initiates change in mental health care, but whether these changes have actually happened, is still a question left without an explicit answer. The fact, that the report not only focuses on mental health care in Norway, but internationally is also a point to be noted. However, several comments have been done by international bodies, regarding coercive treatment in Norwegian mental health care facilities. Some of these comments will be explored in the next section.

2.3.3 Interference of International Bodies in Cases Regarding Coercion

There are several international bodies that have dealt with cases regarding coercion. They have also adopted different terms which may reflect a change in understanding the patients' dignity. In a submission made to the Human Rights Committee regarding persons with disabilities, the Committee presents a paradigm shift in the Convention on the Rights of Persons with Disabilities (Committee on the Rights of Persons with Disabilities, 2013). The perspective of addressing people as patients has changed from the medical model to a rather social model, considering them as equalised as any other human being, with equal human rights. Furthermore, the Committee refers to two Special Rapporteurs on Torture and the High Commissioner for Human Rights which both agree that detention of people with disabilities can cause ill- treatment and torture (Committee on the Rights of Persons with Disabilities, 2013).

In another appeal from the United Nations Special Rapporteurs on the rights of persons with disabilities, on the World Mental Health Day, the Special Rapporteurs *"called on States to eradicate all forms of non- consensual psychiatric treatment"*. They requested all states to end all forms of arbitrary detention, forced institutionalisation and forced treatment, so that all people can be treated with dignity and attain rights on equal level as any other human being (OHCHR, 2015)

In 2007 Oslo University Hospital, Aker was sentenced for violating human rights by Oslo district court. A pregnant woman was involuntarily examined and isolated for 24 hours. She was also separated from her daughter against her will. The Court claimed that all the enforcement during her treatment violated the European Convention on Human Rights (VG, 2007).

In January 2017, the case of a man from Norway was presented to the Office of the High Commissioner for Human Rights by the Working Group on Arbitrary Detention. The man had been committed to compulsory mental health care facilities multiple times. After several admissions without consent from 2006 and onwards, he appealed his case four times to the Supervisory Commission against the negative impact of the confinement on his quality of life. All four appeals were rejected, and the supervisory commission argued that the actions were imposed out of medical necessity concerning the man's condition. Furthermore, he brought

his case to Oslo District Court, then Borgarting Court of Appeal and finally to the Supreme Court. The case was rejected in all three courts. (Bermúdez, Devandas- Aguilar, & Püras, 2017)

The two cases introduced in this section, have had different outcomes regarding the decision of the court. However, what they have in common is the question of whether there are human rights violations in Norwegian psychiatric facilities. It is also of interest that there is a margin of ten years between the cases. Hence, possible changes of legislation may be of interest to improve the situation.

By examining literature on the interference of various international bodies regarding coercion in mental health care, it becomes evident that a great majority of the bodies agreed that different forms of coercion can be harmful for patients in confinement. Examples presented in the section, indicate that coercion can have negative impact on the quality of the persons' life and their inherent dignity. The literature contributes to illuminate the importance of this thesis project and contextualise it through international interference. However, just as important as interference of international bodies, is also the participation of the persons in treatment. This will be illustrated in the next section

2.4 Patients' Participation and Consent During Confinement

In Norway, there has been an increased focus on the need for consent during confinement. This is observed through reinforcement in the literature for the need of consent. In the Official Norwegian Report from 2011 (NOU 2011: 9) patients' consent to treatment is highly emphasised. The report suggests that mental health care is divided between voluntariness based on legal consent on one hand, and voluntariness without legal consent on the other hand. Chapter four of the report presents that the normative starting point of the health legislation is that human beings are autonomous and dignified. Furthermore, the report refers to international human rights documents on the topic. Nevertheless, the demand for consent stresses the respect for integrity and dignity of every patient (NOU 2011: 9).

Literature regarding patients in confinements, reveals the importance of listening to them, which is exactly what ought to be highlighted in this thesis project. Høyer and Dalgaard (2002) claim that the right to autonomy and self- determination are parts of values that need to

be ensured in terms of "weaker" groups interests. These are also some of the fundamental ethical conceptions presented by the two authors. However, they also illustrate that the impression of people with mental disabilities as not able to comprehend a situation, is very common. They are not considered able to make rational decisions themselves. Authors highlight that if interventions do occur with this perspective, then forms of paternalism may be evident. Nevertheless, research proves that plenty of the patients in coercive treatment have a sufficient understanding of the situation, of what a coercive confinement involves, and what the alternatives are, even if they continue to refuse confinement (Høyer , et al., 2002).

International literature also reflects the relevance of consent in all situations of medical wards. In World Health Organization's report from 2001 it is stated that the traditional view, presents consumers of mental health care as passive recipients, who cannot utter their needs and wishes, hence they have to consume treatment made by others. However, this has changed the past 30 years, and they can now express their needs more than before. The consumer organisations around the world are also very significant concerning this matter (World Health Organization, 2001).

From the literature explored in this section, it becomes evident that there is an agreement in the majority of the literature that the persons' participation and consent during confinement is important. The literature also makes it evident that there has been an improvement, concerning the participation of patients, and their ability to take part in decision making. Nevertheless, that does not imply that the current situation is sufficient enough. Thus, the importance of this research project which aims to give people with experience in mental health care facilities a voice that can be heard.

2.5 Coercion as an Ethical Issue

Ethics, or moral philosophy, explores what is right and wrong, and what is good or evil in a social context. This can however be considered as a somewhat simplistic definition of ethics. Complexity in the literature reveals that no one perspective has the right to define what is right or wrong concerning the occurrence and use of coercion. Even though it is important to search for legal origins of the ethics, some authors argue that legally legitimate actions could still be unethical (Poulsen, Gottlieb, & Adserballe, 2000).

Considering coercion as an ethical issue, the literature observes it from two perspectives. On one side, it is the duty of the psychiatric institution to use coercion in treatment of their patients. Hence, they receive a power which has the potential to be misused, and therefore requires regulation by society. There are no such professions today, that have unlimited power to decide when it is correct to deprive a citizen of their freedom and personal integrity. On the other side, it is the doctors' duty to save lives through correct and effective treatment. Legal protections, however, should remain carefully considered. The aim is to find a balance that secures both the treatment and protection (Poulsen, Gottlieb, & Adserballe, 2000).

Hem, Molewijk and Pedersen (2014), have found that defining the term coercion is also ethically challenging, because it affects the power of the professionals. The authors suggest that recent research implies that health care practitioners regularly experience ethical challenges when working with coercion. The ethical challenges occur when there is either doubt or disagreement about what is right or good. The authors claim that the coercion is a threat to the autonomy of patients. They add that coercion has unfortunate consequences for the patients and threatens the understanding of what is good care and treatment (Hem, Molewijk, & Pedersen, 2014).

According to Ohnstad, the main aim of the health legislation is to make sure that dignity and relation of trust between patient and health service is secured. The legislation opens up for ethical reflection and occupational judgement. Paul Leer- Salvesen finds it important that health care services emphasise ethics before jurisprudence. Ohnstad claims that the health legislation is based on ethical norms. But the normative legitimacy of the norms is narrower than the legislation, hence the disagreement on what is ethically acceptable or not within the health care service. The author argues that several of the decisions in the health care services are very radical, among them coercion in the psychiatry. But that most people – including the patients and their relatives- would agree that the coercion is desirable and necessary. The main aim of the health legislation is to secure the dignity and the relation of trust between patient and health care. The framework of ethical reflection and occupational judgement is wide. So, saying this, the moral decency and charity are not the contrast of law-abidingness, but law-abidingness is a part of the hierarchy of dignity, which the ethics are based on (Ohnstad, 2005).

There seems to be a debate between ethical and legal understandings of coercion on one side, and patients and health care professionals on the other side. The variety of understandings are

presented in this chapter as they are all considered important in the research. However, the understanding emphasised the most in this research project is the perspective of people with experience from mental health care facilities, which opens up for an ethical discussion of the legal aspect. Similar to the different understandings of coercion, there are also different definitions and perceptions of the concept of dignity. The understanding implied in this thesis, is the Kantian and New Kantian perspective, which will be explored in the next chapter.

Chapter 3: Dignity

The concept of dignity is one of the most debated concepts of moral philosophy. Authors such as: Avishai Margalit, Catherine Dupre, George Kateb, Martha Nussbaum, Immanuel Kant and Ronald Dworkin speak of the concept. Based on the applicable nature of Dworkin and the seniority of Kant in philosophical theory, these philosophical frameworks have mainly been adopted. However, I do not apply the theories blindly to the research, but critically select relevant elements of the theories.

Kant is considered to be the source of the concept of dignity, thus essential for this section. After examining Dworkin's theory regarding dignity, it became evident that several of the main topics he presents in his theory, are related to the topics which appeared during the interviews, and further connects to the topic of dignity. Dworkin's theory also, to some extent reflects and shows similarities to Kant's theory. This research would suggest that despite Dworkin's slight legal focus, he could be considered a modern Kant. Hence, referring to his theory as the New- Kantian theory.

3.1 Kantian Theory

In the following section, I present selected elements from the Kantian theory. The section, is not an overall presentation of the Kantian theory, but rather a selection of the elements found most relevant for this specific research project. By applying the Kantian theory to the project, I develop an understanding of the concept, which will lay a foundation for further analysis and discussion.

3.1.1 Dignity

The Kantian understanding of dignity, also called the rational understanding, is one of the five main understandings of the concept besides Christian, Aristocratic, comportment dignity and meritorious (virtue) dignity (Schroeder, 2010). The rational understanding of dignity, is particularly interesting for this research project, as the rationality of people in treatment of mental health care facilities, is often questioned. The Kantian definition of dignity, emphasises that there is nothing equivalent to dignity, ergo it is 'beyond price'. As he puts it:

> *"What is related to general human inclinations and needs has a market price; that which, even without presupposing such a need, conforms with a certain taste has a fancy price, but that which constitutes the condition under which alone something can be an end in itself has not merely a relative value, that is, a price, but an inner value, that is, dignity"* (Kant, 1998, p. 84).

According to Kant, even career criminals deserve to be treated as human beings with inherent dignity (Kant, 1998). Kant claims that every single human being has inherent dignity. When questioning where this dignity comes from, some religious people may state that the dignity comes from God, or that the dignity is present by the virtue of being made by God. However, the Kantian view gives importance to the human being as *rational*, hence we can set good or bad ends for ourselves and therefore, we have inherent dignity (Kant, 1998).

Applying this part of the Kantian philosophy to the context of the research study, it suggests that also the persons in coercive treatment should be treated with dignity, based on their ability to be rational. The view lays a foundation for discussing what the definition of dignified treatment in such a situation is, and whether the purpose of the action could be of importance when understanding the dignity. The relation between rationality and dignity also seems to be significant.

According to Sensen's (2011) interpretation of the Kantian conception of dignity, the concept can be perceived as a name for value as a method resulted from the moral law. The author claims that Kant sometimes describes dignity as a value, which appears in the outline above as well by for instance saying that *"inner worth, that is, dignity"* (Kant, 1998, p. 435), and by saying that *"dignity, that is, an unconditional incomparable worth"* (Kant, 1998, p. 436).

Sensen argues that the Kantian conception of dignity is rather complex, and relative; "*Rather I shall argue that Kant uses 'dignity' to express that something is raised above something else"* (Sensen, 2011, p. 144). For instance, Kant considers humanity to be raised above any other species based on possessing freedom and reason. In the relative context described, he argues that *"something – morality- has an elevated standing, not merely a relative value, but a higher absolute inner value"* (Sensen, 2011, p. 144). By applying this point of view to the research project, the question of whether the patients possess this absolute inner value, particularly concerning the two key words freedom and reason, is raised.

Avishai Margalit (1996) disagrees with the Kantian philosophy on certain aspects. When commenting upon features to justify respect for humans, he indicates disagreement towards the Kantian view on value. Margalit refers to the theory on use value and exchange value by Adam Smith. *"Use value is the value of the benefit obtained from an object in the fulfilment of human ends. Exchange value is the object's power to induce other people to give up other objects of value in order to obtain it."* (Margalit, 1996 p. 67). The exchange value mentioned, refers to the same as what the Kantian philosophy calls price. The distinction is made because there is a difference between the subjective estimation of the object, and the objective assistance to achieve human ends.

As opposed to the Kantian understanding that a human being is irreplaceable because of intrinsic value, Smith's idea suggests that the object is replaceable. Margalit notes that the Kantian perspective claims that the restriction on elements that justify granting people respect is the same elements that have to justify granting human beings that particular intrinsic value. There is no use value or exchange value present in the Kantian theory. Margalit raises questions concerning the Kantian understanding of dignity, by asking whether his justifying traits actually obey his disagreement towards the intrinsic value. Margalit confronts the Kantian understanding of justifying respect for human beings. He argues that *"the only traits which confer intrinsic value can justify respecting people as human, while traits with instrumental value cannot be justifying traits of this sort."* (Margalit, 1996 p. 69). Margalit finds the argument mentioned restrictive.

3.1.2 Ends and Means

Immanuel Kant states that one should *"act that you treat humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means"* (Kant, 1998, p. 429). This is known as the formula of humanity. In this research project, the formula of humanity is understood as the notion that you should respect other peoples' status as beings of moral worth, as well as respecting yourself. We are not mere objects, that exist to be used by others. We are our own ends; hence we are rational and autonomous to set our own goals and work towards them. For instance, service professionals such as bartenders, taxi- drivers and cleaners. A question raised is whether these people are used as means. The Kantian perspective acknowledges that they are not being used as mere means as long as we remember that they have their own ends. Thus, not correct to step on them or look down upon them (Kant, 1998). Similarly, the persons in this particular research project, also have their own ends, when applying the Kantian philosophy to the context.

According to Kant, one of the reasons we all deserve to be treated with respect, is because we are free human beings who not always will, but *can* set ends for ourselves, that can be endorsed by other rational human beings. He emphasises the fact that we are not like other beings, we are able to be respected and we are capable of respecting other people, and ourselves. We do so by choosing the right ends and the correct motives. Further, Kant states that we deserve to be treated with respect because we *can* be moral beings. In other words, we can choose with our free will to do the right things (Kant, 1998). This indicates the relation between morality and dignity.

The question of whether there is anything that has an 'end' in itself, is relevant to the context of this research project, as well as how value may be measured. To go thoroughly into these questions, we can ask whether it for instance, is possible to trade a person for a certain number of iPhones? Clearly, these are not comparable as people have a different value. This value of a human being, is what Kant defines as dignity (Kant, 1998).

O'Neill (2013) claims in her interpretation of Kant, that he accepts seeing worlds without beneficence and worlds in which nobody develops their potential. The author states that it is not rational for people who know that to achieve their goals they might need help, to ignore either beneficence or development of their own potential. If such an action is taken, these

people overlook conditions that are considered necessary for their own search for ends (O'Neill , 2013).

Furthermore, O'Neill (2013) states that, the Kantian theory characterises the agents dependent on what ends they have. If the end is to complete your work or achieve one of the obligatory ends, then the agents are considered to have a '*pure motive'*. However, if the agents' end is to fulfil some sort of desire, then the action is referred to as acting from '*inclination'* or from an '*empirical motive'*. These desires do not appear, neither are they chosen, rather we just have them. Similarly, if we wish to have any desire, we cannot simply achieve them by choice. The author also separates feelings from duties (O'Neill , 2013).

Sensen (2011) also raises several questions concerning the Kantian philosophy. When Kant refers to respect, he argues that all human beings should be respected. However, not everyone has a morally good will, and this morally good will is what includes an absolute value. *"Or if a value is supposed to be the foundation of moral requirements, why does Kant argue that no value can ground moral requirements?"* (Sensen, 2011, p. 1). Furthermore, Sensen questions Kant's argument that human beings have dignity because they should be respected. *"Why not that they should be respected because they have dignity?"* (Sensen, 2011, p. 1). Implying Sensen's interpretation to the research project, dignity seems to be a result of how the persons are treated. The interpretation also seems close to Margalit's understanding of dignity. Both interpretations relate to the question of metaphysics and indicate the relational aspect of dignity.

Contextualising the concept of ends and means to the situation of the patients, this research questions whether they are being treated as mere means, particularly when referring to their experience with coercive measures. Furthermore, it is suggested that by implying a Kantian perspective to the situation, we can argue that the persons deserve to be treated with respect, on the virtue of humanity, and the approach that they might not be able to set ends for themselves in the moment, but they are still able to do so in the future. However, this issue cannot be discussed without looking into the perspective of the professionals, which relates to the concept of morality. This concept will be explored in the next section of the chapter.

3.1.3 Morality

Kant emphasises that the consequences of our actions do not matter as long as we do the actions in good will. It is however important that we are not told to do so, rather we have to act on our own initiative; the moral law has to come from ourselves. He grounds the morality in logic, and states that we have to listen to reason, and some reason cannot be ignored, and apply to everyone. This means that the rightness or wrongness of one's actions are independent of their consequences. Rather, the motivation behind the action or the reason why one act in such a way, is of importance. Thus, being bad does not make sense. However, one is only considered to have moral worth, accordingly being a good person, if the actions are motivated by morality (Kant, 1998). Applying the notion to the context of the research project, this can be considered from to perspectives. On one hand, the reason or motivation of the practitioners to enforce the coercive measures can be discussed, and on the other hand the reason or motivation of the persons in treatment to act out and maybe want to harm themselves can be discussed.

In what we do, we contribute to what is normal human behaviour, and we have free will to make our choices good or bad. In a sense we set examples for others. Kant also recognises that there is a disconnection between our choices, and what happens in the world of sense. But that does not distract from the goodness of our choices. The tension between wanting to do good and accidently killing somebody is a good example of this. Because the intention behind accidentally killing someone was not bad, the consequence is not considered bad as well. However, if the intention behind the incident was to kill the person, then the action can be considered wrong and bad (Kant, 1998).

When reflecting on the aspect of morality within the Kantian theory, the reflection of whether there is anything that is unconditionally good, can be done. Some may consider health as something unconditionally good. But what if this health allows you to be a very successful mass murderer? The example shows that the health in itself is not necessarily good, but rather the intention and the will that is good.

O'Neill (2013) raises some questions regarding the Kantian theory, and it's understanding of morality. Firstly, the author asks, *"if morally worthy acts are those done for the sake of moral law, why should acts done to treat other rational natures as ends, to perfect ourselves, or to make others happy be considered morally worthy?"* (O'Neill , 2013, p. 131). The author

continues to challenge the intention of moral actions, by asking why one should assume that actions taken for ends are done with a moral motive. O'Neill's question opens up for a critique of the professional's morality in this particular research project, as opposed to Kant who believes that all human beings are capable of being rational and moral.

Avishai Margalit (1996) presents certain components of Kantian philosophy that give humanity value. Margalit claims that some of the components presented by Kant, do not justify his own first two conditions, which describe that they should not be graded or abused. The author states that the traits described in Kantian philosophy are possessed by people in different degrees. This means that the traits are not the same in all human beings. However, he finds it concerning that the traits presented by Kant can be abused. For instance, if a person acts immorally, even though the person has the Kantian trait of living a moral life, Margalit asks why these persons should be treated with respect. Thus, Margalit argues that this in itself is reason enough to not respect criminals, based on their ability to act immorally- hence desecrating their humanity (Margalit, 1996).

Exploring the Kantian perspective of morality, it becomes evident that the actions within mental health care facilities could be seen from two perspectives. On one hand, one could consider the actions of professional health care workers while enforcing the coercion, and whether they, for instance, are putting the patient in restraints based on good reason. On the other hand, this thesis project focuses on the perspective of the patients, thus the Kantian understanding can suggest that the patients have free will to make their choice good or bad.

3.1.4 Hypothetical Imperatives and Categorical Imperatives

In the context of morality, imperatives are understood as commands. The Kantian theory has made a distinction between the things we ought to do morally, and the things we ought to do for other immoral reasons. Most of the time, independent of whether or not we ought to do something is not necessarily a moral choice, but rather it is only contingent on our desires. From this we can understand that if you desire to earn money, you will aim to get a job. These statements of 'if- then' are called hypothetical imperatives. The hypothetical imperatives give importance to having a choice and a desire to do something (Kant, 1998).

The categorical imperatives however, are the things we *have* to do regardless of our desires. These categorical obligations are our moral obligations; hence the Kantian philosophy indicates that it derives from pure reason. It does not matter whether you want to be moral or not, because you are simply bounded by the moral law to act according to the categorical imperatives. This does not mean that we should only do something if it is good for everyone. Rather, we should only act a certain way if it makes sense that everybody would act the same way. According to the Kantian theory, these actions result in being moral. In a sense, we are setting examples to others through our actions. In what we do, we contribute to what is normal human behaviour, thus we universalise our actions. In such a context, the Kantian theory suggests that one should not make exceptions for yourself (Kant, 1998).

When asserting the hypothetical imperatives to the topic of this research project, it becomes evident that the professional health care workers in mental health care facilities will most likely be enforcing coercion, based on moral reason. However, the findings in the project may suggest otherwise when seen from the persons' perspective. Seen from Kantian perspective, we can argue that professional health care workers must act in such a way, because of their moral obligations just as the categorical imperatives suggests.

Through the criticism presented of Kant, it becomes evident that he might emphasise the rational human being too much. In such a context the dignity may be considered as synonymous to rationality. This is not the understanding applied in this research project. Rather, the perception applied is that dignity is something all human beings possess, a quality all human beings have. This makes the understanding of Kant in this particular research project rather nuanced. To develop the nuanced aspect of the theory further, the New- Kantian philosophy is explored in the next section of the thesis.

3.2 New- Kantian Theory

The concept of dignity, as described through the New- Kantian theory by the philosopher Ronald Dworkin, and as perceived in this research project, relates to different essential principles of the concept. The philosopher describes ethics as the study of how we live well, and morality as the study of how we should treat other people. This distinction, characterises his Kantian tendencies, and is considered his moral theory. Dworkin is particularly known for his work *"Justice for Hedgehogs"* (2011) and is a modern philosopher.

3.2.1 Political Morality and Distributive Justice

Dworkin presents different branches to the concept of morality. He introduces his book by illustrating the concept of political morality, through two guiding principles. Firstly, Dworkin believes that government should show equal concern for the fate of every citizen over whom it claims to govern. Secondly, he emphasises that the government must respect the responsibility and right of each person to make something a value of their life (Dworkin, 2011).

Dworkin claims that the two principles presented, limit the theories of distributive justice. The theory of distributive justice is described as the equality of resources (Dworkin, 2002). These theories are *"theories that stipulate the resources and opportunities a government should make available to people it governs"* (Dworkin, 2011, p. 2). He argues that there is no politically neutral distribution; hence every distribution has to be justified by showing how it respects the principles of equal concern and respect for responsibility (Dworkin, 2011). The theory of distributive justice is also related to the notion of unintended harm in the New-Kantian theory. Similar to the Kantian theory, the New- Kantian theory emphasises the intention behind an action. For instance, Dworkin claims that one may accidentally hit someone with their car. The harm is committed unintended, therefore the person committing the action will not gain anything from it. However, the philosopher asks: *"Who should bear the costs of these accidents?"* (Dworkin, 2011, p.290). The question of compensation is considered as a moral question related to the distributive justice, as well as an ethical question regarding the relation between judgemental and liability responsibility (Dworkin, 2011).

People themselves are not responsible for what determines their place in society. Referring to the second principle, there is nothing that would entitle the government to adopt a position which leads to such great inequality. For instance, if the government says they will provide wealth as completely equal to all citizens, that would not respect the responsibility of people to make something of their own life. This is based on the argument that people make choices according to the consequences of their choices (Dworkin, 2011).

By applying Dworkin's principles of political morality, to the research project, one can argue that the government should equally respect the dignity of persons with experience from mental health care facilities, as any other citizen. Secondly, this research project suggests that

the government should respect that these persons have the responsibility to make something a value of their life. However, whether these people are able to make something a value of their life, dependent on their mental health care, is another question left for later discussion. Comparing the New- Kantian understanding of morality to the Kantian understanding of the concept, it becomes evident that the New- Kantian philosophy focuses on political involvement in a larger extent than the Kantian understanding. The two diverse understandings focus on morality as externally influenced factor versus internally influenced factor.

3.2.2 Liberty and Freedom

Dworkin continues to construct a theory of liberty and defines freedom as an action of doing anything one would like to do, without government restraint. Liberty on the contrary, is illustrated as a part of the freedom which the government would do wrong to constrain. The philosopher indicates that he does not accept any general right to freedom, but he supports having the right to liberty (Dworkin, 2011).

The New- Kantian philosophy has described liberty through three branches. Firstly, people have the right to ethical independence. Secondly, people have the right to free speech. Thirdly, people have the right to govern themselves. The latter is understood as using resources that are rightfully yours, as you wish, provided that you do not use them to harm others. Following, also the distinction between negative and positive liberty. For instance, *"the popular view that taxation invades liberty is false on this account provided that what government takes from you can be justified on moral grounds so that it does not take from you what you are entitled to retain"* (Dworkin, 2011 p.4). The particular view makes a foundation to believe that even though the 'government' deprives you of your freedom, there is a moral justification for doing so. This also suggests that there are certain elements everyone is entitled to retain, also the persons in treatment.

Dworkin questions whether morality can be true and states that moral responsibility is an important virtue. We must expect responsibility from our fellow citizens, hence form a theory of responsibility. By developing such a theory, he notes that we could respond to people in disagreement, but still tell them that we recognize the integrity of their argument, and their

moral responsibility. Such a theory can also be referred to as moral epistemology, because one is able to think good or bad about moral issues (Dworkin, 2011).

Dworkin argues that a theory of moral epistemology is part of a substantive moral theory, further connected to a theory of interpretation. The moral epistemology is described as our account of good reasoning regarding moral issues. He claims that moral reasoning is interpretative reasoning. *"Our moral judgements are interpretations of basic moral concepts, and we test those interpretations by placing them in a larger framework of value to see whether they fit with and are supported by what we take to be the best conceptions of other concepts"* (Dworkin, 2011 p. 12). His interpretative approach is based on the fact that we all generalise. The philosopher also emphasises that this interpretative approach needs to be taken to all moral and political concepts (Dworkin, 2011).

By applying Dworkin's definition of freedom to the persons in mental health care facilities, we can understand their freedom as the action of doing whatever they want, to themselves or to someone else. However, by applying his definition of liberty, which he rather supports, we can see that as a person in treatment you might be in danger of harming yourself or others. Therefore, patients still have three basic rights that Dworkin presents, provided that they are not harmful towards others, and themselves as well.

3.2.3 Free Will and Responsibility

Dworkin disagrees with the notion that we have no responsibility because of a lack of free will. This is however, connected to the ethical question of what the character of a life well lived is. The philosopher presents a division, between the definitions of ethics, as between the study of how we live well, and morality- as the study of how we should treat other people (Dworkin, 2011).

The two ideas of free will versus responsibility are separated in the New- Kantian philosophy. When referring to the principle of self- respect, Dworkin stresses that everyone has the responsibility to take their own life seriously. It is important to give your life value and to believe yourself that your life matters. This particular value, a person can give to life, is called adverbial value, which is the value in how you lead it, and not in what you leave behind. The second principle, is the principle of political morality, which was introduced in the previous

section. Through this principle, the philosopher argues that every individual must accept their responsibility to identify for themselves, what counts as living well. Hence, defining for ourselves what actions would result in adverbial value. Dworkin argues that such actions need to be taken. These principles are based on the virtue of humanity; thus all human beings share these principles simply by having a life to lead, and a death to face. This is considered the basis of sound morality. Furthermore, life should be lived well to cherish dignity (Dworkin, 2011).

Applying the New- Kantian philosophy to the context of this research project, lays a foundation for discussing the persons' responsibility to take their own life seriously. Questions regarding whether the persons who are considered to be harmful towards themselves or others, are taking their own life seriously, are relevant to the discussion. Some of the persons in treatment may have suicidal intentions, and some may even have tried to commit suicide or harm themselves in other ways. According to Dworkin, we can understand that this is not correct, because your life matters, and you need to give your life value. The author relates the concept of dignity and self- respect to the action of living well, but also explores various dimension of dignity.

3.2.4 Morality and Dignity

The New- Kantian philosophy, claims that several philosophers ask why one should be moral. By connecting morality to the ethics of dignity, Dworkin believes that it is possible to find an effective answer to the philosophers' questions. *"We can then reply that we are drawn to morality in the way we are drawn to other dimensions of self- respect"* (Dworkin, 2011 p. 14). The philosophy explores various ideas to give an account of the answer. Dworkin claims that it is compatible with the Kantian philosophy when regarding the notion, that it is not possible to respect your own humanity, unless you respect the humanity in others. He suggests that we should have certain personal goals regarding our obligations, duties and responsibilities towards other people. When examining morality, the New- Kantian philosophy questions the connection between others suffering and the understanding of a more ideal life for the helper. This proposal is applicable to the topic of the research project, as we could see whether the staff would help persons based on their own understanding of a better life or whether they help persons because they deserve it (Dworkin, 2011).

Dworkin indicates disagreement towards more austere views when referring to the question of why people should be moral. This particular view, answers the question by saying that we should be moral simply because morality requires us to do so. The philosopher claims that morality can be perceived as burdensome. Nevertheless, morality is understood as something that exists and something that we regularly have to overcome. *"We want to think that morality connects with human purposes and ambitions in some less negative way, that is not all constraint and no value."* (Dworkin, 2011 p.193). Based on the New- Kantian perception of morality presented, this research project suggest that the particular philosophy implements morality as categorical.

The philosopher suggests a distinction between living well and having a good life. This distinction is related to the ethical division of the right and the good. Living well is described as the attempt to create a good life, *"but only subject to certain constraints essential to human dignity"* (Dworkin, 2011 p. 195). The two concepts are understood as interpretive concepts, and the philosopher urges the importance of adopting convenient conceptions of both, as it is our ethical responsibility. He stresses that this responsibility is first and foremost upon ourselves (Dworkin, 2011). Where Kant seems to think it is possible to find the universal norms, Dworkin tends to be more realistic by saying that the norms are interpretations.

Relating the dimensions of morality and dignity to the context of this research project, it becomes evident that the New- Kantian theory suggests the dignity of persons in coercive treatment is related to living well. Even though New- Kantian philosophy focuses on their own responsibility, it also agrees with the Kantian philosophy on treating people with humanity. Hence, the importance of professionals treating the persons well, and providing a good life even in confinement.

3.2.5 Self- Respect and Authenticity

The New- Kantian philosophy defines dignity through the two ethical principles of self-respect and authenticity. The principle of self- respect emphasises that everyone should take their own life seriously and to make something out of their life, rather than wasting it. The principle of authenticity, highlights that "*Each person has a special, personal responsibility for identifying what counts as success in his own life; he has a personal responsibility to create that life through a coherent narrative or style that he himself endorses"* (Dworkin,

2011 p. 204). These two principles make the conception of human dignity. In other words, dignity requires these two principles (Dworkin, 2011).

When exploring the concept of self- respect, Dworkin refers to the notion of equal worth, which is a moral principle illustrating how people should be treated. The idea stresses that all human lives are inviolable, therefore no human being should be treated less worthy than another (Dworkin, 2011).

Dworkin explores various sides of authenticity. He refers to a famous essay by Lionel Trilling, in which the principle is distinct to sincerity. The author argues that the use of the term should be considered thoroughly (Dworkin, 2011). Dworkin himself, regards authenticity as another aspect of self- respect. *"Because you take your life seriously, you judge that living well means expressing yourself in your life, seeking a way to live that grips you as right for you and your circumstances"* (Dworkin, 2011 p.209). Another dimension of authenticity is considered to be our relation to other people. Dworkin argues that every human being should aim towards independence. However, the author does not exclude being influenced or persuaded by other people. Nevertheless, he separates influence from being dominated. This separation is emphasised with ethical importance. The authenticity is neither compromised by circumstances

Dworkin claims misconceptions regarding the idea of dignity, even though it is referred to in several human rights documents and constitutions. He argues that the term is used without consideration and continues to suggest the importance of defining and identifying the concept, which he himself is doing through the two principles of self- respect and authenticity. This research agrees with Dworkin, when saying that the idea of dignity needs to be identified and defined explicitly, and believes that it would contribute to improvement in coercive treatment because of less subjective interpretation of the legislation.

By exploring selections of the New Kantian philosophy, it becomes evident that Ronald Dworkin emphasises the discussion of dignity from a moral and ethical aspect. His definition of dignity is based on the two components self- respect and authenticity. Dworkin combines the Kantian and consequentialist understanding. For this particular research project, it is relevant to discuss the impact coercive treatment has on dignity through whether the mental health care facilities in Norway are providing support for autonomous living and self- respect.

In addition to exploring academic literature and relevant philosophical theories relevant to the topic, this research project has also aimed to conduct information through a qualitative methodology. This methodology will be introduced in the next chapter.

Chapter 4: Methodology

This research project gives a voice to persons with experiences from mental health care facilities in Norway through presenting their narratives. To provide an expanded understanding of coercive treatment and dignity, their voices are considered extremely important. To answer the research questions, I have adopted a qualitative method, which will be illustrated further in this chapter.

4.1 Research Design

The framework for the collection and analysis of data is outlined in the research design. The research design *"reflects decisions about the priority being given to a range of dimensions of the research process".* (Bryman, 2012, p. 46). In the following section, I will reflect upon the decisions made regarding my research design.

This particular research project, examines the mental health care facilities in Norway as a case study. Bryman (2012) reveals that a case study can focus the research on one single organisation. The case mentioned in this context can refer to a location, community or organisation. In this research project, the case examined is mental health care facilities. It is significant in case studies that the research reveals the unique features of the case (Bryman 2012). The unique features of this study is that the persons who have experienced coercive treatment are sharing their own narratives, which provides a personal and subjective perspective to the research.

4.1.1 Qualitative Research Strategy

A qualitative approach is adopted in this research project. This strategy contributes to answer my research questions through in-depth interviews with persons who have experienced coercive treatment in mental health care facilities. Qualitative research approaches encourage a subjective perspective, which complements my focus on in this research project. Extensive quantitative data have previously been collected by VG regarding statistics related to coercive treatment. Even though the newspaper has revealed stories of several persons in coercive treatment, they have not explored the extent of harm the coercive treatment may cause to the dignity of these persons. By exploring this aspect, this particular research project stands out as unique. The literature presented suggests a lack of research done from the perspective of persons in treatment. This highlights that it is beneficial to adopt the particular approach, which focuses on the experimental nature of coercive treatment in psychiatric facilities.

4.1.2 Epistemological Background

A case study design seeks to examine the chosen case from either a positivist or interpretivist epistemological view (Hart, 2005). According to Bryman, the interpretative approach is relevant to a qualitative strategy, through its' demand to grasp the subjective purpose of the social sciences. This makes it appropriate for the aim of the research which is to examine the perspective of persons with coercive experiences in psychiatric facilities.

In qualitative research, the relation between theory and research is considered from an inductive view. This means that in this research project my theory is generated out of the research, as opposed to the deductive theory (Bryman, 2012). I have adopted an inductive approach in the research (Bryman, 2012). As Bryman states *"The social world must be interpreted from the perspective of the people being studied, rather than as though they were incapable of their own reflections on the social world"* (Bryman, 2012, p. 393). Hence, by seeing the situation from the perspective of persons with experience from mental health care facilities, I illustrate that they are capable of doing their own reflections, which provides to suggest their rationality. The epistemological approach adapted in this research is also described as interpretivist, as it examines the persons own experience of the treatment.

This research adopts a constructionist ontological approach. Ontology is the theory of the nature of social entities and can be perceived as objectivism or constructionism/ constructivism. This view stresses that the "*social properties are outcomes of the interactions between individuals, rather than phenomena 'out there' and separate from those involved in its construction"* (Bryman, 2012, p. 375). As social properties are outcomes of communication between individuals, my communication with the persons is considered fundamental for the social properties. This communication has happened through interviews that will be given account for in the next section.

4.2 Research Methods

In this research project, I have done semi- structured interviews. The interviews, reveal the most about my topic and contribute to answer my research question. It is also important to note that because this is a very challenging group to get in touch with, a random selection was not possible. The persons who offered themselves to participate to the study, were included in the project. In this section I will present my research method further and reflect upon the process as well.

4.2.1 Qualitative Interviews

By doing semi- structured interviews I have let the participants talk freely about their situations, while still being able to structure the interviews to cover the most significant topics. Qualitative interviews provide flexibility in the interviews; therefore, I have added sub- questions during the interviews if considered necessary. "*Also, the interviewer usually has some latitude to ask further questions in response to what is seen as significant replies"* (Bryman, 2012, p. 201).

The process of finding possible interview subjects started early November 2017. E- mails were sent to the following organisations: Hvite Ørn, Mental Helse, Senter for psykisk helse og rus (Council for Mental Health) and Forandringsfabrikken. Several local psychiatric hospitals were also contacted through e-mails. When there were no replies within two weeks, all the

organisations were called. Some responded to the calls and promised to reply to the email as soon as possible.

When two more weeks passed, no organisation had replied, and once again e-mails were sent, and several psychiatric hospitals were called again. At one of the hospitals, the person responsible for discipline and quality responded to my call. He promised to bring the request further to the consumer council and suggested that I contact the Facebook group: '*Erfaringsnettverket'* (translation: experience network). I made a post to express my need of participants for the research and most of the participant in this research project contacted me through this group. One of the interview subjects contacted me through the Council for Mental Health and Forandringsfabrikken suggested three interview subjects who were not interviewed as I had already conducted enough information. Seen that most of the interview subjects were contacted through Facebook, they were also spread all over the country, which was beneficial in developing an overall view in the study, and not only a local perspective.

After studying available research and literature relevant for my study, it became evident that there is a lack of studies performing in depth interviews with consumers of mental health care facilities. I talked to the following six people with experience from psychiatric hospitals in Norway. The persons have several years of experience from mental health care facilities and are partly still being followed up by psychiatric facilities, thus the unique feature of this research. All names presented in the thesis are pseudonyms, chosen in order to protect the confidentiality and anonymity of the participants. These names represent typical Norwegian names and reflect their gender, but otherwise do not reveal any nature of their identity:

1. *Tina:* 20 years, lives in an apartment with available staff. She is currently a university student and was exposed to coercive treatment in mental health care facilities for the first time when she was 14 years old. The interview lasted for about 55 minutes.
2. *Lisa:* 67 years old, used to teach vocational subjects in high school. She lives alone and is currently a recipient of disability benefits. The interview lasted for 78 minutes.
3. *Anne:* 56 years old, is educated as a midwife and currently lives with her husband. She was exposed to coercive treatment in mental health care facilities for the first time 12 years ago. The interview lasted for 40 minutes.
4. *Ola:* 20 years old, is currently living in a mandatory designated apartment and the interview took place in his childhood home, with his mother present, since he is diagnosed as slightly mentally handicapped. Hence, majority of my communication

happened to be with his mother. He was in mental health care for the first time when he was 8 years old. The interview lasted for about 45 minutes. Because the interview was seen mostly from his mother's perspective, and not his, I later decided to leave this interview out of my findings sections.

5. *Guro*: 41 years old, has an education within nursing, teaching and as an alternative therapist. She currently lives with her children; and has experienced coercive treatment in mental health care for the past ten years. This interview was done through skype and lasted for about 35 minutes.
6. *Magnus:* 32 years old, is currently applying to receive disability benefits. He has been working until five years ago, and among other things he has experience from IT, as a salesman and as a construction worker. He lives with his wife; and has been in treatment of mental health care for the past 8 years. This interview was done through Skype and lasted for about 35 minutes.

Since my interviews were based on a thematically organized interview guide, all the interview subjects covered the main topics I was interested in talking about. However, the questions varied from person to person as the interviews were conducted more as conversations, and less as interviews. This led to different questions and follow- up questions according to their stories. But as Bryman (2012) also emphasises most of the questions were asked similarly and similar wording was used.

Before doing all the interviews, I asked for permission to record the conversations, which all six participants agreed to. After conducting all of the interviews, the recording materials covered 233 minutes. The next step in the process was to transcribe the interviews, which resulted in about 70 pages of transcribed material.

According to Bryman (2012) the interview guide should consist of questions or a list of issues that are likely to be addressed during the interviews. As a first step to compose the guide, I used my study of literature and theory to develop the following themes: background information/ introduction, understanding of coercion, rights, dignity. These main topics were deliberately chosen in accordance with Bryman's (2012) statement that the researcher should open for the interviews to collect the research participant' perspective of their social world and that there is flexibility when conducting the interviews. Furthermore, questions were formulated within each topic in a way that they could contribute to answer the research topic. I was aware that I needed to formulate the questions in a language that was accommodated for

the interview subjects and that I didn't lead them during the conversations or through my questions (Bryman, 2012).

4.2.2 Coding and Analysis

The process of coding is also sometimes referred to as indexing; *"coding is the starting point for most forms of qualitative analysis"* (Bryman, 2012, p. 581). Bryman suggests that both the coding and transcribing happens as soon as possible. I found it reasonable to transcribe the interviews immediately after conducting them. Nevertheless, doing the coding as soon as possible was to some extent a challenge, because the interviews took happened throughout eight weeks. However, Bryman also suggests reading through all transcribed material and then secondly read through it again while making notes on observations. This is the main element in the coding process, which is followed by reviewing the codes (Bryman, 2012). After transcribing all the interviews, I used Bryman's suggestion to start the process of coding.

Complying with the themes of the interview guide, I adopted a thematic analysis. This is considered as one of the most common approaches within qualitative research. This particular approach is adopted with the aim to organize the interviews, as well as having main themes that can make the interviews flow more as conversations and less focused on specific questions. *However, unlike strategies such as grounded theory or critical discourse analysis, this is not an approach that has an identifiable heritage or that has been outlined in terms of distinctive cluster of techniques."* (Bryman, 2012, p. 584). At this stage of the process, the thematically organised interview guide is also very helpful for further labels on the themes. The connections between these concepts can then be examined, and the analysis written up to justify these themes (Bryman, 2012). However, some information seemed to appear in all the interviews, and therefore provided developing the themes for my findings and analysis.

4.3 Ethical Considerations

Ethical considerations reflect upon two main issues (Bryman 2012). The first issue talks about how researchers should treat participants in research. This is a point to considerate, as the

participants in this research belong to a vulnerable group that may be sensitive to certain topics, depending on their mental health. The second issue concerns whether there are activities in which we should or should not engage in our relation to them (Bryman, 2012).In this research such activities could for instance be to explicitly ask about their diagnoses and background of their mental health, as it could cause retraumatising bad memories. Therefore, the interviews focused on open conversations, where the participants could share as much as they wanted to.

4.3.1 Ethical Principles and Social Research

There are mainly four areas that should be taken into consideration within the topic of ethical principles while doing social research; whether there is: harm to participants, lack of informed consent, invasion of privacy and if invasion is involved (Bryman 2012). These areas are important when interviewing the consumers, and this research project made sure not to violate the principles.

My expectations before conducting the interviews, were that I might need to spend some time conducting the interviews, based on the participants' sensitivity towards certain topics due to their mental health or experiences. Therefore, it was considered important to be aware of this during the interviews. The location of the interview, whether there were other people close during the interviews and whether I was recording the interviews, could also be essential factors that might influence the interviews. Mainly because of this, I let the interview subjects decide the time and location of the meeting. By doing this, I could be sure they chose an environment they were comfortable in, hence it might be easier talking about their very personal experience from mental health care facilities.

4.3.2 Confidentiality and Consent

The participants of the study may be vulnerable and participating in these interviews could be a huge step. Therefore, the confidentiality and consent should be ensured during the research. Even if the participants are not in coercive treatment at during the interview, they should give their consent to participate, and there should preferably be written papers of confidentiality. This way, the persons will know that they can trust the interviewer, and it can possibly

influence the amount of information shared. If the person is not able to give consent, there might be a chance that there is a guardian that could give consent or even look through the papers of confidentiality. In this research project, all the consumers except for one was able to give their written consent. The reason why one of the consumers did not give her written consent was because the interview happened through Skype, and she did not have a printer available.

The knowledge created in the research is dependent of the social relationship between the interviewer and the participant, and depend on the interviewer's ability to make an atmosphere in which the interview subject feels free and safe to talk about the private experiences (Kvale & Brinkmann, 2009). For this research project the atmosphere was mainly created by letting the interview subject take initiative to contact me if they wanted to participate in the research. Furthermore, the location and time was also left for the interview subjects to suggest. By giving them some of the responsibility, I believed they would feel more confident in the situation and relation to me as a researcher.

Seen that the information given by the participants is personal, it is important to notify NSD (Norwegian research ethics board) before collecting data. NSD defines personal data as, for instance, information that could be used to identify the interview subject. Considering that the narratives shared in this research were of extremely personal character, there was no doubt that the research needed to be applied to NSD. The research was approved by them 31st October 2017.

In this chapter I have described the process of conducting and working with the interviews. I have presented decisions I have had to make during the research process and challenges I have met in the process of finding interview subjects, as the topic chosen is sensitive, and care and consciousness needed to be taken. In the next chapter I share reflection regarding my own position in the research.

4.4 Positionality

My positionality in the context of this research project is of interest when discussing the narratives shared through the interviews. When searching for interview subjects, I presented myself as a student of human rights and multiculturalism. Based on the introduction through the course of study, most people would naturally tend to get the impression that I am doing a

research to improve their situation, thus being on their 'side' is considered significant regarding my positionality in the context.

All of the interviews were done in Norwegian. Similar to the interview subjects, my first language is also Norwegian. The fact that we shared the same language, may cause that they felt more comfortable in the situation, compared to if the interviews would have happened in Norwegian. My role as a researcher and a professional may however have caused insecurity within the participants, hence influenced what they chose to share.

By acknowledging and being aware that there are certain aspects that could influence the relation between the interview subject and myself as a researcher, I have aimed to appear objective to some extent. Nevertheless, I have also wished to sympathise with their situation, and show that I want to share their stories for their own benefit. The sensitive nature of the topic, makes the reliability and validity of the research even more important. These to principles will be reflected upon in the next section.

4.5 Reliability and Validity

There are four criteria that measures the reliability and validity of qualitative research: external reliability, internal reliability, external validity and internal validity. The external reliability refers to the extent that the study can be replicated, which relates to the consistency of whether the findings of the research could be repeated in and result in similar results. The internal reliability assesses whether the findings reflect or represent the reality (Bryman, 2012).

The strategy of choosing participants to the research, is relevant to the external reliability. For this research project the participants were located all over the country. Even though I have stressed that I did not have a lot of people to choose from, the fact that they were spread over the country and have experience from different mental health care facilities, strengthens the reliability of the study. When concerning the internal reliability of the study, made sure that I present the information as similar to what the participants shared. This has been done by recording the interviews, transcribing, translating and presenting quotations to prove that the analysis is as similar to the actual statements as possible. It is however important, that what is shared is their reality and their truth, independent of their mental health. By asserting the

participants, roles as extremely important for the study, I may have contributed to make them feel less vulnerable and more empowered.

The internal validity relates to whether the findings of the researcher correspond with the theoretical ideas developed, thus the trustworthiness of the study. The external validity concerns to what extent the findings can be generalized across social settings (Bryman, 2012). When discussing the internal validity of this study, it is important that I have described and given grounds for choices regarding the research process. I have also given an account of my choices concerning the theoretical framework and my own position in the research. This contributes to strengthen the validity of this study. In the discussion of the external validity, the focus group of this particular study is of importance. Even though this research particularly examines persons who have experienced coercive treatment in Norwegian mental health care facilities, the concept of dignity is very applicable to other social settings.

Seen that I do not share the same experience as the participants in the study, there is a risk that I may be perceived as an outsider. The knowledge I had gained of the context, was through a thorough literature review. On another note, the role as an outsider could also be considered as an advantage because it provides to avoid colouring the study with my views. Hence, it strengthens the validity of the study. I believe that a researcher cannot act completely objective in a study, but rather that one should give an account of what relation one has to the area of study. Thus, my personal background can be considered as both a resource and a disturbance in the research.

Chapter 5: Findings and Analysis

In this chapter, I will outline the findings and thematic analysis constructed from empirical qualitative interviews, as presented in chapter 4.2. I will be elaborating and describing the following themes, which are developed from the overarching themes and subthemes throughout this thesis: coercive measures, patients' rights, dignity and relation to practitioners.

The selection of findings has been done according to what is considered important and relevant to the topic of this research project. This may be perceived as the first step of interpreting the transcribed material. It is also of importance that the interviews have been

done in Norwegian and are also transcribed in Norwegian. This section is therefore a translation that ought to be as similar and accurate as possible, to the information narrated by the participants. Nevertheless, such a translation might cause changes in meaning or purpose of the original message.

5.1 Coercive Measures as Experienced by the Patient

The interview subjects shared their narratives and thoughts regarding several situations where the coercion occurred. The coercive measures initially referred to in the interviews, were based on the coercive measures illustrated in § 4-9 of the Mental Health Act. However, some of the participants perceived and defined coercive actions as broader than the legal definition. This has been interesting for the development of the research project and the understanding of the concept.

5.1.1 Mechanical Restraints, Involuntary Medication and Physical Holding

Tina emphasises that her first impression of the psych ward was surprise at how frequently mechanical restraints were used. She gives some examples of situations from her time in confinement, and her thoughts regarding the use of mechanical restraints. When Tina, and other participants refer to a *paragraph,* I assume that they are referring to paragraphs of the law:

"The very first time I experienced coercion…hmm… I wonder if it was a coercive admission? Maybe it was. Because I have experienced or felt coercion in other… which is not under any paragraph if you understand."

"… Not necessarily coercion coercion, or more like, maybe carelessness. As in when I haven't been able to walk, they would feel free to like "no, you don't need to use the toilet" or "you're on your period and need to change sanitary pad", yes then we'll just pull off your trousers and change it for you. Or another time when I had taken a lot of tablets and I told them I needed to use the toilet, and they came with… like a chair, with a toilet seat and placed it in the middle of the medical room. Everyone was in their uniforms and white coats and all

that, and then I was supposed to sit there and pee in the middle of the room. I experienced that as very much, yeah less dignified".

"But when I have been put into restraints for instance, they've always been like… yes, you do feel like you lose all control, and they take power away from you, but I have always been asked: "Do you want us to help you drink? Do you want a cold rag on your forehead? Is anything too tight? So even though it might be experienced as provoking in the situation, I have understood later kind of… that they meant good, even though I experienced it as very painful".

From what Tina describes, it seems like she does have a certain overview of the jurisdiction concerning what includes as coercive measures. We can also understand that she does not necessarily perceive the coercive measures as harmful themselves, but rather the actions where the staff feels free to cross her intimate limit. However, she expresses understanding and has rather positive reflection towards the use of mechanical restraints.

When Lisa shares her experience from coercive treatment, she introduces us to certain unwritten rules in the psychiatry:

"Yes, I have been in restraints once too. I must admit that I had been a little angry. (…) But at least they strapped me down for maybe some hours. But what was good, once again I have to praise the foot soldiers – the social workers. And that was David (pseudonym)! He came in to look after me. I think he is from somewhere in Africa, so he knows more about how you should treat people. He was in a little despair on my behalf, and what he could do to get me through the horrible situation. And frankly, there is a standing rule in the psychiatry that you should not touch the patient. Never. Ever. It doesn't really make sense, because that's exactly what people need – to be touched. Maybe even a hug. So what David did, was he took my arms and rubbed them hard from the elbow and down. So that I could feel his touch. I felt that there was a human being there. It was fantastic. He was the one to get me through those hours".

Lisa is emphasising the importance of details in the treatment, and we can understand from what she is saying that David's physical touch changed her experience of mechanical restraints to something rather bearable, based on him showing human compassion. Magnus on the other side, has a different view and experience of mechanical restraints. He particularly refers to one situation, and indicates dissatisfaction:

"(…) But when I was put in restraints for 24 hours, or 26 hours was it in total… firstly, I was involuntarily medicated before I was put in restraints. And I was calm after an hour or two. But they wanted me to start taking a medication named Zyprexa. And I refused to take any medications, so I wasn't released from the restraints before I agreed to take Zyprexa. 25 hours had already passed. I didn't like this. It was… I felt insulted. Firstly, I was scared to death. Secondly, I was injected a shot in my bottom. And then you're put in restraints for so many hours after. I wasn't too happy with my therapist at that moment to be honest."

From what Magnus describes, it becomes evident that similar to Tina and Lisa he is not negative towards the use of restraints in itself, but rather the period of time he was kept in restraints as well as the way the staff proceeded in the process from the forced medication to the moment he was released from the restraints. It seems like fear is an essential factor in Magnus' experience.

Guro talks about her very tough childhood. Just as Magnus, she is not satisfied with some of the treatment, as for instance being held physically for 20 minutes and then put into restraints were retraumatising terrible memories from her childhood:

"Because I had a childhood where I experienced very much… very much pain. I was physically held as a child. I was also locked up when I didn't do as I was told to. So, for me it was a new infringement, to be held physically. Because as a child you can't act out and tell that it's not okay when the adult does something wrong. But as an adult, my reactions the past years have kind of been late anger reactions to what I experienced as a child. (…). What I needed was a lot of comfort, but also the opportunity to express everything I had inside of me. But instead I was put in restraints and it wasn't kind of permissible anymore."

From this section, we can perceive that a vast majority of the participants experienced mechanical restraints combined with being physically held prior to being put in restraints. One of the participants was also involuntary medicated before he was put in restraints. From the information given in the interviews, it seems like there are certain details that the participants find essential. Most of the interview subjects, indicate the importance of information. For instance, we could understand from Magnus' narrative, that his fear could be connected to not knowing. This opens for an ethical discussion of the legislation. Furthermore, details in how staff go about to practice coercive treatment is also revealed as important. Through Guro's experience, we can understand that just as important as informing

the patient about the situation and process, it is important that the practitioner gathers information about the person's background, so that the treatment can be considered as therapy and not retraumatise bad memories. By avoiding to inform the person about the process, this study suggests that the practitioners indicate their opinions regarding the persons' rationality. The foundation of being rational, is considered to correspond with being able to receive information, in this research.

5.1.2 Isolation

Lisa talks about the first time she was admitted to a psychiatric hospital, and she was also surprised at how often the coercive measures occurred. The first time she experienced coercion herself was through isolation:

"... So, sometimes they have done something called stripping the room. That simply means that they remove everything from the room. And then they let me keep one single instrument. This could for instance be five papers from the copy machine and a pencil. That's kind of the minimum of what I need to have. The measure wouldn't work for me if I didn't have this. Then I would have experienced it as punishment or torture or something like that. But since it was explained to me, and that I had the limited possibility I had, to take advantage of that pencil and concentrate to make the most out of it. And then it starts to look like therapy. Because then I am able to collect my thoughts with the little I am given. Instead of flying around to be inspired and distracted by everything else. Then it is therapy".

From Lisa's description of the isolation, we can understand that she has a rather positive view towards this form of coercive measure. Her example makes it evident how important details can be to distinguish the treatment from torture to therapy. However, Magnus did not experience isolation in the same way as Lisa did:

"(...) That was when they locked me in my room and placed a sill or a doorstop under the door. This was in the security ward. I was isolated in my room. I had some contact with people when they brought me food and stuff like that, but I was isolated at my room in six to eight weeks or something like that, and that was eight boring weeks to say it like that".

From what Magnus describes, his room was not stripped of belongings. However, he describes his time in isolation as being locked into the room to keep everyone around him safe

from him, not to help him. When talking about her time in confinement, Guro shares her feelings regarding her rights as a patient she says:

"No, I think being in psychiatric confinement has been worse than being in prison. Like, I haven't been in prison, but I have read about it. I simply experienced it as torture to be locked into the psychiatric ward, a closed ward.

Guro's comparison of the psychiatric confinement as similar, or even worse, than imprisonment is found interesting to this research project. Again, the word torture is used to describe the situation.

From the very different examples given in this section, it becomes evident that the margin between perceiving coercive actions as either therapy or as torture is quite narrow. From Lisa's narrative, we can also understand that giving her a tool while in isolation, was just what she needed to perceive the situation as therapy. However, Magnus did not receive any form of tool, had very limited contact with human beings for quite a long period of time and still indicated understanding towards the situation, even though he describes it as 'boring'. One of the participants also indicated awareness of the fact that her understanding of coercion might be broader than the legal definition of coercion. Her narrative suggests that the perception of coercive treatment does not correspond with the legal instructions of coercive treatment. This research then questions whether the legislation is explicit and sufficient enough. The deviation between law and its' implementation may indicate a need of change in the law. The deviation will be explored further in the next chapter.

5.2 The Deviation Between Law and its' Implementation

As presented in chapter 1, patients' rights can be found in both national and international legislation. However, the practice of these rights and the understanding of the rights that are present can appear as different to what is written down. Therefore, I will present the interview subjects' understanding of their rights in confinement through their experiences, in this part of the thesis. Their perspective is important in the research project as their stories present their own truth, which can further contribute to understand the effect of the coercive treatment and the implementation of legal guidelines concerning the treatment.

5.2.1 Distribution of Information

Tina shares her thoughts on how much influence she had on the treatment and how much information she was given:

"I don't feel like there was so much self- determination. If there was any self- determination present, it was more like "what do you want on your bread?". The day was planned as it corresponded in a best possible way for the nurses and psychologists."

"Yes, I was informed about the possibility to complain, but this was also something I taught myself after a while. I think that may be the reason why they avoided to inform me too. But they can of course not just assume anything. But I did just have a decent overview of these kind of things myself. (…) I only got the information like "there is a possibility to complain, and the Supervisory Committee comes every Wednesday, every second Wednesday." You have the possibility to take up anything with them, if you want to. But you probably don't have anything… yeah."

From what Tina shares, it seems like she indicates a feeling of powerlessness, both regarding self- determination, and the information provided. Tina also makes it seem like she excuses the lack of information with the fact that she managed to gain information by herself. Anne shares a somewhat similar perception to Tina and Magnus when talking about the information received when she was admitted to the psychiatry:

"No, I can't remember having received any information regarding my rights. If so, I must have overlooked it. (…) except from that I also know of the Supervisory Committee. They are supposed to come and talk to patients under coercion, every second or third month. I can't really remember having talked to them at all. So, I don't know whether they just refrained from doing it for a while, or if they only would have responded if I contacted them first."

"In a way, I have the right to receive help. They did help me, even though that meant losing my freedom, but that was their way of helping me. It might sound weird to say it like this, but I believe that it helps me, and my experience was that they didn't help me. That they were just forcing me. But it is a human right to receive help. At least here in Norway, we have the right to receive help."

From Anne's experience, similar to Tina's it seems like there is a perception of powerlessness. The fact that she does not remember receiving any information regarding her rights, makes a foundation for curiosity and reflection on whether this is because of her mental health, or if she did not receive any information at all. Lisa however, has a rather positive attitude towards the information received when she was admitted to the psychiatric hospital:

"(...) and the information given there isn't too bad because they operate with these binders available for the patients at their bedside tables. So, that is pretty good. And it is pretty essential that the information is written down, because you might not be receptive to information the same day as you're admitted. (...). But I have practically registered that I have no legal rights. (...). As a patient I am informed of my rights to complaint to the Supervisory Committee and I have done that every single time I have been admitted. But they cannot consider cases regarding medication. And that doesn't bring my case any further, because that's exactly what I am complaining about. I don't want the medication I don't tolerate."

The example given by Lisa, makes it evident that her mental health when she was admitted to the psychiatric hospital was good enough to the extent where she was able to register the information provided in these binders.

From this section, it seems like there are certain keywords that are being repeated by several of the interview subjects, when talking about the distribution of information. One of the main key words appearing is torture. Another perception that seems to be repeated by several of the interview subjects, is the feeling of powerlessness. As suggested in the previous, chapter the lack in distribution of information, relates to the perception of persons in treatment as not rational enough to receive the information. This further relates to their dignity. However, there also seems to be a difference between the distribution of information, and actually giving the person rights. This leads us to the next section.

5.2.2 Perceptions of Human Rights

Seen that human rights and dignity are essential for the research, the participants were asked about their perception and definitions of human rights. When sharing her thoughts on human rights, Tina states:

"Human rights are something all human beings have kind of, independent of ethnicity, background or illness… or like…but the psychiatrists…eh...they kind of have a little exception from that to be honest. I don't know, I don't want to say that I have been exposed to a violation of the human rights. (…). But there is a difference in whether it is done with the consideration of treatment or when you are ill and can't take the correct decisions, or you're not able to take care of yourself, kind of. I experienced it as more painful to be bullied by children of the same age for instance. I would rather go through coercion and all that, than experiencing that again."

From Tina's experience, we can understand that she is aware that even though the experience was painful to her in the moment, and she did feel like she had no human rights, she also understands the necessity of it. However, by claiming on one hand that the psychiatrists have an exception to human rights, while on the other hand being careful to claim that she has encountered a violation of human rights, we can assume she feels like she is not in the position to claim so. Why she would feel that she is not in a position to claim a violation of human rights, could further relate to whether this is what she has indirectly or directly been told while in treatment. If she is put in a vulnerable position by the professionals, through for instance coercive measures, then she would naturally implement this role to other situations as well. Lisa nevertheless, seems to be more determined with her claims:

"I was sitting there and wondering "how on earth is this possible, where are the human rights? When I am here, and I have told them that I don't want this medication, where are the human rights now?" But… there has to be some kind of an abnormal situation or state of emergency. Because it stops prior to that. It stops already at the right to complain about your treatment. That right is ceased (….). So, it doesn't even reach the human rights. (…) I don't think I have had any rights as a patient in the psychiatric hospital. I don't think anyone has any to be honest. Not in the reality. Maybe it is written down on some papers somewhere, but not in the reality. And if I can give any advice to other patients, it is to not protest before you are discharged."

The narrative presented by Lisa, makes it seem like she links her perception of human rights to a lack of self – determination. There also seems to be a feeling of helplessness connected to not being heard at any level.

The rights analysed and presented in this section, suggest respect for law as an ethical discourse. The rights are considered to be a part of an ethical discourse. Through the participants' own perceptions, the rights are analysed as sub-concepts of dignity, in an ethical reflection. It is considered ethical to inform the persons of their rights, thus the rights become a parameter of unethical behaviour. Both of the narratives presented, indicate that persons in psychiatric mental health care facilities perceive a lack of rights, hence the deviation between the law and its implementation is larger than desired. This notion supports the assumption that persons in treatment of mental health care lack rationality, which further affects their dignity. Hence, the interest in how the participants construct their understanding of dignity, which leads to the next section.

5.3 Subjective Construction of Dignity

Seen that the main scope of this thesis is contextualizing dignity from the perspective of the people with experience from mental health care facilities, this section presents my findings concerning dignity and the infringement of dignity. The definition of dignity in this section is based on the definition of each interview subject, aimed to develop a foundation for the discussion of the concept.

5.3.1 Defining Dignity

The interview subjects were asked about their perception of dignity, and how they could relate their understanding of the term to their own experience. When explaining her understanding of what dignity is, Tina says:

"I think it is important not to take it for granted that your dignity will be left injured or jolted after experiencing coercion. That doesn't matter of course. Because I don't feel like less of a

human being today, just because I have different experiences than other people might have. I did feel like my dignity was injured in the situation, but I also understand now that it was necessary. I guess it wasn't meant to feel like that. That is of course not desirable from either side.

From what Tina narrates, it seems like she differentiates her perception of dignity from the intention of the practitioner. By doing this, we can understand that she believes it was necessary to feel less dignified in the situation, and that this was only during the situation, not something she feels afterwards. Anne however, shows a rather legal understanding of dignity:

"I perceive dignity as the safety you have the entitlement to. That the human rights are fulfilled. If you do that, people show that you are dignified. (…).

From the two descriptions given of the term dignity, we can comprehend, that people with experience from psychiatric facilities may have different perceptions of the term. This makes a foundation for analysis of what they actually feel is being infringed when they claim an infringement of dignity.

5.3.2 Infringement of Dignity

When Tina is asked about her perception on infringement of dignity, she describes a situation from her time in confinement:

"I especially remember this one time, when they just stood there looking, while I was biting and ripping up my stitches. And then they just let me lay in my own blood until the next day or afternoon. (..) So, the staff that night just sat there watching and said that if you need stitches, we'd rather put you in belts. (…) And the whole next day they just let me lay in my own blood. And I didn't want any food or water or anything. And they were still like "if you need new bed sheets you have to clean up your blood and change them yourself." And then when the staff changed the next afternoon, they were like "wow shit, why haven't they done anything?". And they met me with a more empathic behaviour, and naturally I cooperated then. Then I agreed to eat a little food and get ready. So, yeah, I don't know. I feel like this has been worse than being put in belts in a way. What is the most correct regarding professional directives can be discussed, but this was at least my experience of it."

Tina is seemingly describing a situation of being in a powerless position, left unheard in vulnerability and fear. Her account of the incident also expresses the importance of how the persons' interaction to the practitioners may affect their dignity. Magnus, as the only male participant in this study, relates his perceptions to gender roles:

"I experienced that I am not a person to talk a lot about my feelings and I have noticed that I, myself – and other men, receive a lot less attention. Because girls have a tendency to unfold themselves more or talk about their feelings and maybe cry a little. Maybe express their feelings more. They need to be better at talking to each patient more"

Even though Magnus, does not use the particular wording related to dignity in this section, we may assume that his perception of dignity is related to the gender role he is talking about. The narrative describes importance of the relation to practitioners when talking about dignity, and the importance of the practitioner's perception and general stereotypes regarding gender roles. By being more aware, the practitioners may avoid overlooking, not only men but also all other persons who seem to be more silent.

Lisa on the other side, says that she has been treated with respect and dignity, but finds it problematic that there is a lack of knowledge within the field. She speaks about her opinions and experiences regarding dignity:

"The chief physician has been arrogant. This is when the respect ceases. In a way, I am left and almost convulsively holding onto my dignity. All alone. Because he hasn't shown any tiny amount of understanding.

In her account of dignity, Lisa clearly describes a hierarchic power relation, between the practitioner and herself. Guro seems to have a similar perspective of the situation as Lisa:

"No, that is exactly what I feel after all these years in psychiatric confinement, that my dignity was not protected at all. Because when you are isolated, physically held or put in belts – I also experienced shadowing, continues follow up. So, you kind of lose yourself a little in it. It is a fight that no one will understand."

The extract seems to describe dignity as something Guro *has*, which can be understood as something that belongs to her, hence it needed to be protected. Her narrative makes it seem like she expected the professionals to protect her dignity, but rather she felt the need to hold onto her dignity as if they were doing the completely opposite of protecting it. When Anne is

asked about her thoughts regarding dignity while being in psychiatric confinement she shares a rather different perception than Lisa and Guro:

I didn't feel dignified, but I felt that they were trying to make me feel dignified. That and everything in my surroundings. Both husband, children, family and friends and everything around me. Which they needed to remind me of. From my perspective there was no dignity, but from their perspective there was. (…) I felt like I could disappear from the earth and no one would care. It wasn't worth living. But that was how I understood the situation. They did what they could to stop it. To show me that I had dignity. (…) As I said, they were putting me on a pedestal. They really gave me dignity even though I wasn't worthy of that dignity at the time. Because I felt like I was behaving like a little brat to be honest. I did what I could to escape, and they didn't give up on me."

As opposed to the other women, Anne seemingly had a positive interaction with the practitioners, hence her reflection afterwards shows satisfaction towards the staff. Magnus, on the other hand indicates dissatisfaction towards the situation and interaction, but positive reflection after some time as well:

"You don't feel so dignified when someone has to hold the bottle for you when you pee and when you have to take an injection you don't want to have shot, and to be put in handcuffs and belts and threatened with pepper spray. You don't feel like you're worth a lot. But, but again, you feel insulted in the situation, but if you have any introspection, you will understand afterwards that it was necessary."

This section reveals that the persons' perception of dignity is related to feeling more or less as a human being, fulfilment of human rights and that the perception of infringed dignity occurs when the persons feel that they are not being heard, when they feel vulnerable and scared. The narrative that gives a good example of how the treatment did not cause an infringement of dignity, reveals that the person was treated like a human being with care and nearness. One of the participants even seems to believe that she has to protect her dignity from the practitioners in the facilities. These narratives prove that the perception of dignity relates to the persons' interpretation of the enforcement of coercion and relation to the professionals in the facilities.

5.4 Comprehending the Enforcement of Coercion

Seen in the previous section, the enforcement of coercive treatment, causes various understandings of dignity and the infringement of dignity. The participants also share different perceptions, depending on experiences from different facilities. The variation of enforcement, relates to the governmental and legal instruction given to the hospitals. Various organisations for persons with experience from mental health care and groups in social media, prove that there is a discourse happening regarding the experiences. Thus, possible inconsistencies in the treatment and comparing these among the persons, may cause confusion and further influence their dignity.

5.4.1 Inconsistencies

Tina talks about how not only staff in different psychiatric hospitals but, also staff in different wards can behave differently towards the persons:

"At (names hospital) they have ward A and ward B, which are the two wards I have mostly been to. There is a huge difference between culture among the staff. They listen more to you at B, or they spend more time with the patients and things like that. But at A, they mostly talk among themselves, read their newspaper and things like that."

The narrative reminds us that interaction and relation between staff and patient, is essential to the perception of being heard and following the perception of dignity. Guro experienced different behaviour among the staff, influenced by the grounds of her admission:

"(…). It's kind of like… when you're involuntarily committed, you notice that the staff has a different attitude towards you. It is a little difficult to define, but among other things, I for instance have one experience that is difficult to forget. I was admitted voluntarily once; and then something happened. A situation in the ward which resulted in me panicking, so some people came to hold me. And then one of the female staff members shouted that I was on §3-2 and blah blah and then they could do whatever they wanted to me, but another woman said that no she's here voluntarily. And then they kind of backed completely off. So, the way she was talking was very degrading, it felt like "when you're in coercive confinement, we can do whatever we want to you" in a way."

Guro seems to describe her experience in the extract as a feeling of powerlessness, fear and vulnerability, based on being labelled as a patient in coercive treatment.

The findings of this section, reveals that the inconsistencies among staff, and among wards may depend on the grounds of admission. The persons indicate tendencies of objectifying them through labels of coercive or voluntary admission, which determines how they are treated by the practitioners. This suggests the importance of the relation between the persons in treatment and the practitioners.

5.4.2 The Practitioners

As the interaction with the practitioners comes through as essential in the perception of the coercion, Lisa accounts of her view concerning the staff in the psychiatric hospital:

"The staff has been exceptional all the time. They work instinctively all the time. Always in the situation, here and now. I don't have anything to complain about when it comes to the social workers. They have been absolutely fantastic. But the knowledge part within the field, there I do have a lot to point my finger at."

But when she talks about other professions within the psychiatric institution, she has a rather different point of view:

"As I've already said, I'm very pleased with the social workers. I have nothing negative to comment upon them. And that first psychologist I had was also pretty brilliant. She had caught up everything. Because I read in my journal now, and she has repeated what I had been exposed to the previous week. But then… not accommodated on anything. Not done anything about it… it's just written down there, in black and white. Where is the weak link here? What leaves things hanging?"

"I do think the psychologist's moral is to make me well. And when concerning the moral of the chief physician, rarely do I know what morals those boys have. No, well, they were kind… and, but arrogant. Doctors you know. Maybe doctors do lack moral. I don't think they have enough knowledge of ethics. I don't think so! Because the profession is more like "we have to repair the body" to begin with."

The extracts from the conversation with Lisa, seems to describe inconsistencies concerning power relations among the professionals. Magnus however, also has some experience with the police from his time in confinement:

"They could have responded to me in another way, for instance when they sent the police in. They sent the largest men they found in the department, or at the house. And for my part, I had pretty good contact with a couple of the smaller male staff and a couple of the female staff, so I felt that to get more out of the situation, they could have sent some of them and explained that "you will be put in restraints now. If you don't take your medication, you will be put in handcuffs now". Then I would have managed to think that I'll do so, instead of risking to be put in restraints. But instead, they are on their way towards the door while I was sitting completely calm in my room. That was not a moment I was acting out, I was in my room waiting for food. And suddenly the largest people in the ward are standing there with four police men, threatening me with pepper spray. So, there are absolutely things that could have been done differently in this situation."

Magnus seemingly emphasises power relations through physical appearance, and the importance of interaction between him and the practitioners. He accounts of the necessity of the coercive actions.

From the findings conducted in this research project, certain factors appeared as more prominent than others, relating to the persons' dignity. These main results are presented in figure 1.0, which presents the four elements seemed to be affecting the dignity of the participants. These four elements further, relate and depend on each other. The findings are summarised and limited in the figure, to provide an overview of the findings in general. The findings presented in the figure are influenced by interpretation and analysis of the information conducted, as this is a part of the process. The figure makes a foundation for further discussion and conclusion in the next chapter.

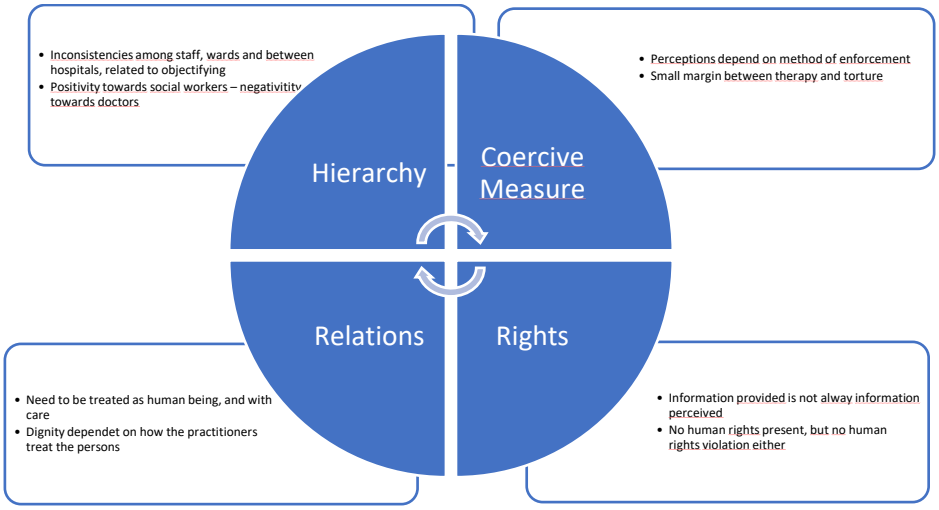

Figure 1: Dignity

Chapter 6: Discussion

In the previous chapter, the participants shared their narratives from coercive treatment, and together they shed a light on different aspects of possible issues. Their experiences were concluded in a figure presented towards the end of the chapter. The figure made a foundation for further discussion on the most prominent findings related to dignity. In the following chapter, I will discuss the thematic analysis and these findings in context of the literature review and theoretical framework, to answer my research questions. I have developed further questions in this section, which will contribute to answer my research questions. These questions will assist to guide my reflections and structure the discussion and I do not aim to provide explicit answers to the questions.

To examine the relation between coercive treatment and dignity, it is important to explore the understanding of both. The philosophical aspect of the term is explored in the theoretical framework, through Kantian- inspired perspectives. International legal documents, justify dignity as something all human beings possess and something that should be protected. These documents still do not provide a definition, neither do they explain what particularly the concept of dignity involves. Explored in the literature review of the thesis, the perceptions of both coercion and dignity vary among professionals and among persons with experience from coercive treatment. This opens for a discussion regarding diverse perceptions of the concepts and their potential consequences.

6.1 Do Professionals Lack Morality?

The findings suggest that the interview subjects' perceptions of dignity were based on how they were treated in mental health care facilities, and possible infringements of their dignity seemed to depend on their relation to the practitioners. One of the interview subjects even suggested that the doctors' profession itself may lack morality. Altogether, a great majority of the participants indicated positivity towards their relation to the social workers, and negativity towards their relation to the doctors.

According to Kant, our actions do not matter as long as the actions are taken in good will. (Kant, 1998). This has been questioned by several authors, whereas Avishai Margalit claims that the Kantian philosophy contradicts itself, and disagrees with Kant on the notion of respecting everyone, independent of their morality (Margalit, 1996).

Seen from a Kantian point of view, the findings lay a foundation for discussing whether the persons perceive doctors as illogical in their decisions regarding coercive treatment. The findings provide a discourse on whether the allegations can be related to their dissatisfaction and disagreement towards the decision of enforcing the coercive measures. The patients may wonder whether the enforcement of coercion is done with good will, or whether it is necessary. The findings reveal that several of the participants indicate that the coercive treatment was enforced upon them depending on available staff. If the coercive treatment is not enforced upon the person in good will- which according to the Kantian theory is hypothetical imperatives, the intention would lay a foundation for the relation between the person and the practitioner. However, the research acknowledges that the persons might misinterpret the situation of enforcing coercive measures, based on their mental health, thus the importance of later reflection on their experiences.

It is also important to bear in mind that there is an inconsistency in both understanding the term morality and the intention behind the actions. The findings reveal that there is a power-dynamic present, in which the social workers appear as 'closer' to the persons in treatment than the doctors in charge of making decisions concerning coercive treatment.

By applying the Kantian understanding of categorical imperatives and hypothetical imperatives, to the findings, several questions are relevant. The hypothetical imperatives relate to what someone ought to do based on their desires, independent of their moral reason to act in such a way (Kant, 1998). Firstly, this research questions whether the enforcement of

coercive measures is something the practitioner *has* to do morally. The legal framework and literature reviewed makes it evident that there are comprehensive international, regional and national regulations and guidelines regarding coercive treatment. However, these guidelines only cover the legal aspect and not the moral. According to the Kantian theory, morality comes from within. In addition to following regulations from above regarding the enforcement of coercive measures, there is an ability to make decisions from within every professional. However, Kant states that these hypothetical imperatives emphasise that one does have a choice and follows what we ought to do morally. In this specific context, the legal instructions may overcome any moral desires.

The findings suggest that some of the actions enforced during coercive treatment, may go beyond the legal instructions. For instance, some of the interview subjects refer to situations of which they have been put in isolation or mechanical restraints for a long period of time. The time was considered unnecessarily long, and the interview subjects described being kept in the restraints even after calming down. Furthermore, this relates to the moral aspect of the enforcement. The categorial imperatives relate to what a person is obliged to do. You are not bounded by an external factor, but by moral law. The legal instructions, are not considered to be moral law, therefore they may not count as something the professionals *have* to do according to Kantian philosophy (Kant, 1998). The literature explored in this study, also proves that there is both a lack of studies regarding the necessity of coercive treatment and disagreements on the necessity. However, national and international legislation and literature suggest reducing the use of coercive treatment.

Dworkin's New- Kantian representation of morality, adopts a political understanding of the term. As all the professionals in the facilities are obliged to comply with legal instructions, this also relates to the dignity and power relations, just as the interpretation and discussion of the Kantian understanding implied. Dworkin's first principle relates to how the government should show equal concern for all citizens (Dworkin, 2011). The principle can be discussed in relation to the legislation presented in the legal framework. The legislation does not particularly differentiate between people in treatment, however the implementation of the legislation suggests that there are inconsistencies present. The second principle of the author illustrates that the government should respect the responsibility and right of all citizens to make something a value of their life (Dworkin, 2011). Applying Dworkin's second principle within political morality, we could discuss to what extent the Norwegian government shows

respect and responsibility towards the rights of persons in coercive treatment to make something a value of their life.

The literature explored, makes it evident that there is a disagreement concerning the value of the persons' life. This leads to a discussion of elements that are found important when discussing the value of the patients' lives. Firstly, the value of the life before being coercively admitted is considered important. Some may believe that there is a lack of value, considering their mental health and some persons' wanting to harm themselves or others. If such an argument is believed, we could discuss whether the government contributes with the intent to increase the value of their lives whilst in treatment, compared to before being in mental health care facilities. Lastly, it is important to note that the persons talked to in the interviews, were not in treatment at that specific time. Despite this, there seems to be a discrepancy among the participants concerning whether the value of their lives have been increased after treatment.

In this section, the relation between coercive treatment and dignity has been discussed in perspective of Kantian- inspired understandings of morality. The discussion was initially based on the claim that some professionals lack morality. The discussion proves that there is a foundation to believe that ill- treatment is enforced upon the persons in treatment, based on a lack of morality. The hierarchic positions seem to appear as decisive regarding the perceptions of treatment. Another important element in the discussion of morality in coercive treatment has been the value of a person's life which is illuminated in different ways through Kantian- inspired theories. In this research project, the persons in treatment are experts regarding their value of life themselves. This provides an answer to the research question through the discussion of morality in the context of coercive treatment. The professionals should take into consideration the persons' perception in the situation no matter what perception they have of the value of their life. This is important to avoid the feeling of their dignity being harmed. A good example is given by one of the participants who claimed that the coercive treatment actually increased her view on her own dignity. The claim that professionals lack morality also proves that an improvement of the relation between professionals and persons in treatment is needed.

6.2 Is there an Intermediate Stage Between Rationality and Irrationality?

The findings reveal that persons with experience from mental health care facilities relate their perception of dignity to being human, to fulfilled human rights and describe that dignity is something they all have. The dignity seems to be affected by certain ways of enforcing coercive treatment. Parts of the literature reviewed make it evident that there is a conflict between ethical and legal understanding of coercion on one hand, and the health care professionals' and persons' understanding on the other hand. This provides reflection regarding the importance of the persons own perspective, and whether their reflection should be taken into consideration differently in treatment compared to after treatment. It becomes evident in the interviews that the persons' reflection subsequent to the treatment was rather different than their perception whilst in treatment. Their change in reflection can also be related to their rationality and whether they were more rational after the treatment. This also opens up for whether there could be an intermediate stage between rational and irrational or if one could only be either rational or irrational.

Kant defines dignity by relating it to the concept of value. He emphasises the importance of human beings as beyond value. And he describes that all human beings have an inner value, which is beyond price, and this value is illustrated as dignity. This inner value is present in all human beings, based on the ability to be rational (Kant, 1998). With the Kantian aspect of value as vantage point, this research displays some critical questions. If the persons' perception of dignity is related to their humanity, the questions raised relate to whether they feel less humane when they describe situations in which their dignity is perceived as infringed upon. Discussing their perception of dignity through the Kantian theory, based on the notion of dignity being a value innate to every human being, several questions can be raised. The discussion also provides a discussion concerning what professionals in these facilities can do to avoid that the persons perceive their dignity as infringed.

There needs to be made a distinction of whether dignity is perceived as something that makes persons human beings, or as a value within that every human possesses. Even though the participants related their definition of dignity to being human, and human rights, they also argued that they did not feel less of humane after the perception of their dignity being infringed. Secondly, if it is true that dignity is something within every human being, then this proves that only human being themselves can know whether their dignity is affected by the coercive treatment or not. Lastly, Kant emphasises that every human being is rational, thus all

human beings possess dignity. Now, this leads us to the discussion concerning these persons, who are clearly struggling with their mental health and whether they are rational or not. From a professional point of view, the persons might be considered irrational based on their diagnoses. The literature explored also illustrates that the impression of people with mental illnesses may be related to their ability to not comprehend situations (Høyer & Dalgaard, 2002). This research tests the claim through the Kantian view on rationality.

According to Kantian philosophy, all human beings are rational, and all human beings should be treated with dignity, no matter what they have done or who they are. This argument is based on everyone's ability to make good or bad choices for themselves, even in situations when they do not do so (Kant, 1998). By applying this part of the Kantian theory to the discussion, it is claimed that persons in coercive treatment should also be treated with inherent dignity, independent of whether they wish to harm themselves or others in that particular situation. This research suggests that the persons deserve to be treated with respect, on the virtue of humanity and they may not be able to set ends for themselves in the particular moment, but they are still able to do so in the future. Furthermore, it is important for this thesis that there are intermediate stages between rationality and irrationality, thus persons cannot be labelled as irrational based on their mental health.

By applying the Kantian concept of dignity, to the context of coercive treatment, this research argues that the persons should be treated with inherent dignity, independent of their diagnoses. Hence, the medical model is irrelevant in the discourse. By presenting dignity as synonym to rationality, Kant suggests that if dignity is violated, rationality may be affected. However, the application of this aspect of Kantian theory in the context provides issues. In the research project, the participants' responses indicate that dignity is something all human beings possess, but not something that makes them rational, Neither, is dignity a defining characteristic of a human being. If we believe that dignity decides whether one is human or not, this allows for the dehumanisation of individuals who have had their dignity violated.

The New Kantian philosophy describes the concept of dignity through the two main elements authenticity and self- respect. Dworkin highlights that human lives are inviolable, and that everyone has the responsibility to respect their own life. The philosopher emphasises that dignity requires these two principles (Dworkin, 2011). However, the New- Kantian philosophy provides a discussion regarding the concept of respect. Both the New- Kantian and Kantian philosophy emphasise that you cannot respect your own humanity unless you

respect the humanity in others. This research project disagrees with the two philosophies on this particular notion. The persons in treatment may be in a state of mind which result in action that does not respect either your own or others humanity, hence the intermediate stage between rationality and irrationality. Nevertheless, that does not mean that they should not be respected themselves.

By applying New- Kantian philosophy to the findings concerning dignity we can discuss whether the persons themselves possess the two required elements of self- respect and authenticity. On one hand, one can argue whether the element of self- respect is lacking within the persons, as some of them are admitted to mental health care facilities for self-harm, or even attempted suicide. Such actions could suggest a lack of self- respect. However, the principle of self- respect also implies that all human lives are inviolable and should therefore be treated just as worthy as any other person. This makes it evident, that also the New- Kantian philosophy emphasises that the persons in treatment of mental health care facilities should be treated well, just as the Kantian understanding implies. When taking authenticity into consideration, striving towards independence and away from domination is emphasised. From a Kantian approach, this suggests that persons in treatment should avoid coercive treatment. However, in contradiction it could be interpreted as encouraging persons in treatment to undergo coercive treatment to allow for independence.

Dworkin argues that all human beings have free will and responsibility to live their life well. The value a person can give to his life is referred to as an adverbial value, and the life should be lived well to cherish the dignity. All human beings share the principles of free will and responsibility is shared by all human beings by the virtue of humanity (Dworkin, 2011).

The literature reviewed suggests that there is a desire to increase patient participation in mental health care facilities. However, this research suggests this may not be possible when patients are not considered rational human beings, or capable of making decisions for their own good. Similar to the Kantian theory, the difference between being able to do good and actually doing good is present, and a foundation for discussion based on the rationality of the persons.

The discourse of rationality in New- Kantian perspective, reveals the claim that all persons possess free will and responsibility. Dworkin's notions can build upon this, in discussing to what extent persons in treatment are giving their life an adverbial value. Dworkin's

description of living well provides a foundation for several questions. From the literature explored and findings deduced, it becomes evident that the perception of what a life lived well is, is different in this context. When the persons are admitted in mental health care facilities they may believe that their decision to commit suicide is best for themselves. However, practitioners may disagree and wish to provide a life worth living, as one of the interview subjects stated. On another note, we could ask whether the life lived to a mental health care facility, is a life well lived. One of the participants spoke of his time in isolation when he was in confinement, which was argued to be for the protection of those around him. Relating his situation to the New- Kantian philosophy, it provides the discussion of whether the isolation can be considered a life well lived for the person. This research wants to emphasise the importance of protecting the persons free will and responsibility, equally to protecting the people around the person. By violating the persons' dignity, this research also argues that there seems to be a lack of respect for the persons' rationality in treatment.

A discourse concerning the rationality of persons in coercive treatment, is provided in this section. The rationality is further considered to relate to different perceptions of dignity. This specific discussion is based on the argument that persons in treatment of mental health care facilities are not rational. However, a point to be drawn from this claim is whether it justifies not treating these persons with dignity. Another perspective to discuss the notion of rationality from, is whether the practitioners seem to operate rationally or not, when enforcing the coercive treatment. Both of the perspectives provide the discussion of whether there could be stages between rationality and irrationality. The interventions in coercive treatment seem to be based on a lack of rationality, in the context of rationality understood as being able to make good decisions for yourselves. But the question of whether there could be any partial rationality, based on the mental health of the persons, does not seem to be considered in the facilities. This research claims that the Kantian and New- Kantian philosophy may have overestimated the concept of rationality. The philosophies indirectly open for coercive treatment, by proposing criteria to be respected, and presenting persons as either rational or irrational.

In this particular research project, applying both the Kantian and New- Kantian philosophy depends on the interpretation of the theories. Particularly the New- Kantian theory's focus on free will and responsibility, has been interpreted carefully and critically in the context. However, by raising consciousness towards the perceptions of the persons in treatment of mental health care and listening to their voices with their diagnoses in mind, their perception

of treatment will change towards the positive. This will further contribute to reduce the amount of coercive treatment and increase the amount of voluntary treatment. Additionally, by improving the relation between practitioner and person, in particular doctor and person, the persons may feel less powerless and the hierarchical relations will be less visible. This research also discusses and emphasises the relational aspect of dignity. For instance, one of the participants described a situation of coercive measures where she had to use the toilet in front of several professionals. This is not considered to relate to rationality, rather relations. Thus, the study does not qualify for dignity through rationality, but by showing respect based on humanity in relations. This expresses a lack in the Kantian and New- Kantian theory presented. The critique done by Margalit and Sensen is relevant for this research project as they explore a relational aspect of dignity. Thus, this study argues that the Kantian- inspired ethics should be expanded to include the relational aspect.

6.3 Are Persons in Coercive Treatment Being Used as 'Means'?

According to the findings, the respondents did not find coercive measures themselves harmful to their dignity, but rather the methods of implementation to enforce the coercive treatment, was perceived as harmful to their dignity. This seems to make the margin between therapy and torture very narrow. In several situations, the participants described the treatment as torture. When referring to the terms treatment and torture, the interview subjects clearly described them as contrasting.

These findings relate to a Kantian understanding of 'ends' and 'means'. According to the Kantian philosophy, human beings should never be treated as means, but should be treated as ends. Just as all human beings are able to act rational, all human beings are also able to set their own ends. This is further related to the notion of respect, which means that all human beings deserve to be treated with respect based on their ability to set their own ends (Kant, 1998).

Even if beneficial for society, it is wrong to treat people as instruments to make others happy (Kant, 1998). Some people may claim that the coercive treatment violates the dignity of the patients. However, others claim that the coercive treatment is necessary to help the patients gain their dignity. The persons considered in this research, are most likely treated with the intention of helping them out of a mental illness. Thus, it would be hasty to conclude that they

are being used as ends in coercive treatment. They are not exploited for instrumental purposes, unless the practitioners have a need to inflict violent treatment. It would be a risk to lower the standards of coercive treatment, for the convenience of the staff in psychiatric facilities.

In the discussion of whether the persons are being treated as means, this research suggests that they perceive so through being objectified. Several of the participants, describe situations where they needed to be treated as humans. If they are being used as means through objectifying, they may not be satisfying someone's needs, but rather being used as means through the system, and through the relations present. The findings suggest that the persons are being used as objects in advantage for the system, economy and organisational factors.

It is important to bear in mind that the intention of practitioners in mental health facilities is significant. For instance, one of the interview subjects interpreted certain coercive situations by stating that the reason behind the coercive actions was a lack of available staff. Hence, we could argue that the person was used as an end, for other reasons than prescribed through the legislation. Among other things, the findings suggest that this is done to reduce the load of work in the facilities when there is a lack of staff available.

In Dworkin's theory of liberty, he differentiates between liberty and freedom. Freedom is considered the actions taken with no government restraints, whereas liberty is defined through the principles of ethical independence, right to free speech and right to govern oneself. The philosopher's notions support the idea of the right to liberty, and not the general right to freedom for everyone (Dworkin, 2011)

The New- Kantian theory is in particular related to several principles regarding rights. The findings of this research project reveal that several of the interview subjects believe the mental health care facilities are excused of all human rights. However, the same persons believing there are no human rights present, also state that they do not want to claim they have been exposed to human rights violations. Relating their situation to Dworkin's theory, several of the interview subjects seem to perceive a lack of freedom. Now, whether they are referring to a lack of general freedom or a lack of liberty, can be discussed. The necessity of reducing the persons' freedom or liberty is also a relevant matter and is also acknowledged by several of the participants.

When the participants talked about isolation as a coercive measure, one of the persons described that he had almost no human contact for several weeks. Applying the Kantian and New- Kantian theory to his situation lays a foundation for discussing whether the isolation still works as a treatment. As the respondent was considered harmful to the people around him; he acknowledged himself that he was tall and strong and therefore they could not control him. However, he also described that he was calm after a certain time but kept in restraints and still isolated. Persons still have liberty within the facilities, however complete freedom would be potentially harmful for themselves or others. An important factor provided through the findings is that the facilities need to accommodate staff who can work with diverse persons in treatment. For instance, having more and stronger men available could have reduced the enforcement of coercive measures in this particular situation.

According to the literature explored, there are inconsistencies in relevant academic literature regarding the necessity of coercive treatment, and coercive measures in particular. The literature makes it evident that there has been a lack of studies concerning coercive treatment in mental health care facilities over at least a decade. Overall a great majority of literature and jurisdiction aim to reduce the use of coercive treatment. The findings seem to correspond with the literature and jurisdiction regarding the aim to reduce coercive treatment, however one of the interview subjects also state that the treatment was experienced as helpful and dignifying. In this particular situation, the person seemed to have developed a good relation to the practitioners based on dignity and humanity.

This section describes that the perception persons with experience from mental health care facilities have of coercion and dignity, is related to how the practitioners treat them while enforcing the coercive measures. The research claims that the persons in treatment are being used as means for the advantage of the system. There is no doubt that both the Kantian and New- Kantian philosophy support that all human beings should be treated with dignity. However, the New- Kantian philosophy suggests a division between freedom and liberty. The division is related to the necessity of the coercive treatment. This discussion provides an answer to my research question by highlighting the importance of the relation between practitioners and the persons in treatment. Several organisational factors seem to affect this relation, which further affects the perception of being objectifying and used for the advantage of these factors.

6.4 Can Dignity be Considered Static?

The information conducted through the interviews, reveals that in the great majority of the situations, the dignity is perceived as infringed only during the coercive treatment. However, later reflection show that most participants did not feel that their dignity was infringed after the event of coercive treatment. This provides a discussion of whether the dignity can be considered as static, i.e. if it is harmed once, it will remain harmed for ever. By introducing such a discussion I broaden the Kantian view; I both apply Kant and expand his approach which is implicitly a critique of him.

The definition of dignity is based on it being beyond price because all human beings have the ability to be rational according to the Kantian philosophy. As already presented, the Kantian definition of dignity is related to the notion that all human beings are rational, and that human beings are not mere objects, that can be used by others (Kant, 1998).

The rationality of the persons in treatment lays a foundation for discussion in this section as well. If there is made an argument, based on the notion that persons are not rational whilst in treatment, because of their mental health, the assumption that dignity is perceived as infringed because they may not be considered rational themselves is developed. Whilst, after ended treatment, when their mental health has improved, persons may be rational again, thus their ability to reflect on the situation in a different manner. If such a discussion is to be believed, then the questions of dignity, being static, depends on whether the rationality is static or not. Discussing the notion from a Kantian point of view, the rationality is not something that has disappeared in the context, but something which is still there. The ability to be rational is still present even though one may not act or reflect rational in the situation.

Another reason behind the subsequent reflection and change of perception may be related to the long- tail effects of the coercive treatment. As one of the respondents narrated, she believed that the practitioners made her feel more dignified in a context where she initially did not feel dignified at all. The perceptions of the actions taken, and the coercion enforced upon her while in confinement, might have changed subsequently because she realised that the coercive treatment improved her mental health. As opposed to the other respondents, she experienced that her dignity was increased, as opposed to while she was in coercive treatment, and she felt more worthy after the treatment. Even though her experience was different from the other interview subjects, it is relevant to highlight that also her perception of dignity did

change towards the positive. Her positivity towards the social workers and her appreciation towards her relation to them, seemed to further affect her perception of dignity in coercive treatment.

The New- Kantian philosophy suggests that the government must have equal respect for the dignity of all citizens. Dworkin states that people are not responsible themselves for their place in society. Even though the theory focuses on the government's responsibility over its' citizens, Dworkin also emphasises that everyone has the responsibility to make something of their life (Dworkin, 2011).

The practitioners comply with instructions following legislation developed by government. The gap in this situation is nevertheless based on the deviation between what is legally instructed and what is practised in the facilities. A great majority of the respondents express a perception of vulnerability already from the moment they are admitted to hospital regarding the information they are provided. Already from this moment, do several of the interview subjects describe that the information they are provided may not be the information they have perceived, dependent on their mental health in the context.

The literature explored suggests that practitioners are legally bound to act according to the instructions regarding coercive measures. However, according to the interview subjects, they indicated comprehension towards the enforcement of coercive measures. The contradiction regarding the use was rather intended towards parts of the way the coercion was enforced upon them. For instance, some examples show that the coercion was enforced beyond the instructions given in the legislation, which led to a temporarily feeling of violated dignity. Thus, evident that the violation of dignity may not mean it is violated forever, or that you are less of a human being, rather that dignity is something that could be perceived as violated in the moment, without it having permanent effects on your humanity.

From this section, the understanding is perceived that the Kantian and New- Kantian philosophy related rationality, value, respect and responsibility to the concept of dignity. These elements provide a foundation for further discussion of whether dignity is static. The findings have illuminated the importance of persons' perception in the context. The discussion has led to the argument that neither perceptions or rationality is static. In this research project, dignity is perceived as an element within all human beings, not something that determines their humanity, independent of their mental health. Even though dignity does appear to be

harmed or infringed, according to the interview subjects, this does not seem to affect their perception of feeling humane. However, the perception of infringed dignity, even for a short period of time, is considered as something that should be avoided. Therefore, the elements of rationality, value, respect and responsibility are considered extremely important.

Through the discussion provided in this section of the thesis, it becomes evident that the perception of infringed dignity seems to be temporary. Even though the definition of dignity is related to being human by the interview subjects, several of them reveal that they did not feel less humane when they perceived that their dignity infringed. Through the Kantian and New Kantian philosophy, the relation between coercive treatment and the perception of dignity, is associated with rationality, value, respect and the involvement of the government. The discussion reveals that even though, dignity may not be experienced as infringed after the coercive treatment, it is important that the persons are treated with respect in the moment of enforcement. The New- Kantian philosophy shows that this is not only related to the practitioners in the facilities, but that legislation concerning the treatment is of highly importance. By developing a more explicit legislation, there will be less inconsistencies among staff, wards and hospitals concerning the method of enforcement, which would benefit in particular the group of persons referred to in this research project who have experience from several wards and hospitals.

Chapter 7: Conclusion

The thesis was introduced with the aim to answer two research questions regarding the relation between coercive treatment and dignity. The relevant academic literature proves that the concept of dignity is vague and there is a need of more research from the perspective of persons who have experienced coercive treatment. Elements of Kantian inspired theories, have been explored, to provide a thorough understanding of dignity. The literature, theory and findings of the research, have provided a discussion to answer the research questions. The research questions for this project remain:

- In what way do persons who have experienced coercive treatment in mental health care facilities in Norway perceive the coercive treatment and its relation to dignity?

- How can Kantian- inspired ethical understandings of dignity help to provide an expanded understanding of the persons experiences of coercive treatment in mental health care facilities in Norway?

Answering the first research question the findings reveal that there is an inconsistency between legislation and the perception of persons who have experienced coercive treatment. Some of the participants in the research, narrate that practitioners allow themselves to enforce coercion considered to be beyond the jurisdiction. The importance of being informed is also emphasised in the findings, and the study suggests that it relates to being perceived as rational, thus the relevance for dignity. When providing an answer to the second research question, rationality is emphasised as an important element in the Kantian philosophy. However, this study disagrees with the philosophy in certain matters. In this research study rationality seems to be too narrow framework for dignity. The study includes feelings, experiences and relations as dimensions of treatment in dignity. Hence, suggesting a need for more than the Kantian- inspired theories, even though it holds on to the concept of inherent human dignity of all human beings. Thus, suggested that all human beings should be respected, independent of their ability to make good or bad choices for themselves in the particular moment of coercive treatment. The discussion allows for intermediate stages between rationality and irrationality, and not being either rational or irrational. It is possible to be partly rational, thus the importance of listening to persons who have experienced coercive treatment.

The findings also expose through an ethical discussion of legislation, that the distribution of information in mental health care facilities is currently not sufficient and explicit enough. These findings provide an answer to the first research question. Several of the participants seem to believe that the psychiatry is excused of human rights. And that the doctors' profession lacks morality. Seen that the human rights are related to dignity, the particular findings suggest that mental health care facilities in Norway needs to broaden their perspective of the concept of dignity. To answer the second research question, the philosophy explored, relates dignity to humanity. Believing that dignity is a defining characteristic of a human being, Kantian theory allows for dehumanisation of humans who perceive their dignity to be violated. Answering the question in the title of this thesis, dignity should not be compromised in treatment, neither should dignity. The findings reveal that there is an immense need of humanity, proximity and human compassion in the facilities, to avoid the

perception of infringed dignity. Thus, the importance of developing good professional relations and avoiding perceptions of immorality among professions. Good relations could contribute to change the feeling of vulnerability, powerlessness and fear, which seems to influence the dignity of persons in coercive treatment. To avoid subjective interpretations of legislation within facilities, which further results in inconsistencies in the treatment, the legislation needs to be clarified thoroughly so that it is less vague. Through the New- Kantian philosophy it becomes evident that the legislation is equal to all citizens. Both findings and theory make it evident that dignity is defined and perceived in various ways, which makes the definition in this particular context challenging. Agreeing with this philosophy, both the theory and the findings suggest need of changes in the current legislation, to make it more explicit by identifying and defining the concept of dignity.

Because of the various perceptions of dignity, persons perceive the relation between coercive treatment and dignity in different ways. The discussion of this research provides a reflection on whether dignity can be considered static, to answer the first research question. The discussion is based on the findings of later reflection being different compared to the perception of infringed dignity in the moment of experiencing enforcement of coercive measures. The findings prove that infringement of dignity does not relate to being less humane and that the perception may relate to the intermediate stages between rationality and irrationality. This makes it evident that the treatment needs to be adjusted according to every single person in confinement, as some described that they were not heard because they did not scream loudly enough. In addition to feeling less visible, some also describe being objectified while in confinement. Providing an answer to the second research question, this study reveals that persons in treatment seem to be used as what the Kantian theory describes as means. This is done in benefit of the system, economy and organisational factors, such as lack of available staff. The study claims that the government need to lay down explicit guidelines for coercive treatment, to avoid objectifying the persons, as it contributes to feeling less dignified.

Seen that this research has a one- sided focus, further research may provide to explore coercive treatment from the perspective of practitioners. The study has also suggested the importance of the relational aspect of dignity, which could further be studied explicitly.The voices of the persons exposed to coercive treatment and access to their narratives, makes this research particularly unique. This have given me a chance to include these perspectives in an understanding of dignity in this particular field of treatment in health care facilities. The participants in the research have been significant to provide a nuanced understanding of the

relation between coercive treatment and dignity. Through an ethical analysis of dignity, the research wishes to provide suggestions of how and what the coercive treatment can improve to humanise and dignify persons in treatment.

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