

From the Department of Learning, Informatics, Management  
and Ethics  
Karolinska Institutet, Stockholm, Sweden

# **THE MOTIVES AND ETHICAL JUSTIFIABILITY OF TREATING PATIENTS WITH BORDERLINE PERSONALITY DISORDER UNDER COMPULSORY CARE**

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# The motives and ethical justifiability of treating patients with Borderline Personality Disorder under compulsory care

Thesis for Doctoral Degree (Ph.D.)

By

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The thesis will be defended in public at Ingheälsalen, Karolinska Institutet, Tomtebodavägen 18A, 171 77 Stockholm, on the 31<sup>st</sup> of May 2024, at 9 a.m.

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*To all the kind people who have helped and supported me,  
and to all who have taught me the value of patience and  
humility*

## Popular science summary of the thesis

To detain a person against their will in a psychiatric hospital is a serious matter. Imagine if it happened to you – would you not feel frightened, angry, or hopeless? So, when such admission is ordered, one should think that the deciding doctor has very good grounds for doing so and that the expected benefits outweigh the harm of depriving a person of their freedom.

This thesis is about compulsory care of patients with a diagnosis called borderline personality disorder (BPD). These patients suffer from unstable moods, strong emotional reactions to adverse life events, separation anxiety, problems in interactions with other people, and recurrent suicidal behaviours as a response to negative emotional reactions. Because of their suicidality, these patients have been subjected to hospital admissions, including compulsory ones, to a large extent over the last decades. The purpose has been to decrease suicide risk. Unfortunately, this treatment has not shown to be helpful for them – instead, their difficulties and suicidal behaviours seem to increase with longer admissions. Therefore, it has not been clear why psychiatrists continue to order compulsory care to such a large extent as seems to be the case. This thesis investigates their motives and also analyses the ethical justification for using such care.

To answer my research questions I have conducted an interview study with psychiatrists, two questionnaire studies with care providers working in emergency- and inpatient units, and two philosophical, so-called normative, studies to answer the questions of ethical justification.

The results from the interview study and first questionnaire study showed that psychiatrists have diverging opinions on when it is justified to compulsorily admit patients with BPD, when patients with BPD are considered unable to decide about their care, and if the risk of harm to oneself or others should constitute grounds for compulsory admission. These differences in opinion could mean that patients get treated differently depending on which psychiatrist they happen to meet, and that would make the care unequal.

The second questionnaire study showed that compulsory admissions sometimes get prolonged, and thereby could cause more harm to the patient, because of reasons that should not be grounds for compulsory care. Motives for such non-beneficial compulsory care were, for example, problems in finding

proper housing for the patient and doctors' fear of complaints or litigation if they discharge the patient. Most hospital staff experienced that the hospital admissions were too long in their wards and noticed that these patients' self-harm behaviours seemed to increase already after a few days in the hospital. Therefore, they recommended that hospital admissions should be short (around three days) and voluntary, that outpatient care should be more available to the patients, and that the inpatient care should be well-planned from the start – including a set discharge date.

One of the philosophical studies concluded that compulsory care should not be ordered just because a patient with BPD requires it. That sometimes happens and could be explained by the patients's fear of trusting their ability to handle destructive impulses. The other philosophical study concluded that, in most situations, compulsory admission should not be used for patients with BPD. There could however be exemptions on rare occasions, e.g., if the patient suffers from another psychiatric disorder that makes them unable to make a considered decision about the care offered, and stands to benefit from admission. When deciding on compulsory admission, the doctor should be aware of the potential harms of ordering such care, including increased suicide risk. Also, the expected benefits from the treatment should outweigh the potential harms.

Several suggestions on how to make the use of compulsory admission more evidence-based, equal, and beneficial to patients with BPD, are presented in the thesis.

## POPULÄRVETENSKAPLIG SAMMANFATTNING

Att bli frihetsberövad, inlåst på en psykiatrisk avdelning under så kallad tvångsvård, är något som kan upplevas mycket stressande för en människa. Tänk dig själv om du skulle hamna i en sådan situation, utan att veta hur länge du kommer vara inlåst, utan att kunna gå ut som du önskar, och kanske få medicin tillförd din kropp mot din vilja under fastspänning. För att göra ett sådant ingrepp på en människas frihet kan man tänka sig att det ska finnas så pass goda medicinska skäl att dessa överstiger den skada som ett frihetsberövande innebär. Dessvärre är det inte alltid så.

Denna avhandling handlar om tvångsvård av patienter med borderline personlighetsyndrom (här förkortat BPD). Patienter med denna diagnos har ofta snabbt svängande och intensiva känslor, känslighet för avvisanden och växlande identitetskänsla beroende på sammanhang. Dessutom är det vanligt med självmordstankar och självskadehandlingar, exempelvis som reaktion på livets frustrationer eller för att känslorna kan upplevas så överväldigande. Utifrån denna återkommande suicidalitet har patienter med BPD sedan flera decennier tillbaka varit en grupp som i hög utsträckning varit föremål för tvångsvård. Syftet har givetvis varit att hjälpa patienterna så att de ska få bra behandling och kunna skrivas ut icke-suicidala. Dessvärre har den samlade erfarenheten visat att det vården intuitivt trott ska vara bra för dessa patienter, såsom inlåsning och övervakning, inte visat sig vara hjälpsamt. Istället pekar erfarenheten mot att tvångsvård och andra "hindrande" åtgärder i slutenvårdsmiljö verkar försämra patienternas förmåga att själva reglera sina känslor. Dessutom har man märkt att patienternas självskadebeteende verkar öka redan efter en kortare tid på sluten avdelning och att sådan vård inte verkar minska patienternas suicidrisk över tid utan istället kan öka den.

Trots dessa negativa erfarenheter av tvångsvård och tvångsåtgärder för patienter med BPD så fortsätter användandet av tvångsvård för patientgruppen i hög utsträckning. Patienternas egna erfarenheter har beskrivits i både forskningsstudier och i litteraturen, och flera har beskrivit hur långvarig tvångsvård och tilltagande tvångsåtgärder försämrat deras tillstånd och medfört traumatiska upplevelser. Det har dock inte gjorts mycket forskning på varför psykiatriker väljer att tvångsvårda patienter med BPD, erfarenheten till trots. I denna avhandling studeras just vårdpersonalens motiv till att tvångsvårda dessa patienter och jag har också undersökt i vilka lägen tvångsvård kan vara etiskt försvarbart.

Fem studier ingår i avhandlingen, både intervjuer med psykiatriker samt enkätstudier till psykiatri-personal inom akut- och slutenvård. Utöver dessa ingår två filosofiska studier som undersöker i vilka situationer tvångsvård för patienterna kan vara försvarbar ur etisk synvinkel.

De främsta resultaten från avhandlingen är att psykiatrikers uppfattningar om när det är motiverat att tvångsvårda patienter med BPD skiljer sig betydligt. Detta skulle kunna förklara varför användandet av tvångsvård för dessa patienter varierar kraftigt mellan olika kliniker i Sverige. Det framkom även i studierna att det föreligger andra motiv än rent medicinska för att tvångsvårda patienterna längre tid än vad som uppfattas vara gynnsamt för dem. Sådana motiv var bl.a. att läkarna var rädda för att bli anmälda om de skrev ut en patient som har kvarstående suicidrisk eller att det saknas lämpligt boende för patienten. I en studie efterfrågades vårdpersonalens erfarenheter kring att tvångsvårda patienter med BPD och det framkom att patienternas självskadebeteende verkade öka redan efter några få dagars tvångsvård. Det framkom även att de flesta upplevde att tvångsvårdstiderna på deras respektive vårdavdelning var för långa för patientens bästa. För att minska användandet av skadlig tvångsvård för patienter med BPD föreslog vårdpersonalen exempelvis korta frivilliga inläggningar (kring tre dagar långa) när patienten är i kris, tydlig vårdplan vid inskrivning med vad som ska uppnås och när patienten ska skrivas ut, samt mera satsning på öppenvårds-behandling.

En av de filosofiska studierna undersökte om det var motiverat att tvångsvårda patienter när de själva så önskar, vilket verkar ske ibland. Studien kom fram till att det inte är etiskt försvarbart att använda tvångsvård på det sättet. Den andra filosofiska studien undersökte vilka motiv till tvångsvård för patienter med BPD som är etiskt berättigade. Slutsatsen var att tvångsvård för dessa patienter sällan är etiskt försvarlig, såvida de inte lider av ett samtidigt allvarlig psykiskt tillstånd som gör dem oförmögna att ta ett grundat ställningstagande till vården och att man dessutom bedömer att tvångsvård är nödvändigt för att möjliggöra vård som är i patientens bästa intresse.

Just svårigheten för vårdpersonalen att skriva ut en patient med kvarstående suicidrisk, samt rädsla för anmälningar till följd av detta, verkar vara några av de vanligaste skälen till att ogynnsam tvångsvård förlängs för patienter med BPD. Samtidigt verkar denna typ av vård i sig inte skydda mot suicid utan istället kan öka risken för framtida suicid. En förklaring till det fortsatt höga användandet av tvångsvård skulle kunna vara att det finns en spridd intuitiv föreställning om att

inlåsning och övervakning av suicidala patienter är det säkraste valet. Då kan det vara svårt att ge patienten frihet och eget ansvar för sin vård – fastän erfarenheten visar att det verkar vara det mera gynnsamma och långsiktigt säkrare alternativet för de flesta patienter med BPD. För att minska användandet av skadlig tvångsvård för patientgruppen kan det behövas tydlig information till vårdgivare och granskande myndigheter om de skadliga effekter som tvångsvården kan medföra. Rimligen borde läkare som beslutar om tvångsvård för patienter med BPD alltid väga den förväntade nyttan för patienten mot den potentiella risken.

# Abstract

This thesis aims to **investigate what motives** psychiatrists have for detaining patients with BPD under compulsory care. Also, to examine hospital staff's experiences of treating patients with BPD under involuntary care and **improve the inpatient mental health care** for these patients. Finally, to ethically deliberate on if or when compulsory care is justified for patients with BPD, and thereby **provide ethical guidance** to psychiatrists when deciding on such care. The thesis consists of five studies. Here are the abstracts:

**Study I:** A qualitative study based on semi-structured interviews with twelve Swedish psychiatrists to investigate psychiatrists' motives for practising compulsory care of patients with BPD. **Results:** The qualitative data resulted in three themes: (1) patients with BPD are perceived as difficult, (2) there are medical and non-medical motives for compulsory care of patients with BPD, and (3) patients with BPD have decision competence and sometimes demand to be taken into compulsory care. **Conclusion:** The interviewed psychiatrists' judgements and values, rather than clinical and legal directives, were decisive in their practice of compulsory care.

**Study II:** A normative study on the ethical justifiability of treating patients with BPD compulsorily on their demand, as Ulysses contracts. We scrutinize the arguments commonly used in favour of such Ulysses contracts: (1) the patient lacks free will, (2) Ulysses contracts as self-paternalism, (3) the patient lacks decision competence, (4) Ulysses contracts as a defence of the authentic self, and (5) Ulysses contracts as a practical solution in emergencies. **Conclusion:** Ulysses contracts including compulsory care should not be used for this group of patients.

**Study III:** A questionnaire study distributed to all psychiatrists and psychiatric residents working in psychiatric emergency units or inpatient care in Sweden. The aim was to investigate their motives for treating patients with BPD under compulsory care. **Results:** The psychiatrists' views were divided on when it was justified to treat patients with BPD under compulsory care. **Conclusion:** The large variations in doctors' opinions indicate that the care of borderline personality disorder patients is arbitrary. Further, the assessed risk of harm seems to increase the use of compulsory care.

**Study IV:** A questionnaire study, the respondents being nurses and psychiatric aides employed at psychiatric hospital wards in Sweden. The study aimed to investigate the healthcare staff's experiences of treating patients with BPD under compulsory care. **Results:** Most respondents experienced that more than a week's compulsory admission either increased (68%) or had no effect (26%) on self-harm behaviour. A majority (69%) considered the compulsory admissions to be too long at their wards. Respondents recommended care plans with discharge dates and around three-day-long voluntary admissions to reduce compulsory hospital admissions. **Discussion:** These findings imply that many patients with BPD are regularly forced to receive psychiatric care that inadvertently can make them self-harm more.

**Study V:** A normative study on if and when compulsory care is ethically justified for patients with BPD. Analysis of commonly used arguments, which defend the use of compulsory care for patients with BPD: (1) the patients lack decision competence, (2) the patients lack authenticity, (3) compulsory care is suicide-preventive, (4) compulsory care safeguards the doctor against litigation, (5) compulsory care is a practical solution in emergencies, and (6) it is better for the caregiver to 'err on the safe side'. **Conclusion:** Compulsory care is rarely ethically justified, save for exceptional situations when the clinician has probable reason to believe that the patient lacks decision capacity, e.g., by suffering from a severe mental co-morbidity, and stands to benefit from such care.

## List of scientific papers

- I. Lundahl A, Helgesson G, Juth N. Psychiatrists' motives for practising in-patient compulsory care of patients with borderline personality disorder (BPD). *International Journal of Law and Psychiatry*, 2018 May-Jun; 58: 63–71.
- II. Lundahl, A., Helgesson, G. & Juth, N. Against Ulysses contracts for patients with borderline personality disorder. *Medicine, Health Care and Philosophy*, 2020; 23: 695–703.
- III. Lundahl A, Hellqvist J, Helgesson G, Juth N. Psychiatrists' motives for compulsory care of patients with borderline personality disorder – a questionnaire study. *Clinical Ethics*, 2022, 17(4): 377–390.
- IV. Lundahl A, Torenfalt M, Helgesson G, Juth N. Patients with borderline personality disorder and the effects of compulsory admissions on self-harm behaviour: a questionnaire study. *Nordic Journal of Psychiatry*, 2023 Jul; 77(5): 498–505.
- V. Lundahl A, Helgesson G, Juth N. Is compulsory care ethically justified for patients with borderline personality disorder? *Clinical Ethics*. 2024; 19(1): 35–46.

## List of scientific papers not included in the thesis

- I. Lundahl A, Helgesson G, Juth N. Ulysses contracts regarding compulsory care for patients with borderline personality syndrome. *Clinical Ethics* 2017;12(2):82–85.
- II. Lundahl A, Helgesson G, Juth N. Hospital staff at most psychiatric clinics in Stockholm experience that patients who self-harm have too long hospital stays, with ensuing detrimental effects. *Nordic Journal of Psychiatry*, 2022; 76(4): 287–294.
- III. Lundahl A. Suicide-preventive compulsory admission is not a proportionate measure – time for clinicians to recognise the associated risks. *Monash Bioethics Review*, 2024. <https://doi.org/10.1007/s40592-024-00190-6>

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## List of abbreviations

|     |                                 |
|-----|---------------------------------|
| BPD | Borderline Personality Disorder |
| DBT | Dialectical behaviour therapy   |



# Introduction

I work as a medical director and consultant psychiatrist, specialising in the care of patients who suffer from self-harm behaviour and borderline personality disorder (BPD) in an inpatient setting. When I began to work with this group of patients almost two decades ago, care providers in mental health care usually described them as difficult to interact with and treat with any success. Much of the inpatient care resembled imprisonment, with the patients often detained against their will, stripped of their private clothes, monitored, and subjected to coercive measures. Unfortunately, the restrictive interventions were rarely helpful, and the inpatient admissions could go on for weeks or months on end with limited or negative effects. At the same time, the legal grounds for conducting compulsory care of patients with BPD were murky.

In the last decade, several clinical guidelines have advised against long hospital admissions and overtaking of autonomy from patients with BPD, but still, I often hear of patients being hospital-treated in the same way as before. This has made me ponder: why do some psychiatrists still use compulsory care and long hospital admissions when much experience and clinical guidelines speak against it? Is there some critical factor that the clinical guidelines have missed? Are compulsory admissions sometimes medically justified? And, if so, are they ethically justified? There has been much research on patients with BPD and how negatively many of them experience compulsory care and inpatient care (Nationella självskadeprojektet 2015), but that has not significantly changed the clinical practice. So, to answer my questions I thought it time to turn the spotlight from the patients to the care providers and find out what motives psychiatrists have for treating patients with BPD under the Mental Health Act (Lag 1991:1128). The results are presented in this thesis. I hope that my research will help care providers in their clinical decisions on compulsory care of patients with BPD and, by extension, make the use of compulsory care more beneficial and aligned with medico-ethical principles.



# 1 Literature review

## Background and terminology: BPD

### *Borderline personality disorder (BPD)*

Patients with BPD often suffer from separation anxiety, a sense of inner emptiness, rigid and dichotomous thinking, a passive problem-solving style with tendencies to transfer the responsibility for themselves to others (known as active passivity), a context-dependent shifting sense of identity, a sense of inner emptiness, difficulties regulating emotions, impulsivity, difficulty perceiving their own emotions (alexithymia), and difficulties coping with negative emotions and aversive events in their lives. These inner problems can explain the more overt symptoms of BPD. Those symptoms include frequent changes in mood and emotion related to inner and outer stressors, intense emotional outbursts, difficulty handling personal relationships and perceived rejections, use of suicidality as a coping strategy in response to negative emotions or events, constantly shifting life plans, and experience of relentless crises. In moments of high stress, patients with BPD can display transient symptoms of psychotic character, but such symptoms are usually of limited duration (hours rather than days). The symptoms of BPD are present from early adulthood and cause significant long-term problems for patients in several areas of their lives. (Linehan 1993, American Psychiatric Association 2013, Perez-Rodriguez 2018) The prevalence is estimated to be about 2% in the general population, and around 10% in psychiatric outpatient clinics, while the prevalence in psychiatric inpatient care is about 20% (Ellison et al. 2018, Gunderson et al. 2013, Kunksapsstöd för vårdgivare n.d.). Most of the admitted patients with BPD are women and many are repeatedly subjected to compulsory care and coercive measures (Holm 2013, Åkerman et al. 2013, Nationella självskadeprojektet 2015).

### *Neurobiological findings underpinning the BPD diagnosis*

BPD has a heritable component, with genetics influencing around 40% of the symptoms (Distel et al. 2008). Also, cognitive aberrations can be detected using psychological testing, e.g., risky decision-making, deficient emotional empathy,

dichotomous thinking, paranoid cognitive style, alexithymia, and hyperreactivity to negative emotional stimuli (Mak & Lam 2013, Perez-Rodriguez 2018). Neuroimaging studies indicate a dysregulated top-down control of emotions and behaviour, similar to patients with panic disorder. However, none of the neurobiological findings is diagnose-specific and some aberrations seem to be partly reversible when the patients receive psychotherapy (Goodman et al. 2014, Perez-Rodriguez 2018).

### *Differential diagnoses of BPD*

Diagnostics in psychiatry are descriptive and the criteria for different mental health disorders are modified from time to time. This, of course, opens for individual interpretations and there is no denying that some diagnoses seem to go in and out of fashion. There can be tendencies that doctors try to help their patients by assigning them diagnoses for which there are pharmacological or other medical treatments – treatments that doctors can easily prescribe – or come with less prejudice or more popularity in society. This can explain why the use of the BPD diagnosis shifts over time. The symptoms and anamnesis consistent with BPD are sometimes described in terms of other diagnoses, e.g., bipolar disorder, depression, psychosis, PTSD, or ADHD. These diagnoses have some similarities with BPD, such as mood shifts, anxiety and distress, and impulsiveness. By using these other diagnoses doctors can motivate pharmacological treatments – and sometimes hospital admissions – to a larger extent than when the patient ‘only’ has a BPD diagnosis. (American Psychiatric Association 2013, Little & Little 2010, Paris 2018)

Unfortunately, this can lead to inefficient pharmacological treatments, unhelpful hospitalisations, and prevent patients with BPD from receiving more effective, psychological, treatments (Paris 2018). There are several examples of what differentiates BPD from the other diagnoses mentioned above. Firstly, the rapid mood swings, often related to external stressors, and lack of long stable periods – as opposed to the longer episodes of mood shift and long non-symptomatic periods that characterise affective disorders. Secondly, the distractibility and transient character of symptoms – as opposed to psychotic and affective disorders. Thirdly, the lack of psychomotor inhibition – which can be seen in severe depression. Fourthly, the lack of childhood ADHD symptomatology – a mandatory criterion for ADHD diagnosis. And lastly, the lack

of a specific trauma that has prompted most symptoms – as in PTSD. BPD also has certain characteristics which are not described in the other diagnoses, for example, interpersonal problems and sensitivity to rejection, constantly recurrent crises, active passivity, unstable sense of identity, feelings of inner emptiness, and self-harm behaviour. (American Psychiatric Association 2013, Little & Little 2010, Paris 2018)

Having said the above, patients can have more than one diagnosis and it is not uncommon for patients with DBT to have other diagnoses as well, e.g., affective and anxiety disorders (Shen et al. 2018). If so, the patient should receive adequate treatment for the other mental health problems as well as the symptoms related to BPD.

### *Treatments for BPD*

Many treatments have been tried for BPD but with varying outcomes. By and large, psychotherapeutic methods show better results than pharmacological or other standard medical interventions, even though the effects are moderate (Paris 2019, NICE guidelines 2009). Dialectical behaviour therapy (DBT) is perhaps the most well-known and thoroughly researched psychological treatment and has shown symptom reduction for patients with BPD (Cristea 2017, Paris 2019). In short, DBT is a therapy that balances acceptance and mindfulness with the learning of emotional and interpersonal coping skills (Linehan 1993). Pharmacological treatment, on the other hand, has shown limited effects, and there is no pharmacological therapy that has BPD as an approved treatment indication (NICE guidelines 2009, Gartlehner 2021).

When working with patients with BPD, it is generally recommended in the NICE guidelines to promote the patient's self-efficacy. This can be achieved by actively involving the patients in their treatment, even during crises, and by assuming that they have the capacity to make informed choices (unless proven otherwise). In case of admission to a hospital, the admissions are recommended to be limited and agreed upon in advance, and compulsory care should be avoided. Outpatient treatment should generally be preferred to inpatient care so that the patients do not lose abilities to manage their crises. Also, to avoid the negative effects that inpatient care can lead to. (NICE guidelines 2009)

## *BPD and suicidality*

Patients with BPD often suffer from chronically fluctuating suicidality, where suicidal or self-harming acts occur in the interface between the patients' emotional coping abilities and external stressors (see more about self-harm below). Even self-harming acts without suicidal intent can accidentally lead to lethal consequences, but fortunately, most survive their frequent suicide attempts and self-harming acts. (Linehan 1993, Paris 2019) The patients' frequent suicidal ideation and self-harm-behaviour are hypothesised to have many functions. For example, suicidal or parasuicidal behaviour could be a means to reduce or avoid negative feelings like anger or anxiety, or to escape a seemingly unsolvable situation (Linehan 1993, Brown et al. 2002, Brereton 2020). Other functions, probably reinforced by the responses from the environment, could be to communicate ill-being and seek validation – even though the patients need not be aware of their motives in those situations (Linehan 1993, Paris 2004).

On average, a patient with BPD makes three suicide attempts during their lifetime, but some individuals can have much higher numbers. Most suicide attempts seem to have an ambivalent intent since it is common for patients with BPD to communicate their suicidal intentions to others and use non-violent methods with a low risk of lethal outcomes. Suicides occur in about 10% of patients with BPD, with lower risks for younger patients who frequently visit the emergency room and higher risks for middle-aged patients with BPD who have failed to recover from their symptoms after many years of illness. (Paris 2019)

## *The experience of inpatient care for patients with BPD*

It is common for patients with BPD to be admitted to the hospital when they communicate suicidal thoughts, self-harm or make suicide attempts (Linehan 1993, Paris 2004, Paris 2019, Gunderson et al. 2013). This is consistent with traditional psychiatric treatment, which presupposes that hospital admission is the best way to reduce suicide risk and improve treatment (Socialstyrelsen 2022). Nevertheless, for patients who self-harm, and patients with BPD in particular, the collected body of clinical experience from the last forty years has shown no suicide-preventive effect from such suicide-preventive hospitalization. On the contrary, such inpatient care, particularly longer admissions, can lead to an increase in regressive and suicidal behaviour. (Linehan

1993, Paris 2004, Paris 2019, NICE guidelines 2009, Large et al. 2017) One study has also shown that crisis-service utilization in general, such as emergency-room visits and previous inpatient admissions, was associated with increased risk for future suicide in patients with BPD, compared with a matching group of patients with BPD whose needs were met in an outpatient setting (Coyle et al. 2018).

The development of destructive behaviours in inpatient care can be fast and dramatic (Nationella Självskadeprojektet 2015). Some reasons suggested for these negative effects are interpersonal conflicts, loss of self-efficacy and sense of control, the contagion of self-harm behaviour, and negative responses to locked doors at the ward or other restrictions of the patient's freedom (Nationella Självskadeprojektet 2015, Taiminen et al. 1998, Drew 2001, Bowers et al. 2008, Joiner 1999, Chiles et al. 2018). Therefore, long admissions have been cautioned against by experts in the field and by clinical guidelines (Linehan 1993, Paris 2004, Paris 2019, NICE guidelines 2009, Nationella Självskadeprojektet 2015).

There can of course be situations when patients with BPD may need to be admitted to hospital, for example, when in psychotic states, if there is diagnostic uncertainty that needs to be addressed acutely, or for short-term management of acute risk – though this latter indication may lead to increased future suicide risk (Paris 2019, Coyle 2018). In general, hospital admissions are recommended to be short, e.g., overnight or a few days and aimed at crisis management. (Linehan 1993, Paris 2019, NICE guidelines 2009; Helleman et al. 2018)

Other, exceptional, types of admission are planned admissions to voluntarily participate in specific inpatient treatment programs, for example, with intensive DBT treatment. Such programs have been tried for patients with BPD who are not actively engaged in outpatient treatment for varying reasons. Studies suggest that such programs can be effective in reducing symptoms associated with BPD. (Bohus et al. 2004, Bloom et al. 2012). However, such inpatient programs are costly and may come with risks associated with hospitalisation, e.g., an increase in regressive behaviour, losing contact with everyday life, and contagion of self-harm behaviour (Bloom et al. 2012). Therefore, it has been argued that such therapies should primarily be offered in outpatient care (Paris 2018).

In this thesis, the admissions of patients with BPD discussed are the common ones, i.e., acute admissions. The reason for such admissions is most often suicide prevention. (Gunderson et al. 2013, Bloom et al. 2012, Paris 2019)

### *The narratives of previously hospitalised patients with BPD*

There have been several accounts of self-harming patients, foremost with BPD diagnosis, who have had negative experiences from compulsory admissions. Patients have described experiences of constantly increasing yet ineffective coercive measures, sometimes without legal support, as a response to the patients' repeated self-harming actions at the ward (Åkerman & Eriksson 2011). Also, how compulsory admissions can turn into a struggle between the self-destructive patients and the care providers, the admissions get prolonged, and the patients' self-harm behaviour gets worse instead of better (Åkerman 2020, Nationella självskadeprojektet 2015).

When it comes to hospital admissions in general, patients with BPD have expressed positive experiences, for example, being listened to, talking with staff or other patients, and feeling safe in times of crisis. More negative accounts concern how cyclical readmissions can create feelings of dependency on hospitalisation and perpetuate the patient's sense of hopelessness and insufficiency. Other negative experiences concerned lack of contact with the staff, negative attitudes from care providers, compulsory admissions, and poor discharge planning. (Stapleton & Wright 2019)

The patients' lived experiences of hospital admissions are central to understanding how the interplay between patients and care providers affects the patients. In this thesis, we have focused on the care provider's role in this interaction since it has been less researched. That said, the patients' described experiences have been invaluable in recognising the problems that compulsory admissions can bring about.

### *The value of suicide risk assessments*

Suicide risk assessments are made regularly in mental health care and are mandatory for mental health providers in Sweden (Psykiatristöd Region Stockholm 2023). Suicide risk assessments are meant to predict suicidal outcomes by separating patients into low-risk and high-risk groups. Still, the use of suicide risk assessments has been questioned because of their limited sensitivity (proportion of all suicides that were included in the high-risk group) of around 50%, limited specificity (proportion of all non-suicides that were

included in the low-risk group) of around 75%, modest power of discrimination between high-risk and low-risk groups, and very low positive predictive value (probability that a patient in the high-risk group commits suicide) (Large 2018, Bjureberg et al 2021, Bryan 2021, Lind 2019). For example, for short-term prediction of suicide (which is the clinically most relevant prediction), the well-recognised Columbia-Suicide Severity Rating scale showed a PPV of about 0,2%, meaning that only 1 out of 500 patients classified as high-risk committed suicide within a week (Bjureberg et al 2021). Therefore, it is argued that suicide risk predictions should not be used to motivate highly interfering interventions, such as admissions to hospitals. (Bjureberg et al. 2021, Large 2018). Rather, it has been suggested that decisions on hospital admission should be guided by the patient's medical need, irrespective of the assessed suicide risk (Large 2018). Consequently, the NICE guidelines recommend that suicide risk assessment tools should not be used to predict individual risk of suicide (NICE guideline number NG225 2022).

#### *The value of hospitalisation as a suicide preventive measure in general*

Even if the suicide risk could be predicted with sufficient accuracy for a patient, there is little evidence to suggest which intervention, on an individual level, should be taken to lower this risk. When it comes to psychiatric treatments, the risk-lowering properties of most treatments are low – with an exception for lithium in affective disorders and clozapine in psychotic disorders, which seem to have some suicide-reducing effect. (Bryan 2021, Chiles et al. 2018) Admission to the hospital is an often-used and recommended intervention when patients are assessed as suicidal (Socialstyrelsen 2022), probably because it feels intuitively like the right thing to do. On the other hand, hospital admissions have not been shown to have suicide-preventive effects in controlled studies, with a possible exemption for elderly male patients (Large & Kapur 2018, Kapur et al. 2015). Instead, psychiatric hospitalisation is one of the strongest risk factors for suicide, both during admission and in the following months after discharge, even though it is difficult to prove causation (Walsh et al. 2015, Large 2018, Chiles et al. 2018) This association between hospital care and suicide could, to a large part, be explained by the selection of patients. However, the strong hospitalisation-suicide association, accounts of negative experiences from hospitalisation and coercion, the weak association with suicide risk at admission, and significant

variations between clinics, are examples that suggest a causal factor between hospitalisation and suicide. Nonetheless, hospitalisation does not seem to be an effective preventive measure against suicide. (Large et al. 2017, Large & Kapur 2018).

Patients with BPD are often admitted to the hospital due to suicidality, and some doctors motivate such admissions by suggesting that the patients suffer from co-morbid disorders that require inpatient treatment to prevent suicide (Little & Little 2010, Paris 2019). But as described above, there is little evidence to support such a measure if the main purpose is to prevent suicide. Still, the patient could of course suffer from a comorbid disorder which is best treated in the hospital, e.g., if suffering from an acute psychotic state – then the indication would be medical rather than suicide-preventive.

### *BPD and the concept of self-harm behaviour*

Since BPD is the only diagnosis in DSM that includes self-harm (including suicidality) as a criterion, patients with self-harm behaviour have regularly been diagnosed with BPD (American Psychiatric Association 2013, SBU: s upplysningstjänst 2015). Concurrently, most research on self-harming patients has been done on patients with BPD. In later years, the suggested diagnostic concept of self-harm behaviour (repeated self-harming, e.g., self-injury or self-poisoning, with or without suicidal intent) has been used more frequently, since patients who self-harm can receive other development-related diagnoses, e.g., atypical autism and attention deficit disorder, or have affective diagnoses combined with borderline personality traits (Nock et al. 2006, Minshawi et al. 2014, Allely 2014, Stringer et al. 2013, Nationella självskadeprojektet 2016, NICE guideline number NG225 2022). So far, the experiences of treating self-harming patients in hospitals, including compulsory admissions, point to the same outcomes as for patients with BPD, though the research on self-harm behaviour as an independent diagnosis is limited. Self-harming patients treated in inpatient care are mostly young women and the psychological treatment is often the same (or similar) as for BPD. (Bresin & Schoenleber 2015, Nawaz et al. 2021, Kothgassner et al. 2021, Nationella självskadeprojektet 2016, Nationella självskadeprojektet 2015)

## **Background and terminology: Ethics and law**

### *Compulsory care in Sweden*

From a bioethical point of view, overall, it is desirable if patients are treated voluntarily and with respect for their autonomous choices (Beauchamp & Childress 2019), and this also has legal support in Sweden and most Western countries (SFS 2017:30, U.S. Code § 7331). Nevertheless, in exceptional cases and under certain conditions, it is defensible that patients are treated involuntarily. The legal criteria for using compulsory care vary among countries, from focusing on the needs of patients with severe mental disorders to only including patients who pose a threat to themselves or others (Tännsjö 1999). In the field of bioethics, it is commonly considered that a patient should lack decision competence concerning the care offered to be subjected to compulsory care. In addition, such care should be given in the patient's best interest. (Beauchamp & Childress 2019) The concept of decision competence is not mentioned in the Swedish Mental Health Act (Lag 1991:1128 om psykiatrisk tvångsvård) but is implied to some extent. The prerequisites for compulsory admission to psychiatric inpatient care are that:

'(1) The patient suffers from a severe mental disorder, (2) the patient, due to his/her mental condition and also personal circumstances, is in imperative need of psychiatric care, which cannot be met by means other than admitting the patient into a medical facility for round-the-clock care, and (3) the patient opposes the treatment, or there are reasonable grounds to believe that the treatment cannot be provided with the patient's consent due to the patient's mental state.' (Lag 1991:1128 om psykiatrisk tvångsvård)

Hence, the Swedish Mental Health Act focuses more on the patient's needs than their cognitive abilities to make autonomous choices. The Swedish Mental Health Act also states that compulsory care aims to enable the patient to voluntarily participate in the imperative care and that compulsory measures may only be used if they are proportionate to the purpose of the measure. (Lag 1991:1128 om psykiatrisk tvångsvård) According to the legislative proposition to the Mental Health Act, severe mental disorders primarily include conditions of psychotic

character, but severe depression with suicidal ideation and personality disorders with impulsive breakthroughs of psychotic character, are also included in the definition. Personality disorders without such psychotic breakthroughs are not exemplified as severe mental disorders and neither is suicidality by itself. (Regeringens proposition 1990/91:58 om psykiatrisk tvångsvård) Even so, in clinical practice, the interpretations of what could be defined as a severe mental disorder differ among doctors and some consider suicidality by itself to be grounds for compulsory care (Lundahl et al. 2018, Lundahl et al. Clinical Ethics 2021).

### *BPD and compulsory care*

Patients with BPD, in particular younger women, seem to be more frequent when it comes to inpatient compulsory care in Sweden compared to other patients (Holm 2013, Socialstyrelsens statistikdatabas 2021). This is consistent with the findings in other studies, which point to the high utilization of inpatient services for patients with BPD (Bender et al. 2001, Zanarini et al. 2001). The use of compulsory care also differs significantly among Swedish municipalities (Socialstyrelsens statistikdatabas 2021). Compulsory care can be medically indicated at times to give necessary treatment, for example in situations with comorbid severe mental illness or when the patients experience transient psychotic symptoms (a.k.a. micro-psychotic symptoms), and such indications also have legal support (Paris 2019, Regeringens proposition 1990/91:58 om psykiatrisk tvångsvård, m. m). But then, the most common reason for compulsory and inpatient care is to prevent patients from committing suicidal acts. This indication is debatable since compulsory care can have negative effects on the patients, such as decreased self-efficacy and an increase in suicidal behaviour (NICE guidelines 2009, James et al. 2012, Nationella Självskadeprojektet 2016).

When treating patients with BPD, it is important not to reinforce their core difficulties, such as passive problem-solving strategies, handling negative emotions through suicidality, and transferring responsibility from oneself to others. Compulsory admissions can reinforce and perpetuate such symptoms, even though it is not the care provider's intention. That is why compulsory care is advised to be used sparingly for patients with BPD, and if used then with strong medical indication and for a limited time. (Linehan 1993, NICE guidelines 2009)

### *The four principles of biomedical ethics*

Four main moral principles have been considered to function as an analytical framework in bioethics since they are regarded as particularly relevant in the field of medicine and bioresearch. These four principles are supposed to be derived from common sense morality; what people in general think is right or wrong, e.g., norms about not causing and preventing harm. Also, the two main types of basic moral philosophies on what makes actions right and wrong, consequentialism and deontology, have an overlapping consensus about these mid-level principles (principles derived from both normative theories and common morality). (Beauchamp & Childress 2019) For instance, although hedonistic utilitarianism, a form of consequentialism that promotes actions that create maximum net happiness, explicitly denies that respecting autonomy is valuable in itself, respect for autonomy can be argued to have a firm grounding in this theory (Tännsjö 1999). The main principles of bioethics are 1) respecting the individual's autonomy, 2) beneficence, 3) non-maleficence, and 4) justice. The order in which they are presented says nothing about their relative weight; on the contrary, they are all considered to be so-called *prima facie* principles (non-absolute ones) that have to be weighed against each other when in conflict. These principles, termed 'Principlism', are presented by Beauchamp & Childress (2019), and are summarised as follows:

1) Respect for autonomy is about respecting a patient's autonomous decisions to reject offered health care even if we think these decisions are harmful to that patient. The principle thus implies the right for a patient to say no to treatment, even if the treatment would be beneficial to them. It also implies a right to participate in decision-making about medical interventions (at least if the patient is decision-competent). Hence, the principle means that patients have a right – but not an obligation – to exercise their autonomy and not have it infringed by paternalism, manipulation, or coercion (for more on these concepts, see below). This is a principle mainly inspired by deontological normative ethics, saying that we should act according to certain duties and obligations of intrinsic moral value (having value by itself), at least partly independently of the consequences the act could entail (Driver 2007). For a patient's decisions to be considered autonomous, the patient should be decision-competent on the issue at hand. Decision competence, in short, is about being able to retain the

information, reason around possible outcomes of one's decision given, and then decide in light of what one wants to achieve (Appelbaum & Grisso 1995) (see below for further elaboration). The general idea is that the everyday choices of generally competent people are to be seen as autonomous.

Examples of inner coercion are when a psychotic patient is ruled by inner voices or when a severely depressed patient makes decisions based on their depressive account of the world. (Beauchamp & Childress 2019, Tännsjö 1999)

2) Beneficence is about benefiting the patient by actively helping and attending to their welfare; to many, this principle lies at the very heart of both medicine and common sense morality. The principle is tied to consequentialism, a branch of normative ethics that determines the permissibility of an action based on its consequences (Driver 2007, Beauchamp & Childress 2019). There are two different sides to beneficence: positive beneficence, which says something about what should be counted as benefits (e.g., for patients) to start with (suggestions include experienced well-being, health, close relations etc.); and some idea about aggregation, e.g. maximising the overall outcome to benefit most patients (although maximizing benefits are likely not to be part of a common sense view on how benefits should be taken into account, see next paragraph). (Tännsjö 2019) The latter requires a balancing of benefits, risks, and the cost-effectiveness of interventions to determine the best overall result. As central as this principle may be in healthcare, it is not superior to the other principles of Principlism and often needs to be weighed against them. So, one may ask to what extent healthcare providers should practise beneficence and when it may come into conflict with the other main medico-ethical principles.

In the community, there are different ideas about whether we have mandatory obligations to help others or not. However, helping people in our vicinity who are in acute severe danger, who depend on our help to survive, and whom we can help without risking our health, has been argued to be obligatory beneficence. In healthcare, the obligation to help can be tied to the duties assigned to the profession, and the specific help that should be provided is usually determined by healthcare policies. Back in older times, doctors usually decided what was best for the patient and expected their decision to be obeyed, even if the patient disagreed. Today, such behaviour would be interpreted as paternalism, an infringement of the patient's right to autonomy, which points to a conflict between the principle of beneficence and the principle of autonomy in certain situations. (Beauchamp & Childress 2019)

Paternalism refers to the role of the father, being beneficent to his children and making decisions for them in their best interest. Similarly, in a healthcare setting, paternalism means that the care provider takes a superior position and decides for the patient, in the patient's best interest. This disregard for the patient's choices can be divided into soft paternalism and hard paternalism. In soft paternalism, the care provider disregards the choices of a patient who is not capable of acting autonomously, for example, due to confusion or psychotic delusions. This type of paternalism is rarely controversial since it is in line with the bioethical principle of beneficence and acting in the patient's best interest. At the same time, it does not contradict the principle of respecting the choices of an autonomous patient. Hard paternalism, on the other hand, is in line with the principle of beneficence (at least if the paternalist is correct about what is beneficial for those they decide for) but disrespects the will of a patient who acts autonomously. It has been argued that hard paternalism carries an inherent disrespect for the patient's integrity and right to be seen as a moral equal, which can be seen as a harm in and of itself. On the other hand, some contend that hard paternalism is sometimes justified in healthcare situations where there is a risk of substantial harm to the patient unless the care provider intervenes. Suicidality, for instance, is a debated motive for justifying hard paternalism. Some consider that only temporary compulsory interventions are justified in such situations, to ascertain that the suicidal person acts autonomously. Then, the burden of proof for saying that a patient is insufficiently autonomous is considered to lie with the care provider. (Beauchamp & Childress 2019)

3) Non-maleficence is about not inflicting harm on others, and in healthcare that means one should avoid harming the patient, at least not intentionally. Though not causing harm is the core of the concept, it also includes preventing and removing harm, which touches on the principle of beneficence. This principle, too, is linked to consequentialism.

Simple as it may sound, the application of the non-maleficence principle is not uncomplicated. Firstly, there must be an agreement on what is to be considered harmful. Harm can be interpreted as all sorts of negative consequences, from offending or annoying a person to infringing on their basic human rights or physically harming the person. To avoid all these possibly negative consequences would make healthcare work difficult to conduct; it could lead to avoidance of giving care altogether in fear of causing any discomfort or upset feelings. Therefore, the focus on non-maleficence in

healthcare usually concerns not causing harm to the patient's substantial interests or significantly harming the patient physically or mentally. This vague concept of harm of course leaves room for interpretation but it would be nearly impossible to draw clear-cut lines between what is considered harmful or not – especially in cases of minor harm or only subjectively perceived discomfort. (Beauchamp & Childress 2019)

Secondly, non-maleficence, like the other principles, is not an absolute principle but a 'prima facie' one. This means that it should be followed unless there are good reasons not to. For example, actions in healthcare are rarely without side effects and risks, and therefore the principle of non-maleficence often needs to be weighed against the other three medico-ethical principles. Case in point, a surgical procedure that includes both pain and bodily harm but the benefits of the act still outweigh these harms. (Beauchamp & Childress 2019)

Thirdly, non-maleficence is not only about actions taken but about actions non-taken. Not providing adequate care for a patient, thereby putting the patient at risk of harm, could be considered harmful negligence. In healthcare, this means that healthcare providers need to provide care according to certain professional standards. That does not mean, however, that active care must always be provided. In each case, the healthcare provider needs to balance the expected benefits of treatment with the expected risks or burdens. For example, futile treatments which are likely to be inefficacious and cause more suffering than benefits, give the healthcare providers a justified reason to withhold or withdraw treatment. (Beauchamp & Childress 2019)

4) The last presented of the four medico-ethical ground principles is justice. Justice is about how healthcare should be distributed fairly and appropriately but there are different perspectives on what defines such fair distribution. Already during antiquity, Aristotle suggested that equals be treated equally, which could mean that patients with equal healthcare issues should be treated the same. Few would deny such a formal (but vacuous) principle of justice. However, more substantial principles are more controversial: in more modern times, ideas of justice have been elaborated upon and now there are many philosophical theories on how healthcare is best distributed. (Beauchamp & Childress 2019)

Utilitarian theories focus on maximizing overall well-being in society. The problem with these theories is that they give no priority by themselves to the worse off, which many consider counter-intuitive, especially in health care.

(Daniels 2007) In theory, giving lots of healthcare to the already well-off could lead to a higher total amount of well-being than distributing the healthcare more equally, or prioritising the worst-off. Utilitarian theories are mostly recognised in healthcare policies when it comes to cost-benefit analyses – maximising the overall well-being most efficiently, given the available resources. (Tännsjö 2008, Beauchamp & Childress 2019)

Libertarian theories do not focus on healthcare but stress the importance of property rights and individual liberty. According to these theories, healthcare should be a resource available on a free market where people can choose to invest in healthcare according to their priorities and justly acquired material resources. These theories are reflected in healthcare policies endorsing private healthcare insurance and private healthcare institutions. (Beauchamp & Childress 2019)

Egalitarianism, or theories derived from egalitarianism, are the ones most referred to in healthcare policies. The basic thought is that all people are moral equals, and therefore they should have equal basic liberties and basic access to healthcare and other goods in life. (Beauchamp & Childress 2019) One common view, based on 'A Theory of Justice' by philosopher John Rawls (Rawls 2005), is that people should have fair equality of opportunity. This means that healthcare should prioritise those who are worst off, i.e., in greatest need, to diminish the inequalities in health status between people and thereby give them better opportunities to reach their goals in life. Other theories related to egalitarianism are capabilities theories, holding that everyone has the right to physical and emotional capabilities necessary to flourish in their lives, and well-being theories, focusing on the individual's rights to certain core aspects of well-being. (Tännsjö 2008, Beauchamp & Childress 2019)

In real life, many countries practise a combination of different justice theories when developing healthcare policies. For example, healthcare is often supposed to prioritise those in greatest need but at the same time consider cost-benefits, social interests, and opportunities for people to buy private healthcare – especially for interventions that are not publically financed. (Beauchamp & Childress 2019) In this thesis, justice-based considerations are the least important (although they have some role). Since the focus is compulsory care, considerations referring to the other three principles play a larger role.

### *Normative analysis with the method of reflective equilibrium*

A reflective equilibrium is a state of coherence between moral judgments such that we can have some credence in the judgments in question. Accordingly, the idea of a reflective equilibrium is an idea about why and how moral judgments are epistemically justified, i.e., when we have reasons to believe in them. More specifically, a reflective equilibrium is a state when particular moral judgments are aligned with more general, principled, moral judgments. In that ideal state (which may not always be reached), the particular and general moral judgments cohere in that they both support and explain each other: more specific considered moral judgements support more principled moral judgments that, in turn, explain or account for the more specific ones.

Reflective equilibrium as an idea about the epistemic justification of moral judgments is the basis of reflective equilibrium as a method (Tersman 1993). As a method of ethical reasoning, we compare particular moral judgments, which should be considered and fairly specified, with generally accepted moral principles. The reasoning goes back and forth between the judgments compared until a state of internal coherence, or reflective equilibrium, is reached – or, at least, approached. During the process of reaching the reflective equilibrium, both the particular and general moral judgments are open for revision and rejection. In other words, this method of normative analysis considers that even widely accepted moral principles may need to be revised if a situation-specific judgment convincingly contradicts general moral principles, and vice versa. (Rawls 1971 in Lynøe & Johansson 2013, Gustavsson 2018)

This method of striving for a reflective equilibrium, or coherence, between considered particular moral judgments and general moral principles, is the one applied in all ethical arguments in this thesis. For example, a particular moral judgment in this thesis could be 'compulsory care of a patient with BPD is ethically justified because it saves their life'. Then, this particular judgment is compared with more general moral principles, e.g., the four principles of Principlism. In turn, these general principles are not always compatible, so further weighing of the included moral judgments may be needed. In the end, the particular moral judgment proposed, or, more unlikely, the general principles, may need revision or be rejected to approach a state of reflective equilibrium. (Beauchamp & Childress 2019)

A reflective equilibrium can be viewed as narrow or wide, depending on whether the strive for coherence concerns only the particular judgments and

generalised principles, or whether it also includes other relevant beliefs, such as empirical evidence and social theories (Beauchamp & Childress 2019). In this thesis, the wide type of reflective equilibrium will be used since it includes both empirical facts and background theories on BPD.

### *Decision competence and autonomous decisions in healthcare*

Decision competence is a term used when describing the abilities of a person who can make autonomous decisions. In coherence with the principle of respecting autonomy, it is a generally accepted idea in bioethics that a decision-competent person should have the right to decide whether to accept care and therefore not be treated against their will. Therefore, the care provider should assess the patient's decision competence when deciding on compulsory care (though not a prerequisite for compulsory care according to the Swedish Mental Health Act).

The abilities included in decision competence are to be able to understand relevant information, to deliberate treatment options, to appreciate the situation and its likely consequences, and to express one's choice. (Beauchamp & Childress 2013) In clinical and research settings, the most common tool used to assess decision competence is the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) (Grisso et al. 1997). To investigate the patient's decision competence, the patient can, for example, be asked to indicate their choice, paraphrase the information given, describe the condition and treatment and likely outcome of their choice, compare treatment options and explain how they reached their decision (Applebaum 2007). Decision competence is to be assessed independently of the possible consequences of the person's decision and a person is to be presumed to be decision competent unless the assessor can make it reasonable to think otherwise (Hubbeling 2014, Beauchamp & Childress 2013). From this reasoning follows that when the decision competence is marginally decreased, the patient is to be treated as having decision competence (Ayre et al. 2017).

There are situations when decision competence can be impaired by certain psychiatric disorders, such as confusion, thought disorder, and psychotic delusions (Tännsjö 1999). At the same time, severe mental illness by itself does not prove the patient to be decision-incompetent in matters of psychiatric treatment. A previous study on decision competence and mental health

treatment has found that most patients with schizophrenia and depression are decision-competent concerning psychiatric treatment, with decision incompetence more correlated to thought disturbances (like disorganized concepts and active hallucinations) than to the diagnoses alone (Hoge et al. 1997; Applebaum & Grisso 1995). Another study on compulsorily admitted patients found that patients with schizophrenia generally had lower decision-making capacity than patients with bipolar or other non-psychotic disorders. Factors correlated to lower decision-making capacity were psychotic symptoms, manic symptoms, and poor cognitive functioning. (Mandarelli et al. 2017)

### *BPD and decision competence*

There are only limited studies when it comes to assessing the decision competence of patients with BPD by using the MacCAT-T (Grisso et al. 1997). Still, so far, studies and clinical experience indicate that most patients with BPD have decision competence on healthcare matters even when they are admitted to the hospital or visit emergency units (Little and Little 2010, Owen et al. 2008, Pickard 2011, Ayre et al. 2017, Szmukler 2009). For example, a cross-sectional study of 350 inpatients found that 96% of hospital-admitted patients with personality disorders were assessed as decision-competent (Owen et al. 2008). One multi-centre study of 131 patients indicated that *compulsorily* admitted patients who were non-psychotic and nonmanic had a higher degree of decision competence (42%) compared to patients with schizophrenia (9%) or bipolar disorder (32%) (Mandarelli et al. 2017).

Despite these results, the decision competence of patients with BPD and their right to refuse health care has been debated, especially in countries like England and Wales where patients with decision competence have a legal right to accept or refuse treatment according to the Mental Capacity Act (David et al. 2010, Richardson 2013). Even though Sweden has no Mental Capacity Act, the legal and ethical discussions surrounding this law have relevance to the more general debate on the decision-making competence of patients with BPD (David et al. 2010, Szmukler 2009, Richardson 2013, Ayre et al. 2017). In the Mental Capacity Act, personality disorders are not listed among conditions that have the potential to cause disturbance in the functioning of the mind. On the other hand, it has been argued that since BPD is associated with significant social

impairment and neurobiological abnormalities, the Mental Capacity Act should apply to these patients (Ayre et al. 2017). The law has been particularly debated in cases when decision-competent patients with BPD refuse potentially life-saving treatment. Some clinicians and legal instances have reasoned along the lines that if a seemingly decision-competent patient with psychiatric illness refuses life-saving treatment, then their will could be inauthentic because of their psychiatric illness, rendering them decision-incompetent. (David et al. 2010, Richardson 2013, Ayre et al. 2017) In other words, the disputed idea is that authenticity is a necessary condition for making autonomous decisions (Sjöstrand & Juth 2014). We will return to the issue of authenticity below.

The argument that patients with BPD suffer from neurobiological abnormalities is supported by neurocognitive studies, which show that patients with BPD display a heterogeneous array of subtle abnormalities (Dell'Osso et al. 2010, López-Villatoro et al. 2020, Mak & Lam 2013, Perez-Rodriguez 2018). Even though neuropsychological testing appears to be sensitive to the neurocognitive deficits of BPD, the effect sizes of those deficits are discrete when compared with healthy controls. That means there is a significant overlap of test results between patients and healthy controls. In addition, the deficits are not diagnose-specific. The clinical utility of these results is therefore limited. (Ruocco 2005). Neuroimaging studies have also shown certain abnormalities, such as a dysregulated top-down control of emotions. These abnormalities are also not diagnose-specific and, e.g., the dysregulated top-down control of emotions can be seen in panic disorder as well. The latter suggests that the abnormality observed could be the image of an 'upset' brain. (Perez-Rodriguez 2018)

In summary, there is good reason to believe that patients with BPD suffer from cognitive difficulties which may impair their decision-making processes (Dell'Osso et al. 2010, López-Villatoro et al. 2020, Mak & Lam 2013, Perez-Rodriguez 2018). On the other hand, these impairments are subtle and testing of the decision competency of BPD patients so far indicates that most patients with BPD have enough decision competence to decide on the care offered (Ruocco 2005, Little and Little 2010, Owen et al. 2008, Pickard 2011, Ayre et al. 2017, Szmukler 2009). Considering that patients are to be assumed to be decision-competent unless the care provider shows otherwise (Hubbeling 2014, Beauchamp & Childress 2013), implying that when incapacity is only marginal, they should be approached as decision-competent (Ayre et al. 2017), then patients with BPD should generally be attributed decision competence on health care matters. This is, however, disputed – as is described in the next section.

### *Authenticity in mental health care*

It has been argued that some decision-competent patients, as measured with the MacCAT-T (Grisso et al. 1997), should be seen as decision-incompetent because they value and prefer things wrongly. In other words, their values are perceived as pathological due to their mental condition, not reflecting what they truly want deep inside. (Tan 2003 in Sjöstrand & Juth 2014) This notion of an inner 'true will' is often referred to as authenticity and is based on the assumption that all people have a core identity with pro-attitudes, goals and values that are fairly consistent over time – claims that have been disputed. Although it may feel intuitively right to interpret self-destructively acting patients as non-autonomous based on an inauthentic desire, the notion of authenticity is very difficult to apply to a clinical setting, and there is a risk that decision-competent patients are assessed as inauthentic and non-autonomous when the care provider disapproves of their choices. That could open up for hard paternalism, disguised as soft paternalism. (Sjöstrand & Juth 2014) Also, the idea that patients with mental disorders suffer from pathological/inauthentic values, in contrast to somatically ill patients, can be discriminatory against mental health patients and their right to refuse treatment (David et al. 2010, Richardson 2013).

After highlighting the issue from different angles, it has been argued against using the authenticity concept when deciding on compulsory care. (Sjöstrand & Juth 2014, Ahlin 2018)

### *Authenticity and BPD*

Even though the concept of authenticity is difficult to use in clinical situations without leaving room for arbitrary decisions and hard paternalism, it has influenced the discussion about the mental capacity (decision competence) of patients with BPD – as described above. The legal frameworks of the UK Mental Capacity Act state that to have the mental capacity to decide for oneself in medical matters, the patient must have the ability to understand the relevant information, retain that information, use or weigh that information as part of the decision-making process, and to communicate the decision. (David et al. 2010) This 'use or weigh' ability has been interpreted differently among care providers

and judges, making the legal application flexible (Richardson 2013). The 'weighing' of information is supposed to be in accord with the patient's life choices, preferences, and values. Some interpret that this means that if the patient's values are affected by their mental disorder, then they lack decision capacity even if the patient has all the other mental abilities required and has held their present values for many years. (David et al. 2010, Richardson 2013)

It has also been argued that patients with BPD may lack decision authenticity when they do not care about the risks of refusing care or resisting care that is in their best interest – and that this lack of authenticity should justify involuntary interventions. Furthermore, the patients' signs of resistance have been suggested to be a part of the BPD symptomatology – that the patients with BPD sometimes want to punish themselves or feel the urge to harm themselves to regulate their emotions – and therefore not authentic. (Ayre et al. 2017) Others have contended that the treatment refusal of patients with BPD can be ambivalent since the patients often seek health care first and then refuse the care offered, and therefore their refusal does not express what they truly want. (David et al. 2010)

Still, if care providers see themselves as interpreters of the patients' inner incentives and 'true' selves, these interpretations will probably be based on a certain amount of guessing and opinion, since there is no method to objectively assess if desires are authentic or not. In addition, patients with BPD have an unstable sense of identity, shifting depending on the context, which makes the concept of authenticity even more difficult to apply (Sjöstrand & Juth 2014, Linehan 1993, Fuchs 2007). In the end, the interpretations may vary significantly among care providers and some may use the argument of inauthenticity for applying hard paternalism, disguised as soft paternalism, as described above – especially if the patient's life is considered to be at stake (Sjöstrand & Juth 2014). This may explain the opposing interpretations of the Mental Capacity Act for patients with sometimes marginal decision competence and potentially self-destructive wishes, such as patients with BPD (Richardson 2013).

Another argument against dismissing patients' wishes based on inauthenticity, is that it may be counterproductive in the treatment of their condition. It is central to the treatment of BPD that the patient takes responsibility for their behaviour and is actively involved in treatment decisions (Pickard 2011, NICE guidelines 2009).

In all, even though one may sometimes question the authenticity of the decisions of these patients, it is difficult to use this concept in a clinical setting

without risking arbitrary interpretations and hard paternalism. Also, it may undermine the patients' already fragile self-efficacy and thereby increase their difficulties (NICE guidelines 2009).

### *Legally binding Ulysses contracts in mental health care*

Sometimes patients make agreements with health care, that in a future state of specified illness, care providers can limit their freedom and give them certain treatments – even if they do not accept it in that future moment. This can be referred to as Ulysses contracts. The term Ulysses contract is derived from The Odyssey by Homer, in which Odysseus (Ulysses in Latin) wanted to be exposed to the beautiful but dangerous song of the sirens. This song attracted sailors to abandon their ship and then they were killed by the sirens. Therefore, Odysseus asked his crew to tie him to the mast, stuff their ears with wax, and not obey his cries to be released when the sirens sang. In health care, Ulysses contracts have been discussed under different names since the 80s, primarily in the treatment of patients with recurrent manic episodes. Later, in the treatment of substance use disorders. In contrast to manic states, patients with substance use are usually assessed as decision-competent when deciding on health care. (Bell 2015)

Treating a decision *incompetent* person against their present will, in their best interest and following their previous wishes, does not contradict the central bioethical principles of beneficence and respecting autonomy (Beauchamp & Childress 2019). Also, it is rarely a legal problem since, in many countries, patients with manic states can be treated involuntarily under the National Mental Health Act (Lag 1991:1128 om psykiatrisk tvångsvård). When the patient is decision-competent, on the other hand, it is dubious from both a legal and ethical standpoint to say that the patient's previous wishes should be more valid than the present ones. Still, the use of legally binding Ulysses contracts for decision-competent patients has been advocated in the two last decades. In the case of substance use disorders, the arguments in favour have been that the patients have a diseased will that is split from their authentic desires and long-term goals, they suffer from diseased neurobiological processes that remove the voluntary control of their behaviour, the patients lack free will due to their addiction and therefore forced treatment can be given to restore their autonomy, and that the

Ulysses contract endorses a form of self-paternalism where the 'good', true, self can decide over the 'bad', inauthentic, self. (Bell 2015)

### *BPD and Ulysses contracts in the form of compulsory care*

At times, patients with BPD express an indirect or direct wish to be involuntarily admitted under the Mental Health Act to protect their future selves, resembling a legally binding Ulysses contract (Lundahl et al 2017). This request contains a kind of paradox: to voluntarily subject oneself to involuntary treatment. A typical situation is when the decision-competent BPD patient argues that if they do not receive compulsory care, they will not be able to withstand their self-destructive impulses in the near future and can therefore not participate in the care voluntarily. One can speculate on the underlying reasons for this. The answer may lie in a combination of their high emotional reactivity, actively passive approach to dealing with problems (wanting others to solve problems for them), repeated failings to handle negative emotions without acting self-destructively, feeling that the environment does not take their distress seriously, fear of abandonment, and a gender-stereotypical interaction style (Linehan 1993).

Like patients with substance use disorder, patients with BPD are generally perceived as decision-competent (though some dispute this) when demanding compulsory care (Little and Little 2010, Owen et al. 2008, Pickard 2011, Ayre et al. 2017, Szmukler 2009). Hence, the arguments for and against such care can be paralleled with the discussion on legally binding Ulysses contracts for patients with substance use disorder (Bell 2015). Those arguments concern whether Ulysses contracts can be justified with the argument that patients with BPD lack free will because of deficiencies in their neurobiology, that Ulysses contracts can be a form of self-paternalism where the patient gets to care for themselves, that patients with BPD lack decision competence due to having 'pathological' values, and that Ulysses contracts express the patient's authentic desires (Bell 2015, Lundahl et al. 2020). One can also suggest another argument for using Ulysses contracts: that is as a practical short-term solution in emergencies when there may be diagnostic uncertainties and assessed suicide risk (Lundahl et al. 2020).

## *Controversies concerning the use of compulsory care for patients with BPD*

The treatment of patients with BPD and similar conditions that include self-harm is under constant debate – in my experience, the group of patients on which psychiatrists disagree the most. Interventions to reduce patients' suicidality, such as compulsory admission, can feel intuitively right and align with what society expects but may have the opposite effect to what was intended. There is much experience saying that patients with BPD benefit from being treated as competent and able to make decisions about their care (NICE guidelines 2009). Even so, the sometimes overwhelming helplessness and resistance to active participation, which patients with BPD express when in crisis, can be difficult for the care provider to handle without using compulsory interventions. Also, the strong emotionality and wide range of symptoms expressed by patients with BPD can be perceived as confusing and alarming, and therefore lead to debates about the patient's diagnosis, decision competence, and how best to treat the patient (Linehan 1993, NICE guidelines 2009, Ayre et al 2017, Little & Little 2010). Traditionally, care providers are trained to take care of patients in a spirit of paternalism – to be the wise and caring parent figure of the helpless and weak patient. Some patients may appreciate this tradition. Even so, when it comes to patients with BPD, this approach may have negative effects (NICE guidelines 2009). On top of it all, there is a political goal to eliminate the occurrence of suicides in Sweden (the Suicide Zero vision), and the main responsibility to achieve this goal is assigned to mental health care (Regeringens proposition 2007/08:110 En förnyad folkhälsopolitik). Concurrently, hospital admission, compulsorily if need be, is one of the recommended interventions for patients who are assessed as suicidal, according to healthcare authorities (Socialstyrelsen 2022). Therefore, mental health care providers may feel compelled to admit, voluntarily or not, suicidal patients with BPD to the hospital, even though such an intervention may increase suicidal behaviour (NICE guidelines 2009, Paris 2004, Coyle et al 2018). If the patient is not admitted and later self-harms, the care provider risks being criticised or litigated for negligence.

Taken together, there are controversies concerning the diagnosis by itself, how the patients with BPD should be treated, whether they are decision-competent, whether their decisions are authentic, whether they should be detained under the Mental Health Act, whether they benefit from long admissions, whether inpatient care and compulsory interventions are lifesaving,

whether suicidality by itself should justify compulsory care, and whether compulsory care should be used to protect the interest of others – including the care provider.



## 2 Knowledge gap and research aims

### Knowledge gap

Much is known about how patients with BPD experience compulsory care, what such care can lead to, and what the care provider should focus on to help patients with BPD (NICE guidelines 2009). Less is known about how this knowledge is currently applied in clinical practice, why the use of compulsory care differs among mental health care clinics in Sweden, what motives psychiatrists have for detaining patients with BPD under the Mental Health Act, and how inpatient treatment can be improved to meet these patients' needs. There are also knowledge gaps when it comes to the phenomenon of Ulysses contracts in the form of compulsory care, whether authenticity should be a factor to consider when deciding on compulsory care, and when compulsory care can be ethically justified for patients with BPD. We have addressed all the knowledge gaps mentioned here in this research project. In summary, our main research questions are:

1. What are psychiatrists' motives for practising compulsory care of patients with BPD?
  - 1a. What motivates psychiatrists to provide patients with BPD with longer compulsory admissions than what is considered beneficial to the patient?
  - 1b. How can inpatient care be improved for patients with BPD, concerning structure and length of admissions?
2. Under what circumstances, if any, is it ethically defensible to uphold compulsory treatment of patients with BPD?
  - 2b. Under what circumstances, if any, is it ethically defensible to uphold Ulysses contracts in the form of compulsory care for patients with BPD in psychiatry?

## **Research aims**

The overall aim of the thesis is to investigate what motives healthcare staff and in particular psychiatrists have for detaining patients with BPD under compulsory care, and in which clinical situations such care is ethically defensible. To reach this aim, the thesis inquires into the motives psychiatrists have for ordering compulsory care, especially when the admissions are longer than what is considered beneficial to the patient. Also, how clinical practices, concerning content and length of admissions, can be designed to improve inpatient care for patients with BPD. The thesis also investigates the phenomenon of compulsory care on the patient's demand, 'Ulysses contracts', and its ethical justifiability. Finally, the thesis normatively analyses in which situations, if any, compulsory care of patients with BPD is ethically defensible.

### 3 Methodology

This thesis contains three empirical studies; one interview study (study I) and two questionnaire studies (studies III and IV). The other two studies (studies II and V) are normative. The methodologies are described in more detail below.

#### **Study I:**

*Choice of method:* In the first study we wanted to investigate what motives psychiatrists had for treating patients with BPD under compulsory care, what their experience was of treating these patients, and what perceptions they had of the patients. These are concrete questions about clinical phenomena of a complex nature, and we wanted to understand the described phenomena from the perspective of those who experience them. Our point of departure, ontologically, was post-positivistic, meaning that there is an independent reality that is only partially apprehensive (Denzin & Lincoln 2018). Considering that our study contained 'what'-questions (inquiring descriptions), descriptions of specific clinical phenomena, and that we wanted information with a low degree of abstraction and interpretation, we found that qualitative analysis of manifest content, as described by Sandelowski (2000) and Malterud (2001), was the best method of choice. Little was known about what motives the psychiatrists had, hence we had no pre-determined categories or themes, and therefore we chose an inductive approach. We decided on conducting semi-structured interviews, to focus on the research questions but also allow the participants to elaborate freely.

*Sample:* We wanted to gather rich material from a relevant sample, to answer our research questions. Relevant informants were psychiatrists with experience in treating patients with BPD and assessing them under the Mental Health Act. Such assessments are most frequently done in emergency and hospital units, and therefore we primarily wanted informants working in such facilities. Informants were recruited continuously during the study period, partly through chain referral and partly by contacting psychiatrists at relevant mental health units, as described above. To attain variation in the sample, and thereby cover different views and experiences, we sought informants from different psychiatric clinics in the municipality of Stockholm. The initial invitation to participate was

sent by email with information about the study and its purpose. All informants were informed that participation was voluntary and could be withdrawn at any time without further explanation and all participants signed written consent before participating in the study (Appendix I). In total, twelve informants were recruited for the study: four from emergency psychiatry, six from hospital wards, and two from outpatient care. Three were women, and nine were men (more men than women work in emergency- and inpatient psychiatry), aged between 35 and 65 (Statistik Om Hälso- Och Sjukvårdspersonal, n.d.).

*Interviews:* Semi-structured interviews with 10 main questions and room for follow-up questions. All interviews were conducted by the main author, also a psychiatrist, and lasted for 30–60 minutes. Only one interview per informant. The interviews were recorded and then transcribed word for word. The informants were informed that all the questions concerned patients with BPD as the main symptomatology and compulsory inpatient care. The questions are presented in Appendix II. When we had gathered a rich and varied material, noticing that no significant amount of new material was gained from the last interviews, we decided that our research questions could be answered and we stopped at 12 interviews/participants.

*Qualitative analysis:* The information was analysed using qualitative analysis of manifest content, as described above (Sandelowski 2000, Malterud 2001). The interview texts were transcribed and read through several times to grasp the content and then discern the units of single meaning that, together, form overall meaning. The Meaning Unit is a condensed version of statements in the text that share the same meaning and are of relevance to the research question. Meaning units sharing commonality were grouped into Subcategories and then Categories, which answer the question 'What is described?' on a successively higher level of abstraction. Next, the Categories were abstracted into overarching Themes that answer the question 'What is this about?'. A summary of the qualitative analysis can be viewed in Appendix III.

*Trustworthiness:* In qualitative research, reliability and validity are replaced by 'trustworthiness' (Lincon et al 1985). This term encompasses 1) credibility – how we can assure that the findings accurately describe the events, 2) transferability – how the findings can be applied to another context, 3) dependability – that the findings are consistent and repeatable, 4), confirmability – ensuring that the findings relate to the informants and not to the researcher's biases. (Lincon et al 1985)

In this study, credibility was assured by peer debriefing – meaning that co-researchers continuously gave feedback on the interviews to increase awareness of the interviewer's personal biases, triangulation – looking at the phenomenon from different perspectives by choosing participants with various experiences, making sure that the categories and themes covered all the data well, and checking that there were enough data to answer the research questions.

Transferability was assured by leaving a sufficiently thick description of the participants, context, data collection, and analysis so that a reader could decide whether the results could apply to other settings.

Dependability is about being able to repeat the findings and evaluate if the results are consistent with the data. Repeating the findings may not always be possible since experiences can vary between different settings, but evaluation of results was made possible by saving original transcriptions and a written trail of how the content was analysed. The co-researchers in the study were also continuously evaluating the interviews, transcriptions, and analysis steps.

Lastly, confirmability was assured by leaving an audit trail, i.e., a step-by-step description of the research process, providing authentic citations from the informants in the manuscript, adding appendixes to the published paper with additional data, having co-researchers interpreting data, and applying reflexivity (awareness of own biases that can affect the research process) by continuously discussing the process with co-researchers. Reflexivity was particularly important in this study since the main author, who was also the interviewer of the informants, is a psychiatrist and hence a professional colleague to the informants. In addition, the interviewer carried her own experiences and attitudes from working as a psychiatrist, which could potentially interfere with the interpretation of data.

*Ethical deliberations:* According to The European Code of Conduct for Research Integrity (2023), research must be reliable (see the Trustworthiness points above), honest, respectful to all people involved, and the researcher should take responsibility for the whole research process. The participants must have given informed consent and the data must be stored securely. Besides complying with the legal system, reflexivity is considered important to ensure ethical behaviour. In this study, we have followed the relevant regulations and guidelines. The study was approved by the Regional Ethical Review Board in Stockholm. The paper data is stored in a secure place at Karolinska Institutet and the audio files are stored on a secure server at Karolinska Institutet. The participants were anonymised and coded from the start, so no single interview or other information in the study can be traced back to an identifiable individual.

## **Study II:**

The second study is normative, investigating the ethical justification of using compulsory care on the patient's direct or indirect request, as a form of Ulysses contract.

*Choosing the arguments for normative analysis:* The phenomenon of compulsory care at the patient's request has been observed in the clinic and can be explained by the patient's lack of trust in their ability and motivation to participate constructively in the inpatient care provided (Lundahl et al. 2017). It has been argued in previous work, e.g., concerning patients with substance disorders, that compulsory care could be used as a form of Ulysses contract (Bell 2015). Patients with substance use disorders and patients with BPD are generally considered to be decision-competent, as measured by MacCAT-T (Grisso et al. 1997), and therefore not generally eligible for compulsory care from certain medico-ethical perspectives (Beauchamp & Childress 2019). At the same time, they make choices that can be seen as self-destructive, often change their minds, and act on impulse. Therefore, many of the arguments used in favour of Ulysses contracts for patients with substance use disorders were considered applicable for patients with BPD. Further, arguments favouring the use of Ulysses contracts for patients with BPD drew on previous work in this thesis (Lundahl et al. 2018).

*The ideal state of reflective equilibrium:* The method chosen for the normative analysis is the method of striving for a 'reflective equilibrium' to justify moral judgments, which is described in the Introduction above. This is the generally accepted method for doing such analyses today. Particular, well-reasoned, moral judgments are compared with more general, widely accepted, moral principles to investigate whether they cohere, i.e., explain and support each other. More specifically, in an ideal state, considered particular moral judgements should support general principles and general principles should explain particular moral judgements within a process of reflective equilibrium. If not, either the particular moral statement or the more general one (more unlikely), may need to be revised. (Rawls 1971 in Lynøe & Johansson 2013, Gustavsson 2018, Tersman 1993) Primarily, we use the four medico-ethical principles of Principlism, as described above, as the general moral principles to which we compare particular moral judgments (Beauchamp & Childress 2019).

*Applying the method of reflective equilibrium:* In this study, several particular moral judgments, justifying the use of compulsory care at the BPD patient's demand, were scrutinised: (1) the patients lack free will, (2) this type of care is a form of self-paternalism, (3) the patients lack decision competence, (4) the care protects the authentic self, and (5) it is a practical solution in emergencies.

When scrutinising these judgments, one constructs an argument in favour of the particular judgment that is as strong as possible and logically cogent or valid (Feldman 1998). For example, looking at the first argument, 'the patients lack free will (and therefore compulsory care is justified)', it can be claimed that if the patients cannot indeed act according to their autonomous will, then there is no autonomy that gets infringed by using compulsory care and, instead, the care should be given in the patient's best interest. In this line of argument, there is an implicit premise that compulsory care is in the BPD patient's best interest because it can be life-saving – and to save a life can be considered to be such a beneficial consequence that it outweighs the potential harms of compulsory care. From this, an argument can be constructed from the explicit and implicit premises and intermediary conclusions, for instance, as follows:

- (1) Patients with BPD are slaves under their neurobiology and can therefore not control their actions freely.
- (2) If (1), then patients with BPD lack free will.
- (3) Intermediate conclusion from (1, 2): patients with BPD lack free will.
- (4) If patients with BPD lack free will, then they do not act autonomously.
- (5) Intermediate conclusion from (3, 4): patients with BPD do not act autonomously.
- (6) When a patient does not act autonomously, they are not decision-competent to decide whether to accept or decline care.
- (7) Intermediate conclusion from (5, 6): patients with BPD are not decision-competent to decide whether to accept or decline care.
- (8) When a patient lacks the decision-making competence to decide whether to accept or decline care, compulsory care in the patient's best interest does not violate the medico-ethical principle of respecting the patient's autonomy and coheres with the medico-ethical principle of beneficence.
- (9, Implicit premise) It is in the BPD patient's best interest to receive compulsory care because such care can save their life, and the benefit of that outweighs any potential harm with the intervention.
- (10) Conclusion from (8, 9): Compulsory care of patients with BPD does not violate the medico-ethical principle of respecting the patient's autonomy and coheres with the medico-ethical principle of beneficence.

Hence, this particular moral judgment, which could be summarised as 'compulsory care of patients with BPD is justified because they lack free will and stand to benefit from such care', would not violate the medico-ethical principle of respecting the patient's autonomy and it would support the principle of beneficence. Also, as is implicitly presumed, the benefit of the intervention (saving the patient's life) outweighs any potential maleficence. The other way around: the medico-ethical principles of respecting the patient's autonomy and beneficence, explain this particular moral judgment. In summary, the particular judgment and the principled judgments explain and support each other; they cohere. This coherence, with mutual support and explanation of the moral judgements, is thought to epistemically justify the moral judgments as spider threads in a spider net – they are in a state of 'reflective equilibrium' (Tersman 1993). However, the conclusion favouring the particular moral judgment postulates that we have reason to believe that the factual claims in the argument are true. This means that the arguments need empirical support and that there are no counter-examples that would undermine or significantly weaken the argument. Also, there should not be any vague or ambiguous terms or concepts used, which could be interpreted in different ways. (Feldman 1998, Juth 2005)

In this example, the factual claims were compared with the available empirical data concerning the ability of patients with BPD to make autonomous decisions, i.e., to be decision-competent when deciding on the care offered. A literature review was made that found little support for this factual claim and more support for patients with BPD generally having decision competence (Little and Little 2010, Owen et al. 2008, Pickard 2011, Ayre et al. 2017, Szmukler 2009). Also, the concept of 'free will' as a condition for making autonomous decisions can be questioned and interpreted in different ways; there is an ongoing debate on this issue. For instance, there is an alternative interpretation of what it means to act autonomously, which does not need to include the concept of 'free will' (DeGrazia 2005, Beauchamp & Childress 2019, Juth & Lorentzon 2010).

The normative study continued in this way to analyse the claims in favour of using compulsory care as a form of Ulysses contract for patients with BPD. In the end, the different conclusions were summarised and there was a discussion on how to clinically manage situations when patients with BPD demand to be compulsorily treated.

### **Study III:**

*Choice of method and sample:* The aim was to investigate the motives doctors in psychiatry have for ordering compulsory care for patients with BPD. In particular, how the respondents viewed the patients' decision competence

under different circumstances, and in which, if any, situations they thought compulsory care was defensible when it was not in the patient's best interest. The questions were inspired by a previous interview study (Lundahl et al. 2018) and the main author's clinical experience. In this study, we were interested in the views of all Swedish psychiatrists and psychiatric residents working in psychiatric emergency units or inpatient care in Sweden. Since we already had some information from previous studies, which we wanted to know more about, we could narrow our questions. But we also wanted to open up for new information that the respondents might have on the topics investigated, and therefore we left room for comments. Taken together, a postal questionnaire study was considered suitable to our aims, with fixed questions and room for comments. Since the questionnaire concerned compulsory care, which is most often decided by doctors in emergency units and inpatient care, we decided that this group was most suitable to answer our research questions.

*Forming of the questionnaire:* The questionnaire consisted of fixed statements that the respondents could agree or disagree with on an ordinal Likert-type scale – but without the middle 'neither/nor' alternative characterising a Likert scale (Likert 1932). The scale had four fixed answering options: 'fully agree', 'agree to a large extent', 'agree to a lesser extent', and 'not agree at all'. Hence, the two first alternatives could be interpreted as more positive than negative attitudes to the statement in question, as opposed to the two last ones. This created a symmetry in answers, which could later facilitate the interpretation of the data. There was also room for the respondents to leave comments. The last question consisted of four different examples of how to view the decision competency of the BPD patient when they have a strong emotional outburst, and whether such a state is grounds for compulsory care. For this last question, the respondents were asked to choose one alternative. The following background variables were checked: age, gender, and years of working in psychiatry. At the end of the questionnaire, there was also a question about how their trust in mental health care would be affected if patients with BPD received compulsory care that was not in their best interest. The questionnaire contained 18 statements in total.

After the first draft of the questionnaire was formed by the main author and her supervisors, the questionnaire was sent to other colleagues, with both research and clinical experience, to receive feedback on the design and quality of the questionnaire. This was to assure the questionnaire's validity, i.e., that it measured what it was supposed to measure.

Before dispatching the questionnaire, a cover letter was also composed. This cover letter contained information about the questionnaire and informed the recipients that participation in the study was voluntary, that they could return an empty envelope if they did not want to receive a reminder, and that no

answers to the questionnaire could be traced back to a single individual. The cover letter also included contact information for the two researchers mainly responsible for the study. The cover letter and questionnaire are presented in Appendix IV.

*Distribution and gathering of the questionnaire:* The addresses of the psychiatrists and psychiatric residents working in psychiatric emergency units or inpatient care in Sweden, were obtained from a national register of psychiatrists/psychiatric residents via the company IQVIA Solutions Sweden AB. The questionnaire was dispatched in April 2018. In total, 857 psychiatrists or psychiatric residents received the questionnaire. The questionnaire was distributed along with the cover letter and a return envelope. Each envelope was marked with a unique number, which made it possible for the researchers to know which recipients had responded and thus should not receive a reminder. Two reminders were sent to recipients who had not returned their envelopes; the first after 7–10 days from the first dispatch and the second after 7–10 days from the second dispatch. The questionnaires were taken out of the envelopes and collected before the envelope numbers were registered, and therefore participants' anonymity was protected in the steps of the process. Once the numbers of the returned envelopes were registered, the names and addresses of the participants were destroyed. One month after the last reminder, the gathering of responses stopped and all addresses were discarded.

*Quantitative data analysis:* The data from the fixed response alternatives and background factors were registered into the statistics program Epi6, in which the statistical analyses were also performed. A response rate was calculated. This was a questionnaire study with response alternatives that were compared to each other as proportions of the whole. Accordingly, categorical data analysis of proportions was conducted (Campbell et al. 2007). The proportion of respondents who chose a certain response alternative was compared to the proportions of those who chose the other alternatives on the same question. The proportions were later presented as percentages. To dichotomise response alternatives leaning toward the negative side from those leaning toward the positive side, and thus make the results clearer, the answering categories 'fully agree' and 'agree to a large extent' were merged into one group and 'agree to a lesser extent' and 'not agree at all' into another. After that, confidence intervals for all proportions were calculated. In this study, a 95% confidence interval was used – this means that we can be 95% confident that the 'true' value lies within this range. If the confidence intervals do not overlap, one can assume, with 95% certainty, that there is an actual difference between the different proportions compared – not only a chance difference. (Campbell et al. 2007)

Not only were the data of the different response alternatives for each question compared to each other but they were also compared to the background variables of gender, age, and years of working experience, as well as the question on trust in mental healthcare. The background variable 'years of working experience' was dichotomised into two groups: 1-15 years, and 16-54 years. The background variables were also analysed themselves, for example, the distribution of gender among respondents. We also performed an analysis of possible differences concerning the main claims or background variables between early and late respondents.

The results were presented in tables and staple diagrams, showing the percentage agreeing with each response alternative and the confidence interval for each calculated proportion.

*Qualitative data analysis:* In this questionnaire, the respondents could leave comments. These comments are valuable since they can provide new information and add richness to the data. All the comments were collected in a single file and read through several times – almost half of the respondents had left comments, so there was much material. The content was perceived as rich and relevant enough to be analysed further. As in Study I, the point of departure was ontologically post-positivistic, we wanted to understand the described clinical phenomena, and we had no pre-determined categories or themes. Therefore, again, we chose to make a qualitative analysis of manifest content, as described by Sandelowski (2000) and Malterud (2001). The process of extracting Meaning Units and grouping them into Subcategories, Categories and lastly overarching Themes, was the same as described above in Study I. To assure trustworthiness, several measures were taken:

- 1) To increase credibility, an accurate description of events, the comments and the qualitative analysis were reviewed by other researchers in the study, and the researchers made sure that categories and themes covered all the data well.
- 2) Transferability, making it possible to apply the findings to another context, was assured by presenting background information about the responders and by leaving a thorough description of how data were collected and analysed.
- 3) Dependability, making the findings repeatable, was assured by saving the original comments and leaving a written trail of how the content was analysed.
- 4) Confirmability, making sure the findings are not affected by the researcher's biases, was assured by leaving an audit trail, having co-researchers interpret data, and applying reflexivity by discussing possible biases with the co-researchers.

The qualitative data were presented in a table, showing the themes, categories and subcategories. The qualitative analysis is presented in Appendix V.

#### **Study IV:**

*Choice of method and sample:* In this study, we wanted to investigate in what way compulsory admissions may affect the self-harm behaviour of patients with BPD, with a particular focus on the length of admissions. We wanted quantifiable data, given by those who meet many patients with BPD and have observed the outcomes of their admissions. Those who usually have the most experience in observing patients with BPD at the psychiatric wards, where compulsory care is usually given, are the psychiatric aides and nurses working in those wards. They are in close contact with the patients and observe the course of psychiatric care. Also, they observe the psychiatrists and hear their motives for making clinical decisions on compulsory care. Taken together, we decided that psychiatric aides and nurses working in psychiatric wards for patients with BPD were suitable to answer our research questions.

There was already some information on the subject from previous studies conducted in Stockholm and general clinical observations (Lundahl et al. 2018, Lundahl et al. 2022, Nationella Självskadeprojektet 2015) but we wanted to know if the findings could be generalised to all of Sweden. Also, we wanted to know more about, for example, the relationship between the length of compulsory admission and self-harm behaviour, whether the healthcare staff thought the compulsory admissions were too long or too short at their wards, what the respondents thought could be done to decrease compulsory admissions, if the patients sometimes demanded compulsory care, and whether there were non-medical reasons for non-beneficial compulsory admissions. Since we had many pre-formed questions and wanted quantitative data, a questionnaire study was decided to be the most suitable method. However, we wanted to be open to new or more detailed information, and therefore we added room for comments in the questionnaire.

*Forming of the questionnaire:* This questionnaire had fixed questions, which the respondents could answer by choosing one of three or two alternatives. For example, the first question, 'In your experience, does the self-harm behaviour of these patients decrease from compulsory admissions longer than a week?', could be answered by either agreeing to the question, stating that there was no difference, or disagreeing. Hence, the response alternatives were ordinal on a Likert-type scale (Likert 1932). Other questions were answered by choosing a 'yes' or 'no', or by being able to choose several alternatives. The response alternatives depended on the content of the question. The respondents were also able to leave comments since we were interested in gathering possible new

information and adding richness to the data. Lastly, the questionnaire asked for background information, such as legal gender, years of working in psychiatry, work title, and which municipality they were working in.

The choice of one week in the first question was based on previous data, indicating that admissions longer than a few days could have detrimental effects (Linehan 1993, Nationella självskadeprojektet 2015, NICE guidelines 2009, Lundahl et al. 2022). Drawing on that information, a week was chosen as the time frame to which the respondents could relate their answers. However, since we did not know whether this choice of time frame was the optimal one, the comments were an important complement. The multiple choice question considered non-medical reasons that could lead to non-beneficial compulsory admissions. The response alternatives were based on findings in previous studies (Lundahl et al. 2018, Lundahl et al. 2022). Yet again, we wanted to be open to new information and therefore left room for comments. The last question concerned how perceptions of the patient could affect how much care the patient was provided with. We wanted to know whether patients who were perceived as 'likeable' or 'assertive' received more or less care – or whether these perceived traits did not affect care. This last question was based on the results from a previous, smaller, study (Lundahl et al. 2022) and the reason for posing it was that such unconscious biases can affect care in other situations – we wanted to know if that was also true for patients with BPD (Chapman et al. 2013).

The main author did the first draft of the questionnaire, which was then reviewed by co-researchers to ensure the questionnaire's validity (that it measured what it was supposed to measure). A similar questionnaire was also used in a previous study (Lundahl et al. 2022), which increased the validity of the questionnaire, or, at least, made the results comparable.

Background variables were requested at the end of the questionnaire: legal gender, profession (nurse or psychiatric aide), years of psychiatric experience, and the municipality of employment. A cover letter was attached to each questionnaire, containing information about the questionnaire, contact information for the responsible researchers, and informed the recipients that participation in the study was voluntary and that no answers to the questionnaire could be traced back to a single individual. The questionnaire can be viewed in Appendix VI.

*Distribution and gathering of the questionnaire:* To get a fairly even spread across Sweden, we chose one psychiatric ward, where patients with BPD

regularly received compulsory care, from each Swedish municipality. There are 21 municipalities in Sweden, and therefore we chose 21 wards. The wards were contacted randomly in each municipality (we called the head nurses), and the first to agree was included in the study. Based on how many healthcare staff are usually on duty in a ward, counted over a few weeks, we decided that 20 questionnaires should be sent to each ward. The questionnaires with cover letters were physically distributed, together with a return envelope, and distributed randomly to the staff by the head nurse. The head nurse later collected all the questionnaires, answered or empty, and returned them to the researchers. One ward, however, copied up two extra questionnaires and therefore returned 22 questionnaires. Eighteen wards participated in May 2021, and, for local practical reasons, three participated in September 2021. Each ward had about a month to return the questionnaires. All questionnaires were answered anonymously.

*Quantitative data analysis:* A response rate was calculated. The data were registered in the software programs Excel and SPSS, the latter a statistics program, and analysed with descriptive statistics for categorical data. The response alternatives were compared to each other as proportions and the confidence interval was set to 95%. In cases when the confidence intervals of two compared proportions are not overlapping, a chi-2-test, will show a p-value  $<0,05$ . Two different methods, rendering p-values, were used: the Chi-square test when the samples were large enough to use this test, and Fisher's exact test for smaller samples. (Campbell et al. 2007)

The response alternatives for the same question were compared to each other and also to the background variables of legal gender, years of work experience, and work title. The different municipalities were grouped into three overarching groups, representing the south, middle, and north of Sweden. The latter was done to facilitate statistical analysis and interpretation of the data. Then, the response alternatives were compared to the grouped municipalities. Also, the responses from those 18 wards who answered the questionnaire in May were compared to the responses from those three wards who answered in September.

The data were presented as staple diagrams of the percentage agreeing with each response alternative, together with confidence intervals.

*Qualitative data analysis:* Many respondents left comments in their questionnaires. This provided us with much material that could both provide new information and describe their clinical experiences in more detail. The comments were read through several times and the content was assessed to be rich enough to undergo qualitative analysis. Again, our starting point was a post-

positivistic ontological outlook, we wanted to investigate the described clinical phenomena with a low degree of interpretation, and we had no pre-determined themes or categories. Therefore, we chose the same method as described in Studies I and III, i.e., a qualitative analysis of manifest content – as described by Sandelowski (2000) and Malterud (2001). In addition to the measures to assure trustworthiness, as described in Study III, the analysis was done independently by two researchers and the outcomes were similar – this added to the credibility of the interpretation of data. To increase confirmability, citations from the comments were provided in the paper.

The qualitative data were presented in a table, showing the themes and categories. Also, citations from the comments were demonstrated and the full qualitative analysis with themes, categories and subcategories was attached to the paper as an Appendix. The qualitative analysis can be seen in Appendix VII.

### **Study V:**

The last study is normative. It investigates if compulsory care of patients with BPD is ethically defensible and, if so, in what situations.

*Choosing the arguments for normative analysis:* The arguments selected to be analysed drew upon previous studies (Ayre et al. 2017, Hubbeling 2014, Lundahl et al. 2018, Lundahl et al. 2023) and were found to be commonly used in favour of ordering compulsory admissions for patients with BPD. The arguments were: 1) the patient lacks decision competence, 2) the patient lacks authenticity, 3) compulsory admission prevents suicide, 4) compulsory admission is the safer option – ‘it is better to err on the safe side’, 5) compulsory admission is a practical solution in emergencies, 6) admitting the patient compulsorily safeguards the doctor from being litigated, receiving complaints, or experiencing anxiety. The arguments were discussed among the researchers involved in the study and were considered to best reflect the main arguments brought to light in the academic debate.

*Applying the method of reflective equilibrium:* As in Study II, the method of reflective equilibrium was used to analyse the arguments from a normative perspective. The ideal state of reflective equilibrium is reached when the particular and general moral judgements cohere; when they support and explain each other. The particular arguments used were the ones stated above, and the general judgments were the four medico-ethical principles of Principlism (Beauchamp & Childress 2019). First, each particular argument was made as strong and well-formed as possible, claiming coherence with one or several of

the medico-ethical principles. An argument is strong when we have good reason to believe the premises leading to the conclusion, for example, because they are supported by empirical evidence. Well-formed arguments have premises that support the conclusion. Secondly, the premises were scrutinised to evaluate if they supported the conclusion, if there were any vague or ambiguous terms used (which may undermine the conclusion), and, lastly, if the premises had empirical support (to the extent they were empirical). (Feldman 1998) The method of reconstructing a well-formed argument and making it as strong as possible is described above in the method description of Study II – the same goes for the method of evaluating the argument.

Finally, the conclusions were summarised and a discussion on the possible clinical implications was held.

### ***Ethics approval and consent to participate***

According to 3–6 §§ and 13 § of the Swedish Ethical Review Act concerning research on human subjects (Lag 2003:460), ethics approval is needed if the research concerns sensitive personal data, personal data concerning delinquency, physical interventions on research subjects, is performed with potentially harmful methods, concerns biological material from humans or physical interventions on deceased humans. Since the studies in this project concern the healthcare staff's experiences regarding the compulsory treatment of patients with BPD, include no sensitive personal data, and no patients are involved, the studies in the project are not sensitive and do not need to be ethically reviewed according to the Swedish Ethical Review Act (Lag 2003:460). Still, in connection with the first study, an application was sent to the Ethical Review Board concerning the overall doctoral project (registration number 2016/1541–3115). The Ethical Review Board offered an advisory opinion, saying that they found no ethical objections to the project and that the research described is not subject to the Swedish Ethical Review Act.

All participants in the completed studies were informed in the cover letter that their participation was anonymous and voluntary. We confirm that all methods were carried out following relevant guidelines and regulations.

## 4 Results

### **Study I:**

Before this first study, a smaller survey study had been conducted at the psychiatric emergency unit in Stockholm and the respondents were on-call doctors working in that unit. This survey study showed that 94% of the respondents recognised the phenomenon of patients with BPD sometimes requesting to be compulsorily admitted and 55% had used compulsory care that was not in the patient's best interest, for instance, to avoid potential complaints, conflicts, or bad publicity in the press. (Lundahl et al. 2017) These were interesting findings that we wanted to investigate further. Since not much was known about the non-medical motives doctors have for compulsorily admitting patients with BPD, we chose to conduct an interview study with semi-structured questions. The informants were psychiatrists working in different clinics in Stockholm. Besides the motives for ordering compulsory care, the informants were asked about their experiences of compulsorily treating patients with BPD and what they thought about compulsory care on the patient's demand.

Twelve interviews were conducted, after which we decided that the material was rich enough, including different perspectives and experiences, to answer our research questions. A qualitative analysis of manifest content was conducted and resulted in 40 subcategories, 10 categories and three themes.

The themes were: (1) patients with BPD are perceived as difficult: interpersonally, in clinical and legal management, and due to suicide risk, (2) there are medical and non-medical motives for compulsory care of patients with BPD and the consequences can vary, and (3) patients with BPD have decision competence and sometimes demand to be taken into compulsory care.

The categories under the first theme were: 1) patients with BPD are perceived as difficult, in interpersonal relations and clinical management, 2) patients with BPD have an increased suicide risk that is difficult to predict, 3) The Swedish Mental Health Act is a legal grey area when it comes to patients with BPD. The categories under the second theme were: 1) There are medical motives for compulsory care of patients with BPD, which comply with the Swedish Mental Health Act, 2) There are non-medical motives for practising compulsory care of patients with BPD: practical and social aspects, and to avoid external criticism, 3) Risk assessment, considering the risk of danger to oneself or others, occurs in various extent as a motive for compulsory care of patients with BPD, 4) Compulsory care of patients with BPD with decision competence is justified to various extents, with motives such as non-authentic wishes or suicidality, 5)

Compulsory care of patients with BPD can implicate various results: positive when short-term, negative when long-term. The categories under the third theme were: 1) patients with BPD have decision competence, which is sometimes perceived as rapidly shifting, 2) patients with BPD sometimes demand to be taken into compulsory care, which clinicians find challenging from a clinical and legal point of view.

The results of the qualitative analysis are presented in Appendix III. Citations from the informants are included in the paper. Examples of citations:

'I don't find it imperative to be restrictive of compulsory care, to withstand an infinite amount of pressure. So, if I send the patient away once or twice, and the police keep coming back [...], then I'll probably issue a compulsory care certificate or admit the patient anyway in the end. [...] It's not entirely for the sake of the patient – because I might find it negative for the patient – but for the sake of the police, the relatives' sake, our sake, and so on.'

'I believe the tendency to compulsorily detain increases when there's an increased risk of being criticized if you don't. What happens is that many of the younger physicians, even if they know it's stupid to compulsorily detain this patient; that it's actually smarter to send her home [...], but if you make that decision then the responsibility rests on the physician who sent her home. If you issue a compulsory care certificate, then you're safeguarded 'because at least I issued a compulsory care certificate'. Then it's somebody else's job to send her home.'

*Study reference:*

Lundahl A, Helgesson G, Juth N. Psychiatrists' motives for practising in-patient compulsory care of patients with borderline personality disorder (BPD). *International Journal of Law and Psychiatry* 2018 May-Jun;58:63–71.

**Study II:**

This normative study aimed to investigate the ethical justification for compulsorily admitting patients with BPD at their request, as a form of Ulysses contract. The arguments analysed, favouring the use of such Ulysses contracts, drew on previous work (Bell 2015, Lundahl et al. 2018). The arguments were: 1) the patients lack free will, 2) Ulysses contracts can be seen as self-paternalism, 3) the patients lack decision competence, 4) Ulysses contracts defend the authentic self, and 5) Ulysses contracts can be a practical solution in

emergencies.

The point of departure for the normative analysis was that if there was significant uncertainty about the beneficial effects of the practice or uncertainty regarding the decision competence of patients with BPD, compulsory care would not be regarded as ethically justified.

The arguments were analysed with the method of reflective equilibrium, testing the coherence between the particular moral statements and the general principles of Principlism, especially the principles of respecting the patient's autonomy, beneficence, and maleficence. The premises supporting each argument were scrutinised, including the empirical support.

The first particular argument rests on the idea that patients with BPD can be seen as victims of their defective neurobiology when in crisis, and hence they lack free will (Bell 2015). Consequently, they are not able to make autonomous decisions and the care should therefore be given in their best interest, without regarding the patient's will. This argument was rejected since, according to this line of reasoning, all people in crisis could be seen as victims of their neurobiology and therefore no one would be acting autonomously in such situations. Also, a lack of free will does not necessarily mean that the person cannot act autonomously (Juth & Lorentzon 2010).

The second particular argument springs from the notion that Ulysses contracts in the form of compulsory care would be a form of self-paternalism, which could be seen as an empowerment of the patient; a possibility for the patient to decide about their future infringements of autonomy (Bell 2015, Lundathl et al. 2018). The argument was rejected since compulsory admissions of decision-competent patients, which patients with BPD usually are (Owen et al. 2008, Szmukler 2009, Grisso & Applebaum 1998), this type of self-paternalism would still be hard paternalism – especially when the patient later changes their mind and no longer wants to be subjected to compulsory care. If the consequences of compulsory admission were very positive for the patient, this overriding of the patient's autonomy could maybe be justified. However, most evidence indicates that compulsory care is more likely to have negative than positive effects on the BPD patient (Linehan 1993, NICE guidelines 2009, Coyle 2018, Paris 2004).

The third particular argument revolves around the thought that the BPD patient is decision-incompetent when it comes to deciding on the care offered. This argument was rejected because evidence and clinical experience indicate that most patients with BPD are decision-competent about care – even when in crisis (Owen et al. 2008, Szmukler 2009, Grisso & Applebaum 1998).

The fourth particular argument holds that patients with BPD in crisis do not express wishes that are congruent with long-held values and pro-attitudes

(Sjöstrand & Juth 2014). In other words, their wishes are inauthentic and therefore do not express what they 'truly' want. Hence, inauthentic wishes could be interpreted as less autonomous than authentic ones. The use of Ulysses contracts could be seen as protecting the authentic self from inauthentic, irrational, wishes (Bell 2015). This argument was rejected because there is no objective way of assessing authenticity in clinical settings, which could open up for arbitrary interpretations (Sjöstrand & Juth 2014). Also, there is no support for assuming that unwise or self-destructive wishes are inauthentic based on their content.

The fifth particular argument, that Ulysses contracts are a practical solution in emergencies (Lundahl et al. 2018), was rejected because there is significant uncertainty of whether the BPD patient is decision incompetent or benefits from compulsory admission in those situations.

*Study reference:*

Lundahl, A., Helgesson, G. & Juth, N. Against Ulysses contracts for patients with borderline personality disorder. *Med Health Care and Philos* 2020;23:695–703.

**Study III:**

*Results from the quantitative analysis:*

The response rate was 35% (296 out of 857 dispatched questionnaires).

One question concerned whether patients with BPD should lack decision competence to be compulsorily admitted, and 55% of respondents agreed with this. At the same time, more than 50% of the respondents thought it justified to order compulsory care for decision-competent patients who were assessed as dangerous to themselves or others.

If a patient posed a danger to others, 49% thought it was defensible to compulsorily admit the patient even if it was not in the patient's best interest.

When patients with BPD are in crisis, 84% considered it justifiable to compulsorily admit the patients – either because they considered the patients to be decision-incompetent (31%), or because the patients were considered decision-competent but too dangerous to themselves or others to have the right to reject care (53%). Only 4% considered compulsory care unjustified because the patients are decision-competent and another 4% because compulsory care can have detrimental effects

Few respondents (5%) thought it reasonable to compulsorily admit a decision-competent patient at the patient's request. Still, 25% considered such

care justified if the patient had rapidly fluctuating feelings, and 36% if the care was suicide-preventive.

Eighty-two percent agreed that their healthcare trust would decrease if patients with BPD were provided with compulsory care that was not in their best interest.

The response alternatives were compared to the background factors. This analysis showed that there were no associations between the response patterns and gender, work experience, or healthcare trust. The only exception was that men (39%) were significantly more inclined than women (23%) to consider patients with BPD to be decision incompetent. Early responders were compared to late respondents but no significant differences regarding the main questions or background variables were found.

#### *Results from the qualitative analysis:*

The qualitative analysis resulted in five themes: 1) Compulsory care of decision-competent patients with BPD is justified, 2) Compulsory care of decision-competent patients with BPD is not justified, 3) Compulsory care is applied outside the law for external reasons, 4) There is no legal clarity regarding compulsory care of patients with BPD, 5) Decision competence and authenticity are difficult to assess.

The first theme overarched five categories: 1) Suicidality justifies compulsory care even if the patient is decision-competent or if compulsory care is considered nonbeneficial from other aspects, 2) Violence risk justifies compulsory care even if the patient is decision-competent, 3) Suicide risk is by definition a severe psychiatric disorder and renders the patient decision incompetent, 4) Since it is difficult to exclude severe psychiatric comorbidity in BPD, compulsory care can be justified as a precaution in emergency situations, 5) Compulsory care on decision-competent patients' own request occurs, has judicial support, validates the patient, and is motivated by the patients' unreliability and suicide risk.

The second theme was abstracted from the following four categories: 1) Violence risk does not justify compulsory care, 2) patients with BPD should not be treated under the Mental Health Act as they are decision-competent and are harmed by compulsory care, 3) Compulsory care is only justified when the patient suffers from a severe psychiatric disorder, 4) Compulsory care on a decision-competent patient's request has no legal support and is harmful to the patient.

The third theme contained the following two categories: 1) Compulsory care is applied outside the legal framework, as a means of facilitating the handling of patients and protecting healthcare staff and society from negative consequences, and 2) Social demands for suicide prevention result in expedient suicidal behaviour and compulsory care that is not supported by the legislation.

Theme number four was abstracted from the category 'The Mental Health Act leaves room for various interpretations and can therefore be used arbitrarily as a means to an end'.

The fifth theme followed from the categories 'It is difficult to determine a patient's decision competence, and 'It is difficult to determine a patient's authentic will'.

Overall, the qualitative analysis confirmed the significant differences in opinion, observed in the quantitative analysis, concerning the decision-competence of patients with BPD and whether suicide risk is justifiable grounds for compulsory admission in itself (no matter if the patient is decision-competent). The results of the qualitative analysis can be viewed in Appendix V.

#### *Study reference:*

Lundahl A, Hellqvist J, Helgesson G, Juth N. Psychiatrists' motives for compulsory care of patients with borderline personality disorder – a questionnaire study. *Clinical Ethics*. 2022, 17(4): 377–390.

### **Study IV:**

#### *Results from the quantitative analysis:*

Four hundred and twenty-two questionnaires were distributed and 279 were answered. That left a response rate of 66%.

Sixty-eight percent of respondents experienced that more than a week of compulsory admission increases self-harm behaviour in patients with BPD, while 26% found no difference, and 7% considered that the patients' self-harm behaviour decreased.

Another question concerned whether the respondents thought the compulsory admissions were too long at their wards, and 69% agreed. Eighty-one percent thought that the length of compulsory admission could be decreased without impairing the care quality for the patients.

The phenomenon of patients with BPD demanding compulsory admissions, as a form of Ulysses contracts, was recognised by 91% of respondents. Sixty-six

percent agreed that this occurs more often than once in six months and 25% that it happens once every six months at the most.

The respondents recognised several motives as to why patients receive longer compulsory admission than what is considered good for them. Sixty-three percent agreed that one such motive was the patient's lack of adequate housing, and 48% experienced that the doctor's fear of litigation – if the patient self-harms after discharge – was another motive.

Patients with BPD who were perceived as demanding were either considered to receive more care (49%) or that this perceived trait did not affect the amount of care given (42%), but the confidence intervals were overlapping. Patients perceived as likeable were thought to be given more care by 31% of the respondents, while 64% did not think this perceived trait affected the amount of care given.

The background factors were compared with the response alternatives. No significant differences correlated to the background factors were found, except two: 1) Respondents who had worked longer than five years in psychiatry experienced fewer benefits and more negative effects from longer compulsory admissions than a week, compared to respondents who had worked 0–5 years, 2) Respondents who had worked longer than five years were more positive to decreasing the length of compulsory admissions in their wards, compared to respondents with 0–5 years of work experience. The response pattern of the 18 wards participating in May was compared to the three wards participating in September. There were slight differences between the May group and the September group, but these differences were better explained by regional variability than the time point when the questionnaire was answered.

#### *Results from the qualitative analysis:*

The qualitative analysis resulted in four themes: 1) Pros and cons of compulsory care, 2) Patients' actions and influence, 3) Compulsory admissions for other than direct medical reasons, and 4) Suggested changes to improve care.

The first theme was abstracted from the categories 1) Advantages of compulsory admissions, and 2) Disadvantages of compulsory admissions. Citations were attached to each category:

'Depends on the individual and how easily they can refrain from self-harm with the staff's support. For some, admission automatically seems to have a calming effect, independent of the form of care.'

‘According to experience, the risk of self-harm is lowest after 2–3 days. After that, self-harm behaviours increase considerably!’

The second theme contained two categories: 1) Patients demand compulsory care for various perceived benefits, and 2) Different views on how patients’ interaction style affects their care. Example of citations:

‘Compulsory care can give a sense of being taken care of and being able to let go of the responsibility for one’s safety.’

‘A patient who demands constant attention and is seen and heard and makes demands, often (but not always) gets more care interventions.’

The third theme overarched the categories 1) Compulsory admissions related to doctors’ fears and interests, and 2) Compulsory admission related to outpatient care. Citations:

‘Doctors don’t dare [discharging] because of fear of losing their doctor’s license or being litigated.’

‘The special housing doesn’t welcome the patient back, [they have] cancelled the accommodation while the patient is in hospital. The housing lacks the competence to ‘take the patient back’ because of an increase in self-harm behaviour.’

The fourth theme had the following categories: 1) Positive experiences from short voluntary admissions, 2) Need for better inpatient planning, structure, and care content, and 3) Need for better outpatient and social interventions. Citations with suggestions on how to improve the care:

‘Brief self-admissions to these patients. With a qualifying period between admissions. For example, brief admission 2–3 nights and then 3–7 days must pass before the patient can seek admission again.’

‘Structured and well-planned care. Deciding on discharge date already at the beginning of the admission. What goals are to be met together with the patient during admission?’

‘Better back-up at home, for example, outpatient care, housing support, etc.’

The results from the qualitative analysis can be viewed in Appendix VII.

### *Study reference:*

Lundahl A, Torenfält M, Helgesson G, Juth N. Patients with borderline personality disorder and the effects of compulsory admissions on self-harm behaviour: a questionnaire study. *Nord J Psychiatry*. 2023 Jul;77(5):498–505.

### **Study V:**

This was a normative study, concerning the ethical justification of ordering compulsory care for patients with BPD. As described in the Methodology section, the following arguments in favour of using compulsory care were scrutinized: 1) the patient lacks decision competence, 2) the patient lacks authenticity, 3) compulsory admission prevents suicide, 4) compulsory admission is the safer option – ‘it is better to err on the safe side’, 5) compulsory admission is a practical solution in emergencies, 6) admitting the patient compulsorily safeguards the doctor from being litigated, receiving complaints, or experiencing anxiety. The arguments drew upon previous studies (Ayre et al. 2017, Hubbeling 2014, Lundahl et al. 2018, Lundahl et al. 2023). The method of reaching a reflective equilibrium was used (Rawls 1971 in Lynöe & Johansson 2013, Gustavsson 2018, Tersman 1993).

The first argument rests on the assumption that patients with BPD in crisis lack decision-making capacity when it comes to deciding on the healthcare offered. If so, the patient is not able to make an autonomous decision and hence, deciding for the patient – in their best interest – does not violate the medico-ethical principle of respecting the patient’s autonomy and is consistent with the principle of beneficence. The weakness in this line of argument relates to the lack of empirical support. So far, studies and clinical experience indicate that patients with BPD are decision-competent on healthcare issues – even when in crisis (Owen et al. 2008, Szmukler 2009, Grisso & Applebaum 1998).

The second argument is based on the conception of an authentic self. This core of a person holds certain values and pro-attitudes that are fairly stable over time and constitute parts of the person’s continuous psychological identity (Sjöstrand & Juth 2014, Fuchs 2007). If a patient expresses inauthentic wishes, these can be seen as non-autonomous since they do not cohere with the patient’s continuous psychological identity. The problem with this argument is that one of the core symptoms of BPD is an unstable sense of identity (American Psychiatric Association 2013). Also, people in general can change their narrative identities over time (Dunlop et al. 2016). It would be difficult to prove that a currently expressed wish is less authentic than a previous wish. The lack of objective instruments for assessing authenticity makes the concept difficult to

use in clinical settings and could open up for arbitrary interpretations (Sjöstrand & Juth 2014).

The third argument springs from the generally accepted idea that compulsory admission can prevent suicide (Large & Kapur 2018, Lundahl et al. 2018, Lundahl et al. 2024). If so, a BPD patient with an increased suicide risk could be argued to benefit so much from the compulsory admission – since it saves the patient’s life – that the principle of beneficence outweighs the principle of respecting the patient’s autonomy (Beauchamp & Childress 2019). Again, this argument is refuted based on the lack of empirical support. There are no studies that demonstrate that compulsory admissions decrease suicide risk for patients with BPD. Instead, some studies indicate that hospital admission, including compulsory admission, fails to prevent suicides and may even increase the risk of suicide by itself (Coyle et al. 2018, Paris 2019, Paris 2004, James et al. 2012). This may also be true for patients in general (Large et al. 2017, Large & Kapur 2018, Walsh et al. 2015, Priebe 2019, Large & Ryan 2014, Jordan & McNiel 2020, Huber et al. 2016, Borecky et al. 2019).

The fourth argument builds on the commonly wielded claim that compulsory admission is the safer option. This line of thought can be tied to the precautionary principle (Sandin 2004, Munthe n.d.), saying that one should take precautionary measures against a possible hazard or harm even if the existence of the hazard lacks full scientific support. Analogously, compulsory admission could be seen as a precautionary measure to prevent suicide, even if we do not know if the patient would have committed suicide if not admitted (Lundahl et al. 2022). This notion presumes that compulsory admissions are life-saving for patients with BPD. As demonstrated in the paragraph above, the current evidence does not support the latter presumption. For patients with BPD, there is no completely “safe” option, but keeping the patient behind locked doors in a ward and depriving them of their agency has not been shown to reduce suicide risk – it may even increase it (Nationella självskadeprojektet 2015, NICE guidelines 2009, Paris 2004, Coyle 2018, Bowers et al. 2008). Hence, this argument was also rejected.

The fifth argument pertains to the practicality of compulsory admissions in the psychiatric emergency room. Compulsorily admitting a BPD patient can save time and effort for the on-call doctor (Lundahl et al. 2018). Nonetheless, these motives are consistent with neither the principle of beneficence nor the principle of respecting the patient’s autonomy (Beauchamp & Childress 2019). Having said that, there could be situations when the on-call doctor has good reason to believe that the BPD patient is decision-incompetent and stands to benefit from compulsory admission, for example, in cases when the patient appears to be psychotic. In such a situation, compulsory admission for further observation is

consistent with the medico-ethical principles of respecting the patient's autonomy and beneficence (Beauchamp & Childress 2019).

The last argument relates to what is called 'defensive medicine', i.e., clinical decisions made to safeguard the doctor against medico-legal repercussions instead of being done in the best interests of the patient (Studdert et al. 2005, Krawitz & Batcheler 2006). Even though this is a psychologically understandable phenomenon, this argument is not compatible with the medico-ethical principles of Principlism (Beauchamp & Childress 2019) and therefore it is refuted.

*Study reference:*

Lundahl A, Helgesson G, Juth N. Is compulsory care ethically justified for patients with borderline personality disorder? *Clinical Ethics*. 2024;19(1):35-46.



## 5 Discussion

### *Methodological considerations, strengths and limitations*

#### **Study I:**

The sample selection, choice of method, and how trustworthiness was assured, are described in the Methodology section. There are, however, some addendums.

The question of internal validity concerns the degree to which an instrument measures what it is supposed to measure. The semi-structured interview was designed by the researchers themselves, which renders so-called face validity. This is the weakest form of internal validity of the measurement instrument. (Bolarinwa 2015) However, the questions were merely meant to direct the interview into different areas of interest and the interviewer could explain any unclarities that emerged during the interview. In qualitative studies, the term validity is more commonly replaced by trustworthiness, as explained in the Methodology section.

The sample was selected to be as varied as possible yet embracing informants who were familiar with emergency psychiatry and decided on compulsory care regularly. Twenty-eight psychiatrists were asked to participate and twelve participated. The reasons for not participating were, for example, lack of time, illness, or that the psychiatrist did not order compulsory care regularly. Hypothetically, important information could have been left out by those who chose not to participate. On the other hand, the views expressed were supported by several informants and, in the end, we decided that the material was rich enough to answer the research question.

There were more male than female psychiatrists participating in the study and this related to the fact that more men than women were working in emergency and inpatient psychiatry at the time – this could have diminished the richness of the data since female perspectives may have been insufficient. Another weakness is that there was no registration of how many years of work experience each psychiatrist had. Finally, one may ask if choosing a semi-structured interview limited the information obtained from the informants and whether an unstructured interview would have yielded more new material.

On the subject of bias, the interviewer is a psychiatrist and was acquainted with several of the informants. These two facts could have affected both what the informants chose to share in their interviews and how the data were

interpreted. There is no way of knowing if the informants had chosen to be more candid if the interviewer had not been a psychiatrist. The potential strength of having a psychiatrist as an interviewer is that it could facilitate the interview, since both parties are familiar with the subject discussed, and improve the quality of follow-up questions. To minimise the risk of biased interpretations of the data, reflexivity was applied, i.e., the interviewer regularly discussed her biases and the interpretation of data with her research colleagues. The data was also analysed by fellow researchers to decrease the risk of biased interpretations.

The study was conducted in the municipality of Stockholm, Sweden. One cannot tell how the results would have turned out if psychiatrists from other parts of the country were interviewed. Maybe more information would have surfaced. On the other hand, several of the interviewed informants had worked in other parts of Sweden – this could partly compensate for the fact that only psychiatrists in Stockholm were interviewed.

One may ask if other qualitative methods could have been suitable for this type of study. One qualitative method discussed when planning the study, was that of phenomenology. This method seeks to describe the essence of a complex phenomenon from the perspective of those who experience it (Neubauer et al. 2019). On the other hand, as argued in the Methodology section, the method of manifest content analysis, with an inductive approach, is suitable when one inquires about descriptions of complex clinical phenomena, of which little is known beforehand (Sandelowski 2000, Malterud 2001). This latter method was considered more suitable for our research aims.

## ***Study II:***

The choice of method is explained in the Methodology section.

One could of course argue that there could be other methods to justify moral judgments than to strive for a reflective equilibrium. It is the question of how we can justify our beliefs. I will mention three common theories that concern the justification of moral beliefs: coherentism, foundationalism, and moral scepticism.

The first, coherentism, is aligned with the method of reflective equilibrium since it states that beliefs can be justified by circular support if the circle is large enough. The critics of this theory claim that circular support is not enough to justify a belief.

The second theory, foundationalism, argues that sometimes beliefs are self-justified and hence do not need further support. If a belief can refer back in

a chain of justified beliefs to such a 'foundation', the belief would be justified. The problem is that it is difficult to agree on which beliefs would qualify as such 'foundations', especially since most beliefs in the world are fallible, i.e., one cannot have absolute knowledge that they are true (except, for example, purely mathematical or logical beliefs). Then, even if such beliefs were found, it would be difficult to justify the multitude of different fallible beliefs in the world by linking them to this limited pallet of self-evident and infallible 'foundational' beliefs. (Pritchard 2018)

The third theory, moral scepticism, holds that moral truths cannot be epistemically justified, i.e., we cannot claim that it is rational to believe that a certain moral judgment has the property of being justified. Since this is a non-starter in a thesis in ethics, here it is simply assumed that moral scepticism is not correct.

The method of reflective equilibrium is a commonly used method to justify moral judgements in medical ethics. This method compares particular moral judgments with, in this context primarily, the four medico-ethical principles of Principlism – principles that are founded on common sense morality, deontology, and consequentialism, and can be argued to have wide acceptance (Beauchamp & Childress 2019). If our particular judgments cohere with these widely accepted medico-ethical principles, it is reasonable to think that this coherence supports our particular moral arguments to a certain extent. Therefore, coherentism, applied in the method of reaching a reflective equilibrium, can be argued to be a 'good enough' method for justifying moral judgments (Rawls 1971 in Lynöe & Johansson 2013, Tersman 1993).

### **Study III:**

The choice of method, sample, and choice of analysis methods are described in the Methodology section. Still, certain issues should be addressed further.

Internal validity, as explained above, concerns how well the instrument of choice measures what it is supposed to measure (Bolarinwa 2015). In this study, the questionnaire was validated by letting it be critically reviewed by the researchers and their colleagues – both researchers and clinicians. Also, some of the questions were tried in a previous study (Lundahl et al. 2018). This rendered a face validity of the questionnaire, which is not as strong as if it had been tested in, for example, a pilot study. One wants to know if the questions are easily understood and clear, and if the questions capture the research question. The questionnaire also needs to be reliable, i.e., measure the same way each time.

The latter could be tested by repeating the test on the same set of individuals in a pilot study, but that was not done in this study – which is a weakness. A general potential problem with questionnaire studies is if the respondents dare to answer the questions honestly – if not, this could be a problem for both the internal and external validity. We cannot know to what extent the respondents answered candidly to the questions, but they were given information about their anonymity in the cover letter and that could have decreased the risk of dishonest responses. (Bolarinwa 2015, Siedlecki 2020)

External validity refers to how well the results can be generalised to the larger population – in this case, doctors working in psychiatry (Siedlecki 2020). The response rate in this study was 35%, which is low. Also, there was no collection of background variables from those who did not respond to the questionnaire, which prevents comparisons between responders and non-responders. That makes external validity more difficult to obtain. This low response rate could be explained by healthcare provider's increasing reluctance to participate in questionnaire studies, which has been observed by our research team over the last few years. Still, lower response rates can be considered acceptable, for example, if the subject is controversial and little empirical work has been done on the subject – which is true in this case (Sierles 2003). Also, the sample size was large enough to calculate statistically significant differences between the different groups of respondents.

#### **Study IV:**

The choice of method, sample, and choice of analysis methods are described in the Methodology section. Here are some complementary comments:

The questionnaire was internally validated by being critically reviewed by co-researchers, so-called face validity (Bolarinwa 2015). However, similar questions were used in a previous study (Lundahl et al. 2022), which, in a way, can be viewed as a pilot study. That increased the internal validity of this questionnaire, as well as its reliability. (Bolarinwa 2015, Siedlecki 2020)

When it comes to external validity (Siedlecki 2020), the response rate of 66% was at an acceptable level (Kelley et al. 2003), which is good for generalisability. Seventy percent of the respondents were women but that is consistent with the gender balance among healthcare workers at psychiatric wards (Statistik Om Hälso- Och Sjukvårdspersonal, n.d.). On the other hand, only

one ward per municipality participated in the study, which limits the generalisability because the selection was not randomised. Also, there was no checking of background variables of those who did not respond to the questionnaire, and therefore it is difficult to generalise the results to all hospital staff. Still, the results from this study are supported by the results from a previous study on the use of inpatient care for self-harming patients in Stockholm (Lundahl et al. 2022) and by statistics on compulsory care in Sweden (Holm 2013, Socialstyrelsens statistikdatabas 2021). Also, the results in the study are aligned with findings in other studies (Paris 2019, Nationella självskadeprojektet 2015, NICE guidelines 2009).

When investigating the effects of a certain type of care on a group of patients, it is imperative to take the patients' narratives into account. In this study, we only investigated the experiences of the healthcare providers, which is a weakness. The choice to do so springs from the perspective of this doctoral project – to investigate the motives mental healthcare providers have for compulsorily admitting patients with borderline personality disorder. That said, the narratives of patients with BPD, for example in the literature (Åkerman 2020, Linehan 1993), in studies (Stapleton & Wright 2019, Nationella självskadeprojektet 2015), in the clinic (the doctoral student is a clinically active psychiatrist), and when speaking to patients in the clinic, have indirectly affected the project and the research questions. So even if the patients themselves have not been involved in the studies, their accounts have had a significant impact on the project.

### **Study V:**

The choice of method is explained in the methodology section and the addendums are the same as for Study II.

## ***Interpretation of the results and their significance***

### *Compulsory care as a suicide-preventive measure for patients with BPD*

The scarlet thread running through the results is the orthodox belief that compulsory admissions are life-saving for patients with BPD in crisis and that the patient's right to autonomy is of secondary importance in such cases. Even though the belief that compulsory admissions have suicide-preventive effects lacks empirical support, it is widely accepted among mental healthcare workers (Borecky et al. 2019, Large & Kapur 2018, Wang & Colucci 2017). This could endorse the use of compulsory admissions that are not in the BPD patient's best interest and do not respect the decision-competent patient's right to autonomy (Linehan 1993, Coyle et al. 2018, Beauchamp & Childress 2019).

The claim that hospital admissions, either compulsory or voluntary, do not seem to have a suicide-preventive effect may sound provocative. Hospital admission is the go-to solution for many care providers when a patient is assessed as having an increased suicide risk (Wang & Colucci 2017). To this day, however, there are no studies that have shown that psychiatric hospitalisation in general decreases suicide risk. Instead, the belief that hospitalisation prevents suicides seems based on intuition, anecdotal cases (which tend to be self-confirming), and clinical tradition. A large meta-analysis of data on hospitalised patients from the last 60 years worldwide has shown that there is no stronger risk factor for suicide than previous psychiatric hospitalisation, both short-term and long-term. The association is stronger than the association between smoking and lung cancer and is stronger than the suicide risk associated with all psychiatric diagnoses taken together. (Walsh et al. 2014, Large & Ryan 2014, Franklin et al. 2017) Still, one could argue that this increased risk is not caused by the hospital admission itself. Instead, it can be explained by a very accurate selection of the most suicidal patients for hospital admission. (Large & Kapur 2018) The latter claim, that the most suicidal patients are selected for admission, is however contradicted by the fact that suicide risk assessments have so low sensitivity and limited specificity that they lack clinical value (Large 2018, Lindh 2019). Also, statistical analysis of data from several studies has led researchers to argue that at least some part of the increased suicide risk associated with hospitalisation is best explained by causation (Large et al. 2017; Large & Kapur 2018). Even researchers who find causation difficult to believe have admitted

that the data indicate that hospitalisation at least fails to prevent suicides (Large & Kapur 2018). Compulsory admissions constitute around 15% of all psychiatric admissions in Europe, with national variations between 3 and 30%, and up to 54% in the US (in 2014) (Salize & Dressing 2004, Lay et al. 2012, Lutterman et al. 2017). These compulsory admissions, including locked doors and monitoring, seem to compound the problems that could lead to increased suicide risk; for example, traumatic experiences, loss of agency, and validated feelings of hopelessness (James et al. 2012, Huber et al. 2016, Jordan & McNiel 2020). The latter points to possible suicidogenic effects from removing people's autonomy during hospital admission.

The claim that hospitalisation, including compulsory admission, fails to prevent suicides and may even increase suicide risk, is maybe most supported when it comes to patients with borderline personality disorder – as described in the Introduction (Linehan 1993, Paris 2004, Paris 2019, NICE guidelines 2009, Large et al. 2017, Coyle et al. 2018, Nationella självskadeprojektet 2015, Chiles et al. 2018). Still, as the results of the studies in this thesis have shown, there is a strong belief among care providers that compulsory admissions are life-saving for patients with BPD (Lundahl et al. 2018, Lundahl et al. 2022, Lundahl et al. 2023, Lundahl et al. 2024). As long as that belief is maintained, the use of compulsory admissions as a suicide-preventive measure for patients with BPD is likely to continue.

Having said that, there could of course be situations when a BPD patient suffers from a severe co-morbidity, e.g., psychosis or mania, which renders them decision-incompetent, and it is in their best interest to receive the treatment in an inpatient facility. However, when deciding on compulsory care, the care provider should balance the pros and cons of such an admission. The benefits of treating the severe co-morbid state should outweigh the potential harm, including increased suicide risk, that a compulsory admission could result in. (Lundahl et al. 2024, Lundahl 2024)

More research into the possibly negative effects of hospitalisation, in particular compulsory admissions, is needed – not only for patients with BPD but all patients. Controlled studies are yet missing, perhaps because they would require complex design and researchers have feared that they would not get ethical approval (Large & Kapur 2018). However, from the data that have emerged in the last decade, one could argue that there is enough evidential support to question the suicide-preventive effects of admissions, including

compulsory ones, to run a controlled study (Walsh et al. 2014, Large & Ryan 2014, Franklin et al. 2017, Large & Kapur 2018, Coyle et al. 2018, Borecky et al. 2019).

### *Compulsory care of patients with BPD to prevent harm to others*

In the second study, almost half of the responding doctors thought that compulsory admissions against the BPD patient's best interest were justified if the patient constituted a danger to other people. Of course, one may use psychiatric institutions to incapacitate potentially dangerous patients and, just as imprisonment, the measure could temporarily decrease the risk of others coming to harm. That said, this practice is not aligned with the medico-ethical principle saying that compulsory care should be given in the patient's best interest (Beauchamp & Childress 2019). If psychiatry is to function as an extra-judicial crime-preventive unit, that could lead both to legal uncertainty for the patient and to people losing trust in the healthcare system – since it could act against their best interest. If compulsory admission of a dangerous patient is not in the patient's best interest, then it would probably be better if the patient is handled by judicial authorities, e.g., the police.

On the other hand, if a violent BPD patient is decision-incompetent and it is in their best interest to be compulsorily admitted, e.g., to treat a severe mental comorbidity, then the use of compulsory care would harmonise with both the principle of beneficence, respecting the patient's autonomy, and giving care in the patient's best interest.

### *Paternalistic tendencies in Swedish psychiatry*

The results also point to a strong vein of paternalism (Beauchamp & Childress 2019) among doctors working in psychiatry, i.e., doctors seem to decide what they think is best for the patient, regardless of the patient's autonomous will. For instance, compulsory care seems to be used for several non-medical reasons on likely decision-competent patients with BPD, for example, because the patient lacks proper housing or does not participate in outpatient treatment (Lundahl et al. 2023). Another indication of paternalistic tendencies was that the addition of potential suicidality seemed to affect doctors' view of the BPD patient's decision competence – although decision competence should be assessed without regard for the possible outcome of the patient's decision (Hubbeling 2014,

Lundahl et al. 2022) – or, disregard the patient’s decision competence because they thought that compulsory admission was necessary to handle the risk of harm (Lundahl et al 2022). One interpretation is that as long as the patient agrees with the doctor or is not seen as a risk to themselves or others, the patients tend to be assessed as decision-competent on matters of care. Conversely, when they do not agree with what the doctor thinks is best for them or pose a risk of harm, the patient is assessed as decision-incompetent.

Decision incompetence in matters of care is not a legal criterion in Sweden for ordering compulsory admission. That could have made it more difficult for the respondents to reflect on cases involving decision competence and risk of harm to self or others. Still, decision competence is, from a medico-ethical perspective, a prerequisite for treating a person against their will. Whether the Swedish mental health legislation (Lag 1991:1128) will incorporate the concept of decision competence in the future is not known. Yet, further research into the matter would be desirable. If decision competence were to be regarded in situations of compulsory admission, the care could become more aligned with medico-ethical principles and perhaps the paternalistic tendencies among mental healthcare providers could diminish.

### *Defensive practice seems to increase the use of compulsory admissions*

A perhaps more troubling aspect of the results is the described practice of defensive medicine, which means that care providers make clinical decisions that are not in the patient’s best interest but protect the care provider from medicolegal risks (Krawitz & Batcheler 2006, Studdert et al. 2005, Lundahl et al. 2017, Lundahl et al. 2018, Lundahl et al. 2022, Lundahl et al. 2023). This points to a fear-based culture within psychiatry. A potential consequence could be that care providers’ fears and trepidations make them disregard the potential risks for the patient that the defensive measures, such as compulsory admission, can entail (NICE guidelines 2009, Krawitz & Batcheler 2006).

This fear-based practice could be endorsed by the current control system, mandated by supervising authorities. All suicides in Sweden had to be reported to supervising authorities from 2006–2019, under the assumption that suicides are caused by deficits in the care provided. These investigations led to an increase in healthcare routines, checklists, and focus on making suicide risk assessments – but they did not decrease suicide rates. (Fröding 2021) Still, this

control system has remained almost unchanged, perhaps with the intent to make psychiatry appear safer and more trustworthy to the public. Unfortunately, doctors' fear of critique post-suicide seems to bolster defensive measures in psychiatry, such as using compulsory care for patients with BPD to protect the doctor from medico-legal repercussions [Krawitz 2006, Lundahl 2017]. When our decisions are fear-based, the care tends to focus on not doing anything wrong, rather than doing what is right for the patient [Statens offentliga utredningar 2022]. If supervising authorities only required suicide preventive interventions that are evidence-based, that could be a first step to decreasing defensive measures in psychiatry. Suicide risk assessments and compulsory admissions, for example, are not (Large 2018, Borecky et al. 2019, Lundahl 2024, NICE guideline number NG225 2022).

The issue of defensive medicine in psychiatry should be further investigated if one wants to prevent the non-beneficial use of compulsory admissions and other care interventions that primarily serve to protect the care provider from critique or complaints. Also, to focus the healthcare resources on what is helpful for the patients. There is already a campaign within medicine, 'Choosing Wisely', that aims to prevent patients from being subjected to treatments or procedures that contribute to unnecessary costs and potential harm. One way of achieving that is through improved awareness, shared decision-making, and lists of interventions that are of questionable value. (Maughan & James 2017) Integration of such thinking in psychiatry could prevent doctors from defensive practises, and, as a consequence, befitting all patients.

### *Unequal use of compulsory admission for patients with BPD*

The results of the empirical studies show that there are large differences in psychiatrists' opinions on when it is justified to compulsorily admit patients with BPD. These results are supported by the significant differences in the use of compulsory care between municipalities and clinics in Sweden. (Socialstyrelsens statistikdatabas 2021, Lundahl et al. 2018, Lundahl et al. 2022) As a consequence, patients with BPD are probably treated unequally; the extent to which they are subjected to compulsory care seems related to which psychiatrist they meet or which psychiatric clinic they are referred to. Awareness of how personal views affect care could be addressed in clinical discussions on value-based medicine, in which care providers explore and analyse ethical issues around different

ethical principles (Fulford 2008). Such discussions could lead to more equal care for patients with BPD.

### *Compulsory care in the form of Ulysses contracts and the ethical justification of compulsory admissions*

In this thesis, we investigated a phenomenon, observed in clinical practice, that patients with BPD sometimes demand to be compulsorily admitted (Lundahl et al. 2017, Lundahl et al. 2018, Lundahl et al. 2020). One reason for this behaviour could be that the patients do not trust their ability to handle destructive impulses. By relinquishing their autonomy and letting others take responsibility for their impulses, they could feel safer from themselves. The use of compulsory care under such circumstances can be compared to a form of 'Ulysses contracts', as described in the Literature review above. However, the normative study on the ethical justification of using compulsory admission as a form of Ulysses contracts for patients with BPD found that such care is not justified (Lundahl et al. 2020). The use of such Ulysses contracts for patients with BPD has not been studied before and brings new information to the scientific and clinical debate.

The other normative study, on whether compulsory admission is justified for patients with BPD, found that compulsory admissions are only justified in situations when there are good grounds for believing that the patient is decision-incompetent, e.g., due to a severe co-morbid mental disorder, and admission is in the patient's best interest. In other situations, however, compulsory admission was not found to be justified. (Lundahl et al. 2024) This information brings clinical guidance on when compulsory admissions are ethically justified for patients with BPD.

### *Concrete suggestions on how to improve inpatient care for patients with BPD*

On a positive note, the results provided suggestions from mental healthcare workers on how the use of compulsory admissions could decrease (Lundahl et al. 2023). Many of these suggestions were based on positive experiences in the clinic. For example, the respondents recommended structured care planning with a discharge date set upon admission, around three-day-long voluntary admissions, more focus on the patient's agency, and more available outpatient

care (Lundahl et al. 2023). These suggestions are similar to the ones given by healthcare staff in a previous study – on the issue of decreasing the use of non-beneficial admissions for patients with BPD (Lundahl et al. 2022) and are also aligned with clinical recommendations (NICE guidelines 2009). Therefore, there is reason to believe that these clinical suggestions could be of positive value for patients with BPD. What is new is the more specified amount of days that seem to be suitable for hospital admissions, to avoid negative effects, and the importance of planning the care in detail, including setting a discharge date, from the start of admission.

As of yet, the alternatives to compulsory admission of suicidal patients with BPD have not been thoroughly researched. One explanation could be that healthcare providers have thought that compulsory admissions are the best way of handling acute suicidality. To decrease the use of compulsory admissions for patients (with all types of diagnoses), some interventions have shown promising results (Lay et al. 2018, Aagard et al. 2017). Those interventions include, for example, psycho-education for learning self-management skills and crisis plans (Lay et al. 2012, Lay et al. 2018). For suicidal patients in general, and patients with BPD in particular, educating the patient on how to handle emotional turmoil and constructively resolve crises, seems to be a promising way of preventing suicidality and avoiding hospital admissions (Linehan 1993, Coyle et al. 2018, Chiles et al. 2018, Paris 2019, Bryan 2021). An alternative to acute hospital admission could be to use Crisis Resolution Teams that can support the patient at home, but the results of that intervention have been varying (Wheeler et al. 2015). Another intervention could be self-referred voluntary admissions in times of crisis since it has been shown to decrease the use of compulsory admissions for some patients with self-harm behaviour (Westling et al. 2019).

For patients who, for various reasons, are not actively engaged in outpatient treatment and are recurrently hospitalised because of symptoms associated with BPD, special inpatient treatment programs, e.g., with DBT treatment, could be an alternative to outpatient treatment. Inpatient treatment programs, which would require voluntary participation, have shown promising results in reducing symptoms associated with BPD and could be a means of reducing the use of compulsory admission. Still, more research is needed on the outcomes of such care and how it is best implemented (Bohus et al. 2004, Bloom et al. 2012). For the majority of patients with BPD, however, such specialised inpatient treatment programs will likely be neither an available nor an optimal alternative. The reasons for that assumption are, for instance, the significant healthcare

resources such care requires and the patient-related risks associated with hospitalisation, e.g., loss of self-management abilities, loss of contact with everyday life, and the potential increase in self-harm behaviour (Bloom et al. 2012, Paris 2018, Linehan 1993, NICE guidelines 2009).

## ***Conclusions drawn from the results of each study***

### ***Study I:***

This was an interview study on psychiatrists' motives for compulsorily admitting patients with BPD. The interviews put particular focus on non-medical motives for using compulsory care, the use of compulsory care on the patient's demand (Ulysses contracts), and the view on the decision competence of patients with BPD. The results supported the conclusion that the practice of compulsory care differs significantly between psychiatrists and that the psychiatrists' personal attitudes and judgments seem to affect their use of compulsory care more than clinical guidelines or legal directives. The use of Ulysses contracts in the form of compulsory care was recognised and perceived as challenging. The findings also indicated that the psychiatrists' strive for control over the patients' actions, and compliance to socio-political directives, could stand in conflict with the patients' right to autonomy. Further, there seem to be several non-medical factors that, when combined, favour the use of compulsory admissions for patients with BPD – even when such care may not be in the patient's best interest, or compatible with the Mental Health Act. (Lundahl et al. 2018)

### ***Study II:***

Since patients with BPD frequently shift in mood, self-image, suicidality, and decisions (American Psychiatric Association 2013, Linehan 1993), it can be difficult to reach stable agreements with the patient on which type of care should be provided. Under these circumstances, one could argue that compulsory care on the patient's demand – to protect themselves from future destructive impulses – could be a way of benefitting the patient's genuine goals and empowering the patient. In other words, this type of compulsory care can be

compared to a form of Ulysses contracts. (Bell 2015) This normative study scrutinized commonly used arguments favouring the use of compulsory care on the patient's demand. The point of departure was that to justify such care, there should be no doubt about the patient's decision incompetence or overwhelming benefits for the patient when balancing with the principles of Principlism (Beauchamp & Childress). The premises supporting each argument were compared with the current empirical evidence, and if a premise lacked empirical support, the argument was rejected. The study concluded that, based on the arguments and clinical evidence analysed, Ulysses contracts in the form of compulsory care should not be used for patients with BPD. (Lundahl et al. 2020)

### **Study III:**

The third study was a questionnaire study, investigating, for example, doctors' views on the decision competence of patients with BPD and non-medical motives for practising compulsory care. The results supported the conclusion that doctors working in psychiatry are divided in their views of when compulsory care is justifiable for patients with BPD. The significant differences in opinion could increase the risk of arbitrariness and inequity in the application of compulsory care. The results also indicate that an increased risk of harm trumps decision competence when deciding on compulsory admission, or, that an increased risk of harm is taken as evidence of decision incompetency. Societal expectations on psychiatry to prevent harm, together with the care providers' fear of complaints or litigation, seem to increase the use of compulsory care – despite possible negative effects of such care, and limited legal support. Based on clinical experience and previous studies (Paris 2004, NICE guidelines 2009, Coyle et al. 2018), this type of 'risk-averse' practice could, unintentionally, increase the suicide risk for patients with BPD over time. (Lundahl et al. 2022)

### **Study IV:**

This was a questionnaire study inquiring about the mental healthcare staff's experiences in treating compulsorily admitted patients with BPD. The results supported the conclusion that patients with BPD could be regularly subjected to compulsory admissions that are not in the patient's best interest, and there seem to be several non-medical reasons for such care. In the comments, the

respondents provided suggestions on how compulsory admissions could be decreased, for example, by planning the care and setting a discharge date upon admission, providing around three-day-long voluntary admissions, focusing on the patient's agency, and offering more outpatient care. (Lundahl et al. 2023)

### **Study V:**

The fifth study was normative, analysing the arguments favouring the use of compulsorily admitting patients with BPD. The premises supporting each argument were compared with the empirical support available, under the assumption that it is rational to believe in the evidence that has the most empirical support (Feldman 1998). The particular moral judgments were compared with the generally accepted moral principles of Principlism, according to the method of reflective equilibrium (Beauchamp & Childress, Rawls 1971 *in* Lynöe & Johansson 2013, Tersman 1993). The results supported the conclusion that compulsory admission is not ethically defensible in most situations. However, there are exemptions, for example, if the doctor has probable reason to think that the patient is decision-incompetent, e.g., by suffering from a severe co-morbid disorder, and benefits from such care. (Lundahl et al. 2024) In the latter case, compulsory admission is coherent with the medico-ethical principles of beneficence and respecting the patient's autonomy (Beauchamp & Childress 2019).



## 6 Conclusions

The overall conclusion of this thesis is that compulsory admissions should not be used for patients with BPD, with few exceptions. This is a normative conclusion, supported by empirical evidence.

As indicated above, there can be exemptions, e.g., if the patient becomes decision-incompetent due to a co-morbid mental disorder and compulsory admission is considered to be in the patient's best interest. In most situations, however, the removal of the patient's agency by compulsory admission is not justified.

*The conclusions, in short:*

1. Psychiatrists express diverging opinions on when they find it justified to compulsorily admit patients with BPD. Personal views and attitudes seem to affect their use of compulsory admissions more than clinical guidelines or legal directives. This could lead to unequal treatment for the patients.
2. The patient's right to autonomy seems to be of secondary importance to many psychiatrists, especially when the patient with BPD is considered a potential harm to themselves or others.
3. The Mental Health Act is interpreted expediently sometimes so that psychiatrists can provide the care they think is best for the patient. This points to paternalistic tendencies in mental healthcare and a potential overuse of compulsory care.
4. Patients with BPD sometimes wish to be compulsorily admitted, as a form of Ulysses contracts. A normative analysis of this phenomenon concluded that such care is not ethically justified for this group of patients.
5. Doctors working in psychiatry express diverging views on when patients with BPD are decision-competent. When a decision-competent patient was described as potentially dangerous to themselves or others, around half of the respondents found that compulsory care is defensible. This too points to paternalistic tendencies among doctors in psychiatry, as well as a belief that compulsory admissions decrease suicide risk.
6. The studies show that there seem to be several non-medical reasons for providing non-beneficial compulsory care, such as the patient's lack of housing or that the doctors fear litigation or criticism if they discharge a patient with a risk of self-harm. Such care is not consistent with the Mental Health Act and may inadvertently lead to increased suicide risk or other types of harm for patients with BPD.
7. A majority of healthcare staff at inpatient wards in Sweden found that most patients with BPD displayed an increase in self-harm behaviour

when compulsorily admitted for longer than a week. The increase in self-harm behaviour was described as beginning after around three days.

8. A majority of healthcare staff at inpatient wards in Sweden experienced that patients with BPD were compulsorily admitted too long at their wards, with detrimental effects for the patients, and that this length of stay could be decreased without infringing on care quality.
9. Healthcare staff at inpatient wards in Sweden provided suggestions on how to improve the inpatient care for patients with BPD, for example, around three-day-long voluntary admissions, drawing up a care plan with a set discharge date from the start of admission, and providing more outpatient care.
10. A normative study on whether compulsory admissions are ethically defensible for patients with BPD concluded that compulsory care is not ethically defensible in most situations. There can, of course, be exemptions in extraordinary situations. An example of such an extraordinary situation is if the care provider has good reason to believe that the patient has become decision-incompetent, e.g., due to a severe mental co-morbidity, and admission is considered to be in the patient's best interest.

## 7 Points of perspective

### ***Future research***

This thesis addresses several issues that should be further investigated. The areas of interest for future research are explained in the Discussion section and listed below:

1. There is reason to believe that compulsory admissions fail at preventing suicides and may even increase suicide risk to some extent (Large & Kapur 2018, Borecky et al. 2019). Controlled studies are lacking to clarify the potentially harmful (and positive) effects of compulsory admission – both for patients with BPD and for patients in general. More research in this area would be of importance.
2. Suicide risk assessments are still being used as predictive tools in psychiatric healthcare, even though they lack clinical value and could lead to questionable compulsory admissions (Large 2018, NICE guideline number NG225 2022, Psykiatristöd Region Stockholm 2023, Lundahl 2024). This use of suicide risk assessments in Sweden should be further analysed and, if possible, replaced by more efficient ways of working with suicide prevention.
3. Since compulsory admissions have not proved to decrease suicidality and may even increase suicidality by themselves to a certain extent, more research needs to be done on alternative ways of handling acutely suicidal patients (Large et al. 2017, Wang & Colucci 2017, Large & Kapur 2018, Borecky et al. 2019, Lundahl 2024). For example, by investigating which outpatient alternatives are more efficient.
4. The practice of defensive medicine, i.e., clinical interventions that are not in the patient's best interest but protect the doctor from litigation or complaints, should be further researched. This phenomenon points to a fear-based culture among mental healthcare providers that can lead to unnecessary detentions, overdiagnostics, and overtreatment. (Studdert et al. 2005, Krawitz & Batcheler 2006, Maughan & James 2017).
5. From an ethical point of view, a patient should be decision-incompetent to be subjected to compulsory admission (Beauchamp & Childress 2019).

However, this concept is not a criterion for detaining a patient under the Swedish Mental Health Act (Lag 1991:1128). One advantage of requiring decision-incompetence when detaining a patient would be that compulsory care could be used for non-psychiatric patients who are decision-incompetent and in imperative need of somatic healthcare (Holmgren et al. 2023). Also, since decision competence can be assessed using assessment instruments (Grisso et al. 1997), it would hopefully make the use of compulsory care less arbitrary and less dependent on individual views and attitudes. The possible advantages or disadvantages of implementing decision incompetence as a criterion for compulsory care in Sweden should be investigated.

6. As pointed out in this thesis, psychiatrists have diverging opinions on when it is justified to compulsorily admit patients with BPD (Lundahl et al. 2018, Lundahl et al. 2022). One can speculate if more information on the effects of compulsory admissions for patients with BPD would change the use of such care. This could be further examined in an intervention study.
7. Prisons and locked hospital wards are known to be associated with a significantly increased suicide risk (Bryan 2021). One may wonder what in these coercive environments could explain this increase in suicide risk. One way to answer this question is to conduct an interview study with patients who have experienced compulsory admissions and former prison inmates.

### ***Clinical implications***

1. There is enough evidence to claim that compulsory admissions should not be used as a suicide-preventive measure for patients with BPD. Even if controlled studies are lacking, the sum of the current empirical evidence points to no suicide preventive effects from such admissions and even possible causality between compulsory admission and increased suicide rates (Kapur et al. 2015, Large et al. 2017, Wang & Colucci 2017, Large & Kapur 2018, Borecky et al. 2019, Lundahl 2024). Considering the described negative effects that hospital admission as a suicide-preventive measure can have on patients with BPD, such care should be avoided if possible (Coyle et al. 2018, Paris 2004, Paris 2019, Linehan 1993, NICE guidelines

2009, Chiles et al. 2018). If a BPD patient needs to be compulsorily admitted for other reasons, e.g., to treat a severe mental co-morbid state, the benefits of the hospitalisation should be weighed against the possible risks, including increased suicide risk, that compulsory admission could entail. Clinicians should be made aware of the possible risks of depriving patients of their autonomy – not only patients with BPD but all patients. The loss of autonomy conveys harm in itself and could contribute to the increased suicide risk associated with compulsory admissions. (Large et al. 2017, Wang & Colucci 2017, Borecky et al. 2019, Lundahl 2024, Huber et al. 2016, Jordan & McNiel 2020)

2. To make the use of compulsory admissions more evidence-based, equal, and beneficial to patients with BPD, some measures could be taken, for example: 1) The Choosing Wisely campaign could be implemented in Swedish psychiatry to make healthcare more evidence-based and equal and to support doctors in making wise clinical decisions in the patient's best interest (Maughan & James 2017). 2) The concept of value-based practice, as described by Fulford (2008), could be implemented in psychiatric clinics, to raise awareness of own values and how they affect clinical decisions.
3. Controlling authorities should reconsider the use of suicide risk assessments as a predictive tool since they lack clinical value. The use of these tools can lead to faulty prioritisations of hospital beds and non-beneficial compulsory admissions for patients with BPD. (Large 2018, NICE guideline number NG225 2022, Psykiatristöd Region Stockholm 2023, Lindh 2019, Lundahl 2023, Lundahl 2024). Also, controlling authorities should be more aware of the possible risks associated with compulsory admissions (Borecky et al. 2019, Wang & Colucci 2017, Huber et al. 2016, Jordan & McNiel 2020). If the mandatory investigations of the psychiatric care following each suicide were more evidence-based, the risk of defensive practice in psychiatry could decrease and that would benefit the patients with BPD in the end (Patientsäkerhetslag 2010:659, Studdert et al. 2005, Krawitz & Batcheler 2006).
4. The healthcare staff of inpatient wards treating patients with BPD (Lundahl et al. 2023) suggested several ways of improving inpatient care for these patients, e.g., care planning with set goals and discharge date upon

admission, about three-day-long voluntary admissions when the patients are in crisis, supporting the patient's agency, and making outpatient treatment more available. These suggestions are aligned with previous clinical recommendations (NICE guidelines 2009) but are more tangible – especially concerning length of stay and setting of discharge dates. These suggestions could well be implemented in Swedish psychiatric inpatient care.

5. As an alternative to the hospitalisation of patients with BPD, outpatient interventions should be considered, as described in the Discussion section. To that end, perhaps more resources need to be put into providing good outpatient care for patients with BPD. As far as we know today, psychological treatments, especially ones focusing on how to handle difficult emotions or situations, seem to be the most effective treatments for patients with BPD (Linehan 1993, Coyle et al. 2018, Chiles et al. 2018, Paris 2019, Bryan 2021). Such treatments are usually provided in outpatient settings.

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## 10 APPENDIX

Appendix I: Information to participants study I

Appendix II: Interview questions study I

Appendix III: Qualitative analysis study I

Appendix IV: Questionnaire Study III

Appendix V Qualitative analysis Study III

Appendix VI Questionnaire Study IV

Appendix VII Qualitative analysis Study IV



## **APPENDIX I** (translated by the author)

### **Information to those who will be interviewed about the motives for using compulsory care for patients with Borderline Personality Disorder (BPD)**

#### **INTRODUCTION AND PURPOSE**

Compulsory care for patients with symptoms of borderline personality disorder often evokes emotions in patients, caregivers and the general public. There are also different opinions among clinicians regarding when and why compulsory care should be used for this patient group. We are now conducting a study in which we investigate the motives for using compulsory care for patients with borderline personality disorder, with the aim of taking a position on when and in what contexts such care is ethically justified. In this study, we want to investigate this by interviewing psychiatrists who regularly meet patients with BPD in acute and/or inpatient care.

#### **PARTICIPATION IN THE STUDY AND VOLUNTARINESS**

Since you meet with patients with borderline personality disorder in your professional role, we ask if you would like to participate in the study. Participation means that you will be interviewed about your experience of, and thoughts on, the use of compulsory care for patients with borderline personality disorder. The interview is expected to take up to an hour. **Please note that your participation is completely voluntary and that if you choose to participate, you may cancel your participation at any time without giving any specific reason.** You also have the right to contact us at any time if you wish to leave the study. Any participation in the study will not affect your employment or your work role. No compensation will be paid for participation in the study.

#### **CONFIDENTIALITY AND HANDLING OF PERSONAL DATA**

The personal data (e.g. name, workplace) collected about you in the study will be handled in accordance with the Personal Data Act (Pul SFS 1998:204), which means that unauthorised persons cannot access it and that no personal data is passed on to third parties. The link between the information and the individual is only available to the researchers responsible for the study.

You have the right to apply for a so-called register extract of the collected data. You will be identified by a unique code number so that you and your details cannot be directly linked to your name or social security number. Information about the code number is kept separately only available to one of the researchers in the study. In published study results, it will never be possible to trace information to an individual in the study. The same applies to information regarding patients or patient cases to the extent that they are discussed during the interview.

#### **RESULTS**

We intend to publish the results of the study in scientific journals and possibly in patient- or lay media. The results will not include information that can identify you as a participant or patients/patient cases discussed during the interview.

#### **CONTACT**

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The Research Principal and Data Controller is Karolinska Institutet, SE-171 77 Stockholm, Sweden.

I hereby agree to participate in the study as above:

Date and place: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_



## Appendix II

Semi-structured interview questions, concerning psychiatrists' practice of compulsory care of BPD patients

1. Do you treat patients with BPD? How often?
2. How do you experience managing/treating patients with BPD in emergency psychiatry or in-patient care? How do these experiences affect your clinical decisions regarding compulsory care?
3. What is the typical situation or circumstance at hand when you decide to take a BPD patient into compulsory care?
4. Do you worry about what will happen if you discharge the patient, and does this affect your practice of compulsory care?
5. Does risk assessment concerning suicide or self-harm affect your clinical decisions regarding compulsory care of BPD patients? How?
6. Do you feel affected by the expectations of other agents (for instance, media, relatives, authorities, or colleagues) concerning practising compulsory care of BPD patients? How?
7. It's common to consider that a patient should be decision-incompetent in order to be subjected to compulsory care. ("Decision competence" means that the patient has the ability to understand the information about healthcare/treatment-alternatives and what consequences these alternatives might lead to, as well as the ability to evaluate these consequences in light of what they want to obtain.)
  - a) Do you believe BPD patients can be decision-competent?
  - b) Can it be justifiable to take them into compulsory care even if they are decision-competent? If so, when?
  - c) Can it be defensible to take a decision-competent BPD patient into compulsory care with reference to the fact that the patient is not making decisions according to his/her true desires?
8. Do you believe that suicidality in itself is equivalent to a "serious psychiatric disorder"?
9. Have you experienced that BPD patients sometimes demand, directly/indirectly, to be taken into compulsory care in order not to harm themselves? What do you think of such compulsory care (Ulysses contracts)?
10. According to your experience, what are the usual consequences of compulsory care of BPD patients?



### APPENDIX III *Content analysis of the interviews*

This is a content analysis of twelve interviews concerning psychiatrists' motives for practising compulsory care of patients with main symptomatology compatible with borderline personality disorder (BPD).

| Theme   | Category  | Subcategory   |
|---|---|---|
| <i>Alfa.</i> BPD patients are perceived as difficult: interpersonally, in clinical and legal management, and due to suicide risk. | A. BPD patients are perceived as difficult, in interpersonal relations and clinical management.   | <ol style="list-style-type: none"> <li>1. BPD patients are often perceived as manipulative and provocative.</li> <li>2. It is usually difficult to reach alliance with BPD patients.</li> <li>3. There is a lack of consensus among psychiatrists concerning how to manage BPD patients in the clinic – this differs both within and between clinics.</li> <li>4. BPD patients' behaviour often stirs up emotions among healthcare professionals, relatives and healthcare partners.</li> <li>5. The BPD patients' impulsivity and rapidly shifting emotions make their behaviour difficult to predict.</li> <li>6. It is difficult for the caregiver to predict the consequences of different clinical management procedures.</li> </ol> |
|   | B. BPD patients have an increased suicide risk that is difficult to predict.  | <ol style="list-style-type: none"> <li>1. The suicide risk is chronically increased: intentional, impulsive, accidental or instrumental.</li> <li>2. Suicides happen despite correct psychiatric management, and the responsibility is placed on the caregiver.</li> <li>3. BPD patients' suicidal behaviour causes anxiety in their environment.</li> </ol>  |
|   | C. The Swedish Mental Health Act is a legal grey area when it comes to BPD patients.  | <ol style="list-style-type: none"> <li>1. The Mental Health Act is not adapted to BPD patients.</li> <li>2. The interpretation of the Mental Health Act is expanded in order to handle violent or self-destructive behaviour.</li> <li>3. Suicidality is not equivalent to "a serious psychiatric disorder".</li> <li>4. Suicidality is not equivalent to "a serious psychiatric disorder", but in clinical practice is treated as if it were; thus suicidality justifies compulsory care.</li> </ol>   |
| <i>Beta.</i> There are medical and non-medical motives for compulsory care of BPD patients, and the consequences can vary.        | D. There are medical motives for compulsory care of BPD patients, which comply with the Swedish Mental Health Act.                              | <ol style="list-style-type: none"> <li>1. Comorbidity, for example psychotic-like behaviour and severe depressions with suicide risk, justifies compulsory care.</li> </ol>   |
|   | E. There are non-medical motives for practising compulsory care of BPD patients: practical and social aspects, and to avoid external criticism. | <ol style="list-style-type: none"> <li>1. Issuing a compulsory care certificate facilitates/hastens the process in emergency situations.</li> <li>2. Compulsory care is practised to avoid criticism from relatives, media, police, healthcare partners and authorities.</li> <li>3. Patients' lack of cooperativeness in their healthcare and housing increases the use of compulsory care.</li> <li>4. There is pressure from relatives, related caregivers and authorities to compulsorily treat BPD patients to a greater extent than the physician in charge considers medically indicated.</li> </ol>   |

|  |  |  |
|--|--|--|
|  | F. Risk assessment, considering the risk of danger to oneself or others, occurs to various extents as a motive for compulsory care of BPD patients.    | <ol style="list-style-type: none"> <li>1. Suicide risk is the most common motive for compulsory care.</li> <li>2. Risk of violence justifies compulsory care, sometimes for community-protective and practical reasons.</li> <li>3. Risk of violence does not justify compulsory care.</li> <li>4. Long-term compulsory care, despite negative consequences, can be necessary due to assessed suicide risk or destructive behaviour.</li> <li>5. Hospital/compulsory care can decrease suicide risk.</li> <li>6. Hospital/compulsory care can increase the risk of self-destructive and suicidal behaviour.</li> </ol> |
|  | G. Compulsory care of BPD patients with decision competence is justified to various extents, with motives such as non-authentic wishes or suicidality. | <ol style="list-style-type: none"> <li>1. Non-authentic wishes of a decision-competent patient can justify compulsory care, for example when the patient is considered suicidal.</li> <li>2. Non-authentic wishes of a decision-competent patient cannot justify compulsory care.</li> <li>3. It's justifiable to take patients with decision competence into compulsory care, for example when the patient is considered suicidal.</li> <li>4. It's not justifiable to take patients with decision competence into compulsory care.</li> </ol>  |
|  | H. Compulsory care of BPD patients can implicate various results: positive when short-term, negative when long-term.                                   | <ol style="list-style-type: none"> <li>1. Short-term compulsory care can have a stabilizing effect on the patient's affections.</li> <li>2. Long-term compulsory care can cause negative consequences, like an increase in self-destructive behaviour, increase in compulsory measures, and less ability to take responsibility for oneself.</li> </ol>  |

|   |   |   |
|---|---|---|
| Gamma. BPD patients have decision competence and sometimes demand to be taken into compulsory care. | I. BPD patients have decision competence, which is sometimes perceived as rapidly shifting.   | <ol style="list-style-type: none"> <li>1. BPD patients have decision competence.</li> <li>2. The decision competence is interpreted as rapidly shifting and is correlated to strong emotions and impulses.</li> </ol>   |
|   | J. BPD patients sometimes demand to be taken into compulsory care, which clinicians find challenging from a clinical and legal point of view. | <ol style="list-style-type: none"> <li>1. Patients sometimes, directly/indirectly, demand to be taken into compulsory care.</li> <li>2. The BPD patient's demand for compulsory care is sometimes granted.</li> <li>3. Compulsory care at the patient's demand is perceived as contradictory, inconsistent with the Mental Health Act.</li> <li>4. Compulsory care at the patient's demand can be legally justifiable, since the voluntariness is conditional on being compulsorily admitted and there is an expected development toward decision incompetence in the near future.</li> <li>5. Compulsory care at the patient's demand can be perceived by the patient as a form of refuge, as protection against destructive impulses and discharge.</li> <li>6. Demanding to be taken into compulsory care can signify self-awareness, and granting this wish can help increase the patient's participation in healthcare; thus, this demand should be granted by the physician</li> <li>7. Compulsory care at the patient's demand eases the work of the caregivers, for instance by preventing patients from suddenly discharging themselves during on-call time.</li> <li>8. Compulsory care at the patient's demand can enhance negative behaviour patterns, such as avoidance of taking responsibility for oneself.</li> </ol> |

## **APPENDIX IV** *Cover sheet (translated by the author of this study)*

### QUESTIONNAIRE FOR MEDICAL SPECIALISTS AND RESIDENTS IN MENTAL HEALTH CARE, ACTIVE IN SWEDEN

This questionnaire is part of a research project in medical ethics at Karolinska Institutet and is addressed to you who have Swedish specialist competence in psychiatry, or is a resident in psychiatry.

The questions concern the handling of patients with a main symptomatology consistent with borderline personality disorder, where it exists a chronic long term pattern of fluctuating emotional instability and self-destructiveness.

Participation is voluntary – if you do not want to participate you can abstain from answering the questionnaire. If you do not want reminders please return the appurtenant envelope empty. All analysis occurs at a group level. When the data has been compiled no answers will be traceable to individuals. No individual answers will therefore be traceable to you.

#### *The questionnaire (translated by the author of this study)*

Several questions in the questionnaire concern a patient's decision competency. By decision competency, in this context, we mean a person's ability to autonomously make decisions in a certain matter – e.g. to accept or refuse offered care. If the patient's decision in a certain matter is affected by e.g. threats, coercion, mental confusion or psychotic delusions, the patient is to be considered not decision competent in the matter. **In the questions below we pertain to decision competence concerning offered care.**

In the questions the expression "true will" occurs. By this we mean in this context the patient's actual will, based on the patient's underlying values and life goals.

*Here follows a number of claims that pertains to patients with **borderline personality disorder, without considerable mental comorbidity**. Mark the answering alternative that best agrees with your opinion about the claim, meaning what YOU believe.*

- 
- |   |                         |                          |                  |
|---|-------------------------|--------------------------|------------------|
| 1. A patient must <b>lack decision competence</b> regarding offered care to be eligible for compulsory care         |                         |                          |                  |
| Fully agree   | Agree to a large extent | Agree to a lesser extent | Not agree at all |
| 2. It is valid to give compulsory care to <i>decision competent</i> patients that constitute a danger to themselves |                         |                          |                  |
| Fully agree   | Agree to a large extent | Agree to a lesser extent | Not agree at all |

3. It is valid to give compulsory care to *decision competent* patients that constitute a danger to other people

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

4. It is valid to give compulsory care to *decision competent* patients if their requests are not derived from their true will

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

Comments regarding claim 1-4:

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5. Even if it is *not in their best interest*, sometimes it is valid to give compulsory care to patients when they constitute a risk of violent behaviour towards other people

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

6. Even if it is *not in their best interest*, sometimes it is valid to give compulsory care to patients when there are no other care alternatives, such as psychiatric outpatient care or mobile acute units

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

7. Even if it is *not in their best interest*, sometimes it is valid to give compulsory care to patients when persons in their surroundings (such as relatives or social services) demand it

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

8. Even if it is *not in their best interest*, sometimes it is valid to give compulsory care to patients in order for you to avoid being reported to auditing authorities

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

9. Even if it is *not in their best interest*, sometimes it is valid to give compulsory care to patients when the work situation is so stressed that you don't have time to convince the patient to accept non-compulsory care

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

Comments regarding claim 5-9:

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10. It is reasonable to give compulsory care to *decision competent* patients when they *themselves* request it

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

11. It is reasonable to give compulsory care to *decision competent* patients when they *themselves* request it, e.g. because they are afraid that otherwise they might hurt themselves or others

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

12. Compulsory care on a *decision competent* patients *own request* is tenable because it increases patient influence and can be seen as a form of patient centred care

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

13. Compulsory care on a *decision competent* patients *own request* is tenable when the patient is rapidly fluctuating in her feelings and impulses

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

14. Compulsory care on a *decision competent* patients *own request* is tenable when it can protect the patient's life

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

15. Compulsory care on a *decision competent* patients *own request* is **not** tenable because it does not agree with the Mental Health Act

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

16. Compulsory care on a patient's *own request* is **not** tenable because the patients *decision competence concerning offered care is not affected by the mental disorder*

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

17. Compulsory care on a *decision competent* patients *own request* is **not** tenable because compulsory care has detrimental effects on the patient's own ability to learn to handle negative feelings and impulses

Fully agree      Agree to a large extent      Agree to a lesser extent      Not agree at all

Comments regarding claim 10-17:

18. Which of the following claims concerning patient's decision competency do you think is most in line with your conception? We pertain to patients with borderline personality disorder without considerable mental comorbidity. Choose **one** alternative and mark it in the table.

|   |
|---|
| Patients with borderline personality disorder can in connection to strong emotional breakthroughs not autonomously control their own actions, such as self-harming behaviour. In such situations they should be judged as incapable of making decisions concerning their care and the mental health services may need to use compulsory care to protect the patients from themselves.                                     |
| Patients with borderline personality disorder can in connection to strong emotional breakthroughs not autonomously control their own actions, such as self-harming behaviour. However, even if the patients in such situations are judged to lack decision competency concerning their care, it is not defensible to use compulsory care because such care can have negative consequences on the patient's mental health. |
| Patients with borderline personality disorder are almost always decision competent concerning their care, including in situations with strong emotional breakthroughs, and have the ability to autonomously control their actions. However, sometimes their behaviour is so dangerous for themselves or their surroundings that compulsory care is nevertheless defensible.   |
| Patients with borderline personality disorder are almost always decision competent concerning their care, including situations with strong emotional breakthroughs, and have the ability to autonomously control their actions. Therefore, compulsory care of patients with borderline personality disorder is not defensible.  |
| None of the above. I view borderline personality patient's decision competence in the following way:  |

19. What would happen with your trust for the mental health care if patients with borderline personality disorder are given compulsory care without it being obvious that it is in their best interest?

My trust would:

Increase ☐

Not be affected ☐

Decrease ☐

**General information about you:**

*Legal gender:*

Man ☐

Woman ☐

*Chronological age:* \_\_\_\_\_ years

*Number of years where you have been professionally active in mental health care:* \_\_\_\_\_ years

**APPENDIX V** Analysis of the comments in the questionnaire study, supplementary file to the article “Psychiatrists’ motives for compulsory care of patients with borderline personality disorder (BPD) – a questionnaire study”

| Themes  | Categories  | Subcategories  |
|---|---|--|
| Compulsory care of decision-competent BPD patients is justified | Suicidality justifies compulsory care even if the patient is decision-competent or if compulsory care is considered non-beneficial from other aspects                             | Compulsory care is justified when the patient is in emotional distress with an increased risk of hurting herself   |
|   |   | Compulsory care is justified when a decision-competent BPD patient has an increased suicide risk   |
|   |   | Compulsory care can have negative consequences for the patient but is nevertheless justified by suicide risk   |
|   | Violence risk justifies compulsory care even if the patient is decision-competent   | Compulsory care is justified when a decision-competent BPD patient has an increased risk of violence   |
|   | Suicide risk is by definition a severe psychiatric disorder and renders the patient decision-incompetent  | Increased suicide risk is by definition a severe psychiatric disorder, and the suicidality renders the patient incompetent to decide on the care offered                                 |
|   | Since it is difficult to exclude severe psychiatric co-morbidity in BPD, compulsory care can be justified as a precaution in emergency situations                                 | The BPD diagnosis can be questioned and should be combined with or replaced by other diagnoses   |
|   |   | It is difficult to exclude severe psychiatric co-morbidity in BPD, justifying compulsory care in emergency situations  |
|   | Compulsory care on decision-competent patients’ own request occurs, has judicial support, validates the patient, and is motivated by the patients’ unreliability and suicide risk | Sometimes patients request compulsory care, and such care is usually approved in court   |
|   |   | Compulsory care on a decision-competent patient’s own request may indicate self-insight of her own needs   |
|   |   | Compulsory care on the patient's own request is reasonable for a shorter period due to suicide risk  |
|   |   | A decision-competent patient with rapidly shifting emotions and impulses is not considered reliable in her wishes and compulsory care at the patient's own request can thus be justified |

|   |  |   |
|---|--|---|
| Compulsory care of decision-competent BPD patients is not justified | Violence risk does not justify compulsory care   | BPD combined with the risk of violence does not motivate compulsory care and should be handled by the Police      |
|   | BPD patients should not be treated under the Mental Health Act since they are decision-competent and are harmed by compulsory care | Compulsory care can be harmful to the patient and increase the risk of self-destructiveness                       |
|   |  | BPD patients without co-morbidity are in control of their actions and should not be subjected to compulsory care  |
|   | Compulsory care is only justified when the patient suffers from a severe psychiatric disorder                                      | Compulsory care may only be practised when the patient suffers from a severe psychiatric disorder                 |
|   | Compulsory care on a decision-competent patient's request has no legal support and is harmful to the patient                       | Compulsory care on a patient's own request is not compatible with the (Swedish) Mental Health Act                 |
|   |  | Compulsory care on the patient's own request is harmful to the patient since it reinforces destructive behaviours |

|  |  |   |
|--|--|---|
| Compulsory care is applied outside the law for external reasons    | Compulsory care is applied outside the legal framework, as a means of facilitating the handling of patients and protecting healthcare staff and society from negative consequences | Compulsory care is practised, outside the legal framework and not in the patient's best interest, as a means to handle practical problems, for example: stressful work situations, lack of resources, pressure from the environment, containing violent patients or safeguarding the practitioner from complaints |
|  | Social demands for suicide prevention result in expedient suicidal behaviour and compulsory care that is not supported by the legislation  | The "zero tolerance" for suicide entails suicidality being used by patients as a means of obtaining health care   |
|  |  | The "zero tolerance" for suicide makes practitioners feel compelled to practise compulsory care outside the law   |
| There is legal unclarity regarding compulsory care of BPD patients | The Mental Health Act leaves room for various interpretations and can therefore be used arbitrarily as a means to an end   | The Mental Health Act can be interpreted variously by courts and psychiatrists, leaving it open to be applied as a practical means to control the patient's behaviour   |

|  |  |  |
|--|--|--|
| Decision competence and authenticity are difficult to assess | It is difficult to determine a patient's decision competence | It is difficult to determine a patient's decision-making abilities |
|  | It is difficult to determine a patient's authentic will      | It is difficult to determine a patient's true inner will           |



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## **APPENDIX VI**

### **Questionnaire to you who work with patients with self-harm behaviour in inpatient care**

This questionnaire is directed to you who work as a nurse or psychiatric aide in psychiatric inpatient care and have experience in treating patients with **self-harm behaviour**. All questions in the questionnaire concern **inpatient compulsory care** of this group of patients. By self-harm behaviour, we mean repetitive self-destructive behaviour, both with and without suicidal intent. The diagnoses may look somewhat different, but our questionnaire concerns patients who show symptoms coherent with **borderline personality disorder**. We want to find out how you experience that the inpatient care is working for these patients and if different factors can matter for the outcome of the care. The questionnaire is voluntary and anonymous. All analysis is conducted at group level. When the data have been gathered no answers can be traced back to any individual. No single answer can therefore be traced back to you. The questionnaire is part of a scientific project at the Institution for learning, informatics, and medical ethics (LIME) at Karolinska Institutet.

*If you have questions about the study, please contact us:*

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*Check the alternative you find is most correct according to your experience*

1. In your experience, does the self-harm behaviour of these patients decrease from compulsory admissions longer than a week?

- ☐ Yes, most often the self-harm behaviour decreases from admissions longer than a week  
☐ Most often the self-harm behaviour is not affected by admissions longer than a week  
☐ No, most often the self-harm behaviour increases from admissions longer than a week

Commentary:

2. What do you think about the duration of compulsory admissions at the ward where you are currently working, in comparison to what you think is best for the patient?

- ☐ I think that the patients most often need longer admissions than what they get now to get better  
☐ I think that the duration of admissions is satisfying to make the patients get better  
☐ I think that most often the admissions are too long, causing the patients to get worse

Commentary:

3. Do you think it is possible to decrease the duration of compulsory admissions at your ward without impairing care quality for the patients with self-harm behaviour?

- ☐ No, it's not possible to decrease the current durations of admission without impairing care quality  
☐ Yes, it's possible to decrease the current durations of admission without impairing care quality

If you have answered yes to the question, what changes do you think are needed?

There are some further questions on the next page about your general experience of caring for patients with self-harm behaviour (does not have to involve your current working location).

4. Have you experienced that patients with self-harm behaviour sometimes directly or indirectly wish to receive compulsory care?

- ☐ Yes, it happens from time to time (more often than once per six months)  
☐ Yes, but it happens rarely (max once per six months)  
☐ No, I have never experienced that

Commentary:

5. Have you experienced that patients with self-harm behaviour sometimes receive longer compulsory admissions than what is good for them for non-medical reasons? If yes, what reasons? (you can check several boxes)

- ☐ No  
☐ Yes, because relatives have demanded it  
☐ Yes, because the outpatient clinic or other care providers have demanded it  
☐ Yes, because the care provider has been afraid of litigation if the patient self-harms after discharge  
☐ Yes, because the patient doesn't participate in outpatient interventions  
☐ Yes, because the outpatient clinic couldn't provide close follow-up  
☐ Yes, because the patient lacks housing or is dissatisfied with current housing  
☐ Yes, other reason:

6. Below, we ask if the patients' interaction style with the care providers can affect how much care they receive compared to other equally ill patients.

A. If the patient is perceived as a demanding person, then

- ☐ the patient usually gets more care  
☐ it usually does not affect the amount of care  
☐ the patient usually gets less care

B. If the patient is perceived as a likeable person, then

- ☐ the patient usually gets more care  
☐ it usually does not affect the amount of care  
☐ the patient usually gets less care

Commentary to question 6:

*General facts about you who answer the questionnaire:*

Legal gender:

☐ Man

☐ Woman

Number of years working in psychiatry:

0-5 yrs ☐

6-10 yrs ☐

>10 yrs ☐

I work as:

☐ Psychiatric aide

☐ Nurse

☐ Other title: \_\_\_\_\_

Region in Sweden where the questionnaire is answered: \_\_\_\_\_

***Thank you for your participation!***

**Appendix VII.** Analysis of optional commentaries to the questions in the questionnaire. Answered by psychiatric hospital staff 2021, concerning patients who self-harm.

| Themes                           | Categories   | Subcategories  |
|----------------------------------|--|--|
| Pros and cons of compulsory care | Advantages of compulsory admissions<br>“Depends on the individual and how easily they can refrain from self-harm with the staff’s support. For some, admission automatically seems to have a calming effect, independent of the form of care.” | -Longer compulsory admissions are good for planning<br>-Admissions in general are calming for some<br>-Self-harm decreases temporarily during compulsory admissions  |
|                                  | Disadvantages of compulsory admissions<br>“According to experience, the risk of self-harm is lowest after 2-3 days. After that, self-harm behaviours increase considerably!”   | -There is more anxiety adjacent to the discharge when admitted to compulsory care<br>-Self-harm increases after a few days of compulsory admission<br>-Accessibility to somatic help increases self-harm<br>-Transfer of responsibility to care providers allows patients to let go of control and self-harm more<br>-Patients trigger each other to self-harm more<br>-Loss of agency and skills during compulsory admissions increases self-harm<br>-Longer compulsory admissions cause more harm than good<br>-The longer compulsory admissions, the more anxiety and self-harm<br>-Self-harm behaviour is reinforced by attention and care interventions |
| Patients’ actions and influence  | Patients demand compulsory care for various perceived benefits<br>“Compulsory care can give a sense of being taken care of and being able to let go of the responsibility for one’s safety”  | -Patients sometimes demand compulsory care<br>-Patients transfer responsibility to others to protect themselves from making bad decisions<br>-Some patients want compulsory care and constant monitoring<br>-Patients threaten suicide to keep their compulsory care<br>-Patients want compulsory care to receive longer admissions<br>-Compulsory care renders more attention<br>-Patients identify as “sick” and see compulsory care as proof of that  |
|                                  | Different views on how patients’ interaction style affects their care<br>“A patient who demands constant attention and is seen and heard and makes demands, often (but not always) gets more care interventions.”                              | -Demanding or likeable patients may get more care<br>-Demanding or likeable patients may get less care<br>-Care providers more willing to help likeable patients<br>-Silent patients may get less care<br>-Patients receive care according to their needs<br>-Whether the patients’ interaction style affects care depends on the staff working<br>-Level of care depends on the patient’s motivation<br>-Self-harming patients get more attention than they need  |

|   |  |   |
|---|--|---|
| Compulsory admissions for other than direct medical reasons | Compulsory admissions related to doctors' fears and interests<br>"Doctors don't dare [discharging] because of fear of losing their doctor's license or being litigated"  | Doctors decide on longer compulsory admissions than what is beneficial to the patient because...<br>- some doctors are afraid to discharge self-harming patients, but it depends on which doctor is in charge<br>-they fear negative publicity<br>-they fear litigation<br>-they are too paternalistic<br>-the patient wants it and has made friends in the ward<br>-the patient threatens suicide  |
|   | Compulsory admission related to outpatient care<br>"The special housing doesn't welcome the patient back, [they have] cancelled the accommodation while the patient is in hospital. The housing lacks competence to "bring the patient back" because of an increase in self-harm behaviour." | Doctors decide on longer compulsory admissions than what is beneficial to the patient because...<br>-they want to help patients who lack or wait for a new housing<br>-the patient's housing staff lacks the competence to care for the patient<br>-there is a lack of close follow-up in outpatient care   |
| Suggested changes to improve care                           | Positive experiences from short voluntary admissions<br>"Brief self-admissions to these patients. With a qualifying period between admissions. For example, brief admission 2-3 nights and then 3-7 days must pass before the patient can seek admission again."                             | Suggested changes to reduce compulsory admissions without impairing care quality:<br>-Admissions that are limited to not being longer than a few days (around three days, less than a week)<br>-Restrictions on the number of admissions<br>-Voluntary instead of compulsory admissions<br>-Brief self-admissions, i.e., short admissions decided by the patient  |
|   | Need for better inpatient planning, structure, and care content<br>"Structured and well-planned care. Deciding on discharge date already at the beginning of the admission. What goals are to be met together with the patient during admission?"  | Suggested changes to reduce compulsory admissions without impairing care quality:<br>-Discharge date should be set from the start<br>-Goal-directed care planning is needed<br>-Patients should be activated during admissions<br>-More responsibility should be given to the patient<br>-Constant monitoring of patients should be avoided<br>-There should be better doctor continuity<br>-Courage to discharge patients is needed<br>-Care providers need to work in the same way, following routines<br>-Need for more education to care providers about self-harming patients<br>-Patients should be taught skills to handle anxiety and self-harm impulses<br>-Having wards with special competence<br>-Two psychiatrists can help each other with co-assessments of patients who threaten suicide<br>-Zero tolerance for inpatient self-harming (reduces such events)<br>-Relatives should be involved in care planning<br>-Patient-centred care<br>-More staff in the ward<br>-Better cooperation between outpatient and inpatient care |
|   | Need for better outpatient and social interventions<br>"Better back-up at home, for example, outpatient care, housing support etc."  | Suggested changes to reduce compulsory admissions without impairing care quality:<br>-Make outpatient care more accessible<br>-More outpatient interventions are needed<br>-Social interventions are needed<br>-Housings with qualified staff are needed  |