



Psychiatrists' motives for practising in-patient compulsory care of patients with borderline personality disorder (BPD)☆



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ABSTRACT

Introduction: Patients with BPD are often subjected to compulsory care. However, as compulsory care restricts liberty and may have negative effects, it is recommended that it be used sparingly. In this study, we investigate psychiatrists' motives for practising compulsory care of BPD patients.

Method: Semi-structured interviews with twelve Swedish psychiatrists from Stockholm County. These interviews were analysed according to descriptive qualitative analysis.

Results: The qualitative data from our study resulted in three themes: (1) BPD patients 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 BPD patients, and its consequences can vary; and (3) BPD patients have decision competence and sometimes demand to be taken into compulsory care.

Conclusion: The interviewed psychiatrists' own judgements and values, rather than clinical and legal directions, were decisive in their practice of compulsory care. For the BPD patients, this can result in vast differences in the mental healthcare offered, depending on which individual psychiatrist they encounter. Socio-political expectations and psychiatrists' personal views seem to lead to more compulsory care of BPD patients than is clinically recommended and legally sanctioned.

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1. Introduction

The standard form of in-ward care is voluntary, respecting the patient's autonomy and right to accept or decline the care offered (Beauchamp & Childress, 2013). However, under certain circumstances compulsory care can be practised in psychiatry. In Sweden, the patient can be detained and receive care under the Swedish Mental Health Act. According to the Government's legislative proposition regarding the Swedish Mental Health Act (Regeringens proposition 1990/91:58 om psykiatrisk tvångsvård, m. m), conveying the deliberations and intentions of the legislator, the prerequisites for in-patient compulsory care are: "(1) The patient suffers from a severe psychiatric disorder, (2) the patient, due to his/her psychiatric 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 such care as stated in 2, or due to his/her psychiatric state clearly lacks the ability to express

a considered opinion on the subject" (a translation of the present version of the Mental Health Act can be viewed in Appendix I). The compulsory care certificate, a written decision to compulsorily detain a patient, can be issued by a certified physician, but within 24 h a decision on continued compulsory care must be made by a psychiatrist. The definition of "severe psychiatric disorder" is somewhat vague, but includes primarily psychotic disorders and similarly severe psychiatric conditions (Regeringens proposition 1990/91:58 om psykiatrisk tvångsvård, m. m) (Appendix I). Suicidality, without associated "severe psychiatric disorder", is not legal grounds for compulsory care. According to the Swedish mental health legislation (Regeringens proposition 1990/91:58 om psykiatrisk tvångsvård, m. m), the patient's need for care is to be of main importance when making an assessment under the Mental Health Act (Appendix I).

In the literature of medical ethics (Beauchamp & Childress, 2013), it is commonly considered that a patient should lack decision competence concerning the care offered, in order to be subjected to compulsory care. Also, that compulsory care should be given in the patient's best interest. These "ethical prerequisites" seem reflected in the Swedish mental health legislation to some extent. However, this legislation emphasizes the patient's assessed need for psychiatric care more than the patient's competence to make her own decision - the latter is not an explicit legal requirement for compulsory care.

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A group that has been subjected to residential compulsory care to a great extent over the years are patients with borderline personality disorder (BPD) (Bender, Dolan, Skodol, et al., 2001; Holm, Björkdahl, & Björkenstam, 2011; Socialstyrelsens statistikdatabas (Statistics database of The National Board of Health and Welfare), 2016). BPD refers to a set of debilitating personality characteristics with onset in early adulthood and present across contexts. These personality traits include a pervasive pattern of emotional instability, instability in interpersonal relations and self-image, separation anxiety, feeling of inner emptiness, difficulty handling anger, impulsiveness, suicidal ideation and self-harm, and transient dissociative symptoms (American Psychiatric Association, 2013). The BPD diagnosis in itself is not considered to be a “severe psychiatric disorder,” even though the addition of an “impulsive breakthrough of psychotic character” (Appendix I) can be defined as such (Regeringens proposition 1990/91:58 om psykiatrisk tvångsvård, m. m).

The most common reasons for in-patient care, including compulsory care, of patients with BPD are suicide attempts, self-harm, and suicidal communication (Black, Blum, Pfohl, et al., 2004; Brown, Comtois, & Linehan, 2002). Suicidal behaviour in BPD is common, often commanding the attention of others, and can be a way for the patient to handle strong distress and anxiety (Paris, 2004, 2006). There is an increased lifetime suicide risk for patients with BPD (McGirr, Paris, Lesage, et al., 2007). However, there is no evidence that residential treatment, restraint or monitoring reduces the suicide risk in BPD patients (Black et al., 2004; Huber, Schneeberger, Kowalinski, et al., 2016; James, Stewart, & Bowers, 2012; Krawitz, Jackson, Allen, et al., 2004; Maltzberger, 1994; Paris, 2004). Also, suicide risk assessment in psychiatry can be difficult, since there are no scientifically validated methods to predict an individual's suicide with an accuracy that makes it clinically relevant; the available assessment instruments can only point to whether the assessed patient belongs to a statistical group with an increased risk of suicide compared to the general population (Ryan, Nielssen, Paton, et al., 2010; SBU (Swedish Agency for Health Technology Assessment and Assessment of Social Services), 2015). In summary, assessed suicidality is a common reason for detaining BPD patients under the Mental Health Act; however, this measure has little support, as (1) it does not comply with the law (unless combined with a severe psychiatric disorder), (2) it has no proven clinical efficiency, and (3) it is not possible to assess the present individual suicide risk in a way that makes it clinically relevant.

In-patient care for patients with BPD is questioned. Several clinical guidelines recommend brief admissions in situations with acute suicidality, but advise against long admissions and admissions due to chronic suicidality (Australian Government, National Health and Medical Research Council, 2012; Nationella självskadeprojektet (The national project of self-harm), 2015). Hospitalization, at least when it is longer than a few days, does not seem to benefit BPD patients, and sometimes even seems to aggravate the problem of regressive and self-destructive behaviour (Australian Government, National Health and Medical Research Council, 2012; James et al., 2012; Linehan, 1993; Nationella självskadeprojektet (The national project of self-harm), 2015; Paris, 2004). As the NICE guidelines point out:

It may be appropriate to consider admission for patients with a diagnosis of borderline personality disorder following a suicide attempt, but the assessing clinician should consider that such a response might inadvertently increase the risk in the longer term by decreasing the patient's capacity to manage their own risk...despite frequent use of inpatient admissions in the management and treatment of people with borderline personality disorder, the effectiveness of admission as an intervention is uncertain.

[(NICE guidelines, 2009)]

Patients with BPD sometimes demand (explicitly or indirectly) to be taken into compulsory care in order not to self-harm—like Ulysses

contracts. Like Ulysses, who was afraid to be lured by the sirens, these patients feel they cannot trust themselves and are prepared to give up their freedom for a limited time in order to protect themselves. There have also been reports of clinicians practising compulsory care and prolonged in-patient care on this group of patients as a way to avoid conflict or criticism (Krawitz & Batcheler, 2006). These two phenomena, i.e. compulsory care as Ulysses contracts and compulsory care as a defensive measure for the caregiver, were further investigated in a survey of active on-call physicians at an emergency psychiatric unit in Stockholm. We found that 94% of the respondents recognized the phenomenon of BPD patients requesting compulsory care; 21% stated that this request had affected their clinical decision, and 55% had used compulsory care for other reasons than the patient's best interest (Lundahl, Helgesson, & Juth, 2017). Examples of “other reasons” were: avoiding conflict with patients or relatives, protecting others from harm, avoiding being reported to authorities, avoiding bad publicity in media, and avoiding complaints from managers or colleagues.

1.1. Aims of the study

The survey mentioned above left unanswered the question of how these physicians reasoned more specifically when deciding to confine BPD patients to compulsory care in different situations. Hence, we performed a series of interviews to investigate the reasoning and motives behind these decisions, but also to investigate how psychiatrists perceive BPD patients as well as their experiences of treating them.

2. Material and methods

2.1. Informants

Informants were recruited continuously during the study, partly through chain referral but mainly based on whether the informants regularly treated BPD patients and made assessments of them under the Mental Health Act. This was done with the aim of covering different views and experiences of psychiatrists who regularly treat patients with BPD symptomatology. The initial participation request was sent by email with information about the study and its purpose and methods. All informants were also informed that participation was voluntary and could be withdrawn at any time without further explanation. This information was repeated in written form before each interview, and all participants provided written consent before participating in the study.

All twelve informants were working at different psychiatric clinics, with different working cultures, in Stockholm County at the time of the interviews. Stockholm County has about 2.3 million inhabitants. All informants were specialists and senior consultant physicians in general psychiatry, since only psychiatrists are allowed to decide on continued (>24 h) compulsory care. Four participants mainly worked with emergency psychiatry, six at psychiatric hospital wards, and two in out-patient care. Most participants also did on-call work. Three informants were women and nine were men, all 35–65 years of age, having different backgrounds, and some also had experience of working in other parts of Sweden. The study was approved by the Regional Ethical Review Board in Stockholm (Dnr 2016/1541-31/5).

2.2. Interviews

The interviews were semi-structured, including ten main questions with the possibility of qualifying follow-up questions (Appendix II). All interviews were conducted in Swedish by the first author, also a psychiatrist, and all participants were interviewed once. The interviews lasted about 30–60 min, and were recorded with a digital voice recorder and transcribed mainly verbatim. Humming sounds and evident slips of the tongue were not transcribed and smaller grammatical errors were corrected in order to facilitate the reading of the interviews; however,

the manifest content of the informants' statements was not changed. One interview was only partially included in the later content analysis process, due to the informant's lingual difficulties. The interviews/informants were randomly coded with the letters A to L, for identification.

It was explained to the informants that all interview questions concerned patients with main symptomatology compatible with BPD, even if the patients also had, for example, neuropsychiatric comorbidity. The questions on compulsory care concerned compulsory in-ward care. The informants were asked questions about how they handled and perceived these patients, focusing on factors relevant to compulsory care, for instance risk assessment and decision competence (see Table 1). The number of interviews was not predetermined, but after twelve interviews we determined that informational saturation had been reached.

2.3. Qualitative analysis

The twelve interviews were analysed using qualitative descriptive content analysis, as described by Sandelowski (2000), to extract subcategories, categories and themes from the content in the interviews. First, the text was read repeatedly to get an overall impression of the content. Next, meaning units and phrases expressing thoughts relating to the overall research questions were identified in the text. Meaning units expressing the same idea were then sorted into subcategories and then categories (Lundahl et al., 2017; Malterud, 2001; Sandelowski, 2000). The analysis was made inductively, with no predetermined categories.

3. Results

The content analysis resulted in several meaning units, organized into 40 subcategories, ten categories and three themes. The themes are: (1) BPD patients 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 BPD patients and the consequences can vary; and (3) BPD patients have decision competence and sometimes demand to be taken into compulsory care. We will present the themes and categories below and in Table 1. For readability, the subcategories are shown in Appendix II.

3.1. Theme "Alfa": BPD patients are perceived as difficult: interpersonally, in clinical and legal management, and due to suicide risk

This first section presents the informants' reasoning regarding how BPD patients are perceived, the main concerns they experienced with

this group of patients, and how they regarded the legal system concerning compulsory care of BPD patients. Supporting theme "Alfa" are Categories A, B and C.

3.1.1. Category A: BPD patients are perceived as difficult, in interpersonal relations and clinical management

Several informants described how BPD patients are perceived to differ from other groups of patients, by behaving in provocative and manipulative ways and not cooperating with the caregiver. It was considered a problem that there was no consensus among psychiatrists concerning how to manage BPD patients, and that these patients often stirred up emotions among healthcare professionals and others around them. Another described difficulty concerned BPD patients' rapidly shifting emotions, causing their behaviour to seem unpredictable to the caregiver. Also, the consequences of different clinical management procedures were considered difficult for the caregiver to predict:

"There are different subtypes of these [BPD] patients. There's a particular group that's more antisocial and hyper-egocentric that [...] think they have the right to expose their environment to just about anything because they think they've been offended or ill received or treated unfairly. And when they unleash that side of themselves, once they've given themselves that 'license', [...] there can be violence, screaming, insults, threats, plain aggression and things like that. But the most common scenario is that they aren't satisfied until you [the physician] feel bad."

[- Psychiatrist (K)]

"I would say this is one of the most difficult groups of patients for a psychiatrist to manage. [...] There's often an externalized, explosive behaviour that one somehow must be able to handle. Either through voluntary care or, on exception, compulsory care. But in many ways this group of patients differs from the others, and they're more difficult to build an alliance with, more difficult to cooperate with."

[- Psychiatrist (F)]

3.1.2. Category B: BPD patients have an increased suicide risk that is difficult to predict

Suicidality was mentioned as a major concern when it comes to BPD patients. The suicidal acts were described as being of various natures, and it was noted that the patient's primary intention might not always be to die. Instead, BPD patients sometimes use suicidal acts as means of communication, sometimes as a way of regulating emotions or attaining

Table 1

Content analysis of interviews A–L, displaying themes and categories.

The following is a content analysis displaying themes and categories, based on meaning units and subcategories extracted from the twelve interviews. The themes concern how psychiatrists perceive BPD patients, motives for practising compulsory care, views on BPD patients' decision competence, and the phenomenon of compulsory care at the patient's demand. All questions concerned patients with main symptomatology compatible with borderline personality syndrome.

Theme	Category
<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. B. BPD patients have an increased suicide risk that is difficult to predict. C. The Swedish Mental Health Act is a legal grey area when it comes to BPD patients.
<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. E. There are non-medical motives for practising compulsory care of BPD patients: practical and social aspects, and to avoid external criticism. F. Risk assessment, considering the risk of danger to oneself or others, occurs in various extent as a motive for compulsory care of BPD patients. G. Compulsory care of BPD patients with decision competence is justified to various extents, with motives such as non-authentic wishes or suicidality.
<i>Gamma.</i> BPD patients have decision competence and sometimes demand to be taken into compulsory care.	H. Compulsory care of BPD patients can implicate various results: positive when short-term, negative when long-term I. BPD patients have decision competence, which is sometimes perceived as rapidly shifting. J. BPD patients sometimes demand to be taken into compulsory care, which clinicians find challenging from a clinical and legal point of view.

some other objective. Suicide risk was considered to be chronically increased, and suicides were perceived to happen despite optimal clinical management. However, it was experienced that the responsibility for suicidal acts was placed on the caregiver. Working with patients considered to have an increased risk of suicide was described as arousing anxiety in their environment: relatives, partners, healthcare managers, social services and other authorities:

“Yes, [...] you're dealing with a person with a risk of self-destructiveness and consequently suicide risk, either intentional or accidental, which is heavily increased. [...] However, I find it troubling that so many of our surrounding layers of organization seem to act as if there were a possibility in every situation to either make a compulsory detention or reduce the suicide risk to zero. And I often have neither option.”

[- Psychiatrist (B)]

“[...] when there's a serious event, like self-harm, I and many others experience a lack of support when you actually comply with the law and the person self-harms anyway. And the consequence is that the responsibility isn't placed on the patient, but usually on the treating physician.”

[- Psychiatrist (F)]

3.1.3. Category C: the Swedish Mental Health Act is a legal grey area when it comes to BPD patients

The Mental Health Act, stating the conditions for compulsory care, was described as not being adapted to BPD patients but rather meant to be applied to patients suffering from states like psychotic episodes, severe depression, or mania. But in order to manage violent or self-destructive behaviour in BPD patients, psychiatrists described having to expand the interpretation of the Mental Health Act rather than strictly following its content. Most informants did not consider suicidality to be equivalent to “a serious psychiatric disorder” (which is a definition used in the Mental Health Act, and an absolute condition for practising compulsory care), but in practice it was sometimes treated as if it were – thus justifying care under the Mental Health Act:

“[...] I believe the Mental Health Act is designed better to be applied to people with psychotic disease, who evidently lack decision competence for a period of time, and then they receive a medication that totally changes the situation and then they're decision-competent. It's not designed to be applied to people who feel totally fine, but then five seconds later have a strong anxiety reaction and become super suicidal and harm themselves seriously. [...] The inertia and criteria of the Mental Health Act are not quite adapted to that scenario.”

[- Psychiatrist (I)]

“I believe most psychiatrists know the content of the law [the Mental Health Act], which sometimes makes it difficult to practically handle given situations. That, I believe, in certain cases causes a sliding [in the interpretation of the law] into some sort of grey area; that you might apply the Mental Health Act even though it's dubious or wrong from a strictly legal point of view.”

[- Psychiatrist (F)]

3.2. Theme “Beta”: there are medical and non-medical motives for compulsory care of BPD patients, and the consequences can vary

This second section presents the informants' reasoning regarding motives for detaining and caring for BPD patients under the Mental Health Act, and what consequences they have experienced of this type of care (Table 1). Supporting theme “Beta” are Categories D, E, F, G and H.

3.2.1. Category D: there are medical motives for compulsory care of BPD patients, which comply with the Swedish Mental Health Act

A patient's suffering from a “serious psychiatric disorder” is described as a motive for practising compulsory care, and this of course complies with the content of the Mental Health Act:

“[...] it's not the basic state that justifies compulsory care, but something additional. [...] But even BPD patients can suffer from depressions [...]”

[- Psychiatrist (K)]

3.2.2. Category E: there are non-medical motives for practising compulsory care of BPD patients: practical and social aspects, and to avoid external criticism

Besides the strictly medical incentives for compulsory care, informants described several non-medical ones as well. Issuing a compulsory care certificate is said to hasten the process in emergency situations. Sometimes BPD patients are compulsorily detained in order to avoid criticism from society (relatives, media, police, etc.), or because there is a lack of alternative housing or outpatient care. Informants had also experienced pressure from relatives, related caregivers and authorities, to treat BPD patients under the Mental Health Act to a greater extent than the physician in charge considered medically indicated:

“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.”

[- Psychiatrist (B)]

“I don't find it imperative to be restrictive of compulsory care, so as 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 sake of the police, the relatives' sake, our sake, and so on.”

[- Psychiatrist (K)]

3.2.3. Category 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

Several informants described suicide risk as the most common motive for compulsory care. Also, some informants believed the risk of violence justified compulsory care, for community-protective and practical reasons. Still other informants conveyed the opposite view on risk assessment as grounds for compulsory care. Some informants believed hospital care and/or compulsory care could decrease suicide risk, while others believed the opposite:

“Unless I fear that the patient with this type of problem will seriously self-harm... commit suicide, then I believe there are hardly any other grounds for issuing a compulsory care certificate.”

[- Psychiatrist (A)]

“[...] in conclusion, it's foremost the [...] risk of violence that can motivate compulsory care of a patient with an impulsive personality problem. [...] When people with this type of personality problem have displayed a great deal of externalized behaviour, and authorities like the police have been summoned several times, then in the end one

chooses an almost practical solution, i.e. compulsory care, to somehow protect society. [...]"

[– Psychiatrist (I)]

"[...] it [compulsory care] escalates a destructive behaviour or general discontentment at not being allowed to decide for oneself and all sorts of bad behaviours [...] and then also an increase in malaise and an escalation of self-destructiveness [...]"

[– Psychiatrist (L)]

3.2.4. Category G: compulsory care of BPD patients with decision competence is justified to various extents, with motives such as non-authentic wishes or suicidality

Some informants found that decision competence was not an impediment to practising compulsory care of BPD patients. For example, if the psychiatrist interpreted that a decision-competent BPD patient was expressing non-authentic wishes or suicidal thoughts, compulsory care was considered justified. However, views on these matters varied considerably among the interviewed psychiatrists, and opposite opinions were expressed.

Below are examples of two informants answering whether authentic wishes of a BPD patient could justify compulsory care:

"You mean when she's collected and focused but still intends to kill herself? Then I'd be inclined to issue a compulsory care certificate because [...] there's never just 'a moment'. One problem for these patients is that they only see moments – while I see a long chain of events, a medical history/pattern."

[– Psychiatrist (B)]

"Yes, I think so. If it stands very clear that [...] this [wish] is far from the patient's true self."

[– Psychiatrist (G)]

The following is an example of an informant answering the question of whether it is defensible to establish compulsory care of a decision-competent BPD patient:

"Yes. [...] because I don't really agree that one has to be decision-incompetent in order to be subjected to compulsory care. [...] It could, for example, be a patient [...] in [...] crisis or something like that, causing a lack of impulse control [...] which makes the person do things that cause harm to herself or others."

[– Psychiatrist (I)]

3.2.5. Category H: compulsory care of BPD patients can implicate various results: positive when short-term, negative when long-term

Most informants described various results of treating BPD patients through compulsory care. Many had experienced that a short period, for instance a few days, of compulsory care could benefit BPD patients and give them time to calm down from a highly emotional state. Longer hospital stays according to compulsory care, however, were described in negative terms – as increasing self-destructive or externalized/violent behaviour, as an increase in compulsory measures, and as a decrease in the patient's self-governing abilities. This is one informant's description of how BPD patients can develop destructive behaviours during long admissions under compulsory care:

"Well, it's clear that new behaviours develop the longer the hospital stay gets, that the original cause of admittance to hospital gradually fades away and is replaced by secondary, hospitalization-induced, behavioural disturbances. Like [the patient] not interacting with the healthcare staff and starting to experiment with periods of leave, medication, surveillance, and so on, and that has the tendency to gradually

turn worse with time – these types of non-primal disturbances, so to say. The original indication for compulsory care could have been totally different to what it turns out to be when the patient's made some hanging attempts and attacked healthcare staff and collected pills and keeps on. Then, in the end, it becomes like a self-playing piano [...]"

[– Psychiatrist (K)]

3.3. Theme "Gamma": BPD patients have decision competence and sometimes demand to be taken into compulsory care

This third section presents the informants' reasoning regarding BPD patients' decision competence. Additionally, the phenomenon of compulsory care as "Ulysses contracts", i.e. compulsory care issued at the patient's demand, is described. Supporting theme "Gamma" are Categories I and J.

3.3.1. Category I: BPD patients have decision competence, which is sometimes perceived as rapidly shifting

Nearly all informants found that BPD patients could be decision-competent. However, some informants described this decision competence as rapidly shifting, correlating to the patients' impulsivity and strong emotions:

"[...] Of course they're decision-competent, nearly always."

[– Psychiatrist (B)]

"And I must admit my lack of knowledge when it comes to this terminology and how it should be interpreted. But I imagine there could be a continuous shifting in decision competence, and that it could be context-bound [...] So, in a moment there could be decision competence and then three seconds later, in another situation, there could be no decision competence."

[– Psychiatrist (J)]

3.3.2. Category J: BPD patients sometimes demand to be taken into compulsory care, which clinicians find challenging from a clinical and legal point of view

Compulsory care in the form of Ulysses contracts is a phenomenon further investigated in this section. All informants had experienced that BPD patients sometimes demanded to be taken into compulsory care, and some psychiatrists had also granted this request. However, opinions about such "on-demand" compulsory care differed among the informants. Some thought it justifiable and beneficial, while others expressed the opposite. The arguments in favour of this type of care were that it could be legally justifiable since there was an expected development toward decision incompetence in the near future, or that it could benefit patients' participation and safety, but also ease the work of the caregivers. The arguments against it were that it was perceived as legally dubious and contradictory, and that this type of care could enhance negative behaviour patterns and diminish patients' autonomic abilities and coping strategies:

"I would say that if the patient her-/himself requests compulsory care, then the criteria of the Mental Health Act are hardly met."

[– Psychiatrist (F)]

"I believe that the patients may find compulsory care to be a safer form of care. It might also be because they don't want to be discharged."

[– Psychiatrist (H)]

"It [compulsory care of the BPD patient] could feel better for the healthcare staff at the ward, not constantly having to be prepared for

the patient to [...] threaten with discharge in the middle of the night, or something like that."

[- Psychiatrist (K)]

"This [compulsory care at the patient's demand] is not constructive in any way; it only enhances bad behaviour [...] I would say it never, never works."

[- Psychiatrist (D)]

3.4. The informants

The expressed views and attitudes were spread among the informants and were not confined to a certain gender or age group. All sub-categories but one were supported by several informants. Twenty-eight individuals were invited to participate in the study, but only twelve ultimately participated; reasons for not participating included lack of time, illness, and not fulfilling the inclusion criteria (being a psychiatrist and treating BPD patients on a regular basis). However, the different views expressed were supported by several informants, and as no new information emerged from the interviews we believed that informational saturation was achieved.

4. Discussion

4.1. Main findings

The results of this qualitative study show that psychiatrists regard BPD patients as a challenging group in many respects – on this, all informants agreed. Most informants also agreed on some important points: that assessed suicide risk is the most common motive for taking BPD patients into compulsory care, that suicidality is not equivalent to “a serious psychiatric disorder”, that BPD patients are usually decision-competent, that BPD patients sometimes request compulsory care, and that there are negative effects associated with long-term in-patient compulsory care. Many also recognized pressure from external agents – like relatives, the police or social workers – to compulsorily detain BPD patients to a greater extent than the psychiatrist in charge thought medically indicated. What became clear during the interview process was the large disparity of opinions among the psychiatrists in other vital issues, of which two of the most noteworthy were motives for compulsory care and whether BPD patients could control their own actions. These differences in opinion can be grouped together, as explained below.

4.2. Groups of informants supporting certain views and values

As a simplification, the interviewed psychiatrists can be roughly divided into three groups.

The first group of psychiatrists took a paternalistic approach to the BPD patients, which permeated all questions discussed. This group expressed that BPD patients could not truly be responsible for their actions, even if they were decision-competent, since their will was often subdued by strong emotions. Accordingly, it was the responsibility of the caregiver to take charge of the patient and protect him/her from self-destructiveness. The group indirectly expressed low confidence in BPD patients' autonomous abilities and high trust in their own capacity to know what is best for the patients. Overriding individual autonomy, even of decision-competent patients, did not seem to be a moral dilemma for this group, as long as they believed they were protecting the patient's best interest. This paternalistic group generally defended practising compulsory care of BPD patients for the longer term and with wider indications than what is supported by legal directives (Regeringens proposition 1990/91:58 om psykiatrisk tvångsvård, m. m) and clinical guidelines (Australian Government, National Health

and Medical Research Council, 2012; Nationella självskadeprojektet (The national project of self-harm), 2015; NICE guidelines, 2009), emphasizing the importance of a caring attitude and risk reduction.

Then, there was a second group of psychiatrists who expressed that BPD patients were capable of governing their behaviour in accordance with autonomous decisions, but still recurrently applied compulsory care in order to contain the BPD patients' externalized or destructive behaviour, emphasizing the importance of maintaining order and safety in society. This group also seemed more prone than the other two groups to submit to pressure from external agents, like the police or social services, when these agents demanded compulsory care of BPD patients – even if the assessing psychiatrist did not believe it was in the patient's best interest. Safety of others thus outweighed the patient's autonomy and best interest.

A third group of psychiatrists described BPD patients as capable of controlling their behaviour through autonomous will (even in situations with emotional arousal) and thus able to take responsibility for their actions, including self-destructivity. They did not assess the BPD patients as suffering from a severe psychiatric disorder, thus not fulfilling the legal criteria for compulsory care. This group emphasized the moral values of self-governance and individual accountability, practised less compulsory care, and complied more with clinical and legal directives, than the other two groups. However, they also expressed that their way of practice was often met with external criticism from colleagues and other members of society, accusing them of not caring and of risking their patients' lives (suggesting that society has other expectations and demands regarding how these psychiatrists should work).

As demonstrated by the results, the content of the Mental Health Act and the clinical symptoms of the BPD patients sometimes seem to have limited effects on clinicians' decisions. The law on compulsory care was considered to be written in such a vague manner that it could be twisted and stretched according to the psychiatrists' objectives. Also, psychiatric diagnostics were interpreted diversely by the informants. Those who thought it right to take BPD patients into compulsory care, usually for suicide-protective reasons, regarded the patients to be suffering from a more severe and disabling psychiatric condition/comorbidity, and to be in less control of their behaviour, than did the psychiatrists who did not – hence justifying the use of compulsory care. Also, some psychiatrists with a more paternalistic approach argued that authenticity, i.e. what the psychiatrist interpreted to be the patient's true inner will (which could be opposed to the patient's presently expressed wish), could motivate compulsory care – even when the patient was considered decision-competent and as not suffering from a “severe psychiatric disorder”. In general, this paternalistic group of psychiatrists did not see decision competence as an impediment to taking BPD patients into compulsory care (which is not opposed to the Swedish legal prerequisites for compulsory care (Regeringens proposition 1990/91:58 om psykiatrisk tvångsvård, m. m), however not consistent with ethical recommendations (Beauchamp & Childress, 2013)).

Our results show that compulsory care is often applied as means of reducing an assessed risk, concerning the risk of suicide or (to a smaller extent) violence. This practice is primarily defended by the first and second groups of psychiatrists described above. Thus, compulsory care is used as a tool of harm reduction, even though there are no validated instruments for determining the present individual suicide risk on a clinically relevant level (Ryan, Nielsens, Paton, et al., 2010; SBU (Swedish Agency for Health Technology Assessment and Assessment of Social Services), 2015) and compulsory care has no proven suicide-protective effect in BPD patients (Australian Government, National Health and Medical Research Council, 2012; Huber et al., 2016; James et al., 2012; Linehan, 1993; Nationella självskadeprojektet (The national project of self-harm), 2015; NICE guidelines, 2009; Paris, 2004). One explanation could be that there is a strong societal and political drive in Sweden that psychiatry should prevent all self-destructiveness and suicidality (Regeringens proposition 2007/08:110. (Swedish government bill

2007/08:110)). However questioned, Swedish psychiatrists are required to make continuous suicide risk assessments of every patient with risk factors of future suicide (The National Board of Health and Welfare, 2017). Not compulsorily detaining a suicidal (or violent) patient could result in criticism and bad publicity, often blaming psychiatry for “not taking their responsibility” and “not caring”. An assessed suicide risk could also induce fear, pressuring the caregiver to “take action” by depriving the patient of a potentially dangerous liberty, even if this action has little or no clinical or legal support. Thus, the socio-political demand for risk reduction and social safety may stand in opposition to individual liberty and clinical practice in the patient’s best interest, favouring more practice of compulsory care of BPD patients.

The phenomenon of compulsory care at the demand of BPD patients themselves, like Ulysses contracts, was usually defended by psychiatrists with a more paternalistic view. Even on this matter, the content of the law and the clinical implications were interpreted differently depending on whether or not the interviewed psychiatrist was in favour of the idea. However, the existence of this phenomenon was recognized by all informants, and is an occurring form of compulsory treatment of BPD patients that is not mentioned in clinical guidelines and has not been studied until recently (Lundahl et al., 2017). According to the Swedish mental health legislation (Regeringens proposition 1990/91:58 om psykiatrisk tvångsvård, m. m.), a patient must reject compulsory care or lack the ability to express a considered opinion the subject, in order to be subjected to compulsory care - criteria which are not fulfilled when the patient is deemed decision-competent on the subject and requests compulsory care. Thus, using compulsory care in the form of Ulysses contracts could be viewed as unlawful. Still, the phenomenon of such contracts seems to have evolved without being questioned by either the legal authorities or psychiatry. Also, clinical guidelines (Nationella självskadeprojektet (The national project of self-harm), 2015; NICE guidelines, 2009) emphasize autonomy and restrictiveness in taking BPD patients into compulsory care. Based on this knowledge, Ulysses contracts could have potentially negative consequences from a clinical point of view, which stresses the importance of evaluating the use of such contracts in clinical practice.

Drawing on the work of psychiatrist philosopher Bill Fulford (2008), it is known that personal values impinge on how people apply the Mental Health Act in practice, how they diagnose patients and what interventions they prioritize. Similarly, the question of whether a person with emotional arousal should be assessed as suffering from an “uncontrollable” state or not, could be argued to be a question of value-influenced interpretation. This is consistent with the results of our study, showing how psychiatrists’ own views and values were decisive factors in their practice of compulsory care. All of them defended their own way of practice as being the best from a humanitarian, practical, social, behaviour-psychological, or legal point of view. For BPD patients, this could result in vast differences in the mental healthcare that is offered or imposed, depending on which psychiatrist they encounter. Thus, BPD patients with equal symptomatology are treated unequally; this sits ill with the Swedish political aim of offering all citizens equal healthcare (Hälso- och sjukvårdslag (2017:30): 3 kap, 1 §; Regeringens Proposition 1996/97:60. (Swedish government bill 1996/97:60)) and the principle of justice (equal treatment), as described by Beauchamp and Childress (2013).

4.3. Limitations

More male than female psychiatrists were interviewed, mainly because there were more men than women working in emergency and in-patient psychiatry in Stockholm at the time of the study. We did not register how many years each psychiatrist had been working clinically, which is a weakness. However, we did not notice that certain views or attitudes were confined to specific age spans or genders. The content of the interviews was limited by the questions posed (Appendix II), and theoretically more information could have emerged

from the interviews if they had not been as structured. The interviews were conducted by a clinically active psychiatrist, with whom some of the informants were acquainted, which may have facilitated the recruitment process but also affected the informants in different ways, e.g. encouraging them to be more candid, or more restrictive, in the information they provided.

Although in principle one cannot generalize from qualitative studies, we have reasons to believe that our results are applicable to the rest of Sweden. Several informants had experience of working in other parts of Sweden. They described different traditions of practice at different clinics. This is consistent with Swedish statistical data showing regional differences in the use of compulsory care and treatment, especially concerning young female patients (Holm et al., 2011; Socialstyrelsens statistikdatabas (Statistics database of The National Board of Health and Welfare), 2016) (many of whom display a self-destructive behaviour related to personality disorder (Holm et al., 2011)).

5. Conclusion

Our study points at several problems with today’s psychiatry. The study’s results indicate that the practice of compulsory care of BPD patients differs significantly, depending on the assessing psychiatrist’s personal judgements and values rather than on clinical guidelines or legal directives. Also, legal/clinical directives and social/political expectations seem to stand in contradiction to one another: the strive for maximum security and control over patients’ destructive actions (in accordance with social or political expectations) stands in opposition to the patient’s right to individual freedom and autonomy (as supported by legal as well as clinical directives). Taken together, the possibility for personal interpretations of the Mental Health Act and diagnostic criteria, combined with the socio-political expectations described above, favours more practice of compulsory care of BPD patients than what clinical guidelines recommend. These results call for further analysis from ethical, legal, and clinical aspects.

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Declaration of interest

The author(s) declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Appendix I

Translation of parts of the Swedish mental health legislation (our translation)

Law (1991:1128) of psychiatric compulsory care

Swedish Code of statutes 1991:1128

Valid thru SFS 2017:373

Issued: 1991-06-20

https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-19911128-om-psykiatrisk-tvangsvard_sfs-1991-1128

2 § Compulsory care under this law is given as in-patient psychiatric compulsory care or, after psychiatric treatment, out-patient compulsory care. Care given when the patient is admitted to a healthcare facility is referred to as in-patient psychiatric compulsory care. Other healthcare under this Act is referred to as out-patient psychiatric compulsory care.

The compulsory care shall aim to put the patient in a condition, as to voluntarily participate in the necessary care and receive the support he or she needs. *Law (2008:415)*.

2 a § Coercive measures when caring under this Act may be used only if they are proportionate to the objective of the measure. If less intrusive measures are sufficient, those shall be used.

Coercion shall be exercised as gently as possible and with the greatest possible consideration to the patient. *Law (2000:353)*.

2 b § Coercive measures in order to implement the care may be used only if the patient cannot, by being given individually customized information, be prompted to voluntarily participate in the care. Those may not be used to a greater extent than is necessary in order to prompt the patient to this. *Law (2000:353)*.

Prerequisites for compulsory care

3 § Compulsory care may be given only if the patient suffers from a severe psychiatric disorder and, due to his/her psychiatric condition and also personal circumstances,

1. is in imperative need of psychiatric care, which cannot be met by means other than admitting the patient to a medical facility for round-the-clock qualified psychiatric care (in-patient psychiatric compulsory care), or
2. needs to comply to certain conditions in order to be given necessary psychiatric care (out-patient psychiatric compulsory care).

A prerequisite for care under this Act is that the patient opposes such care as is stated in the first paragraph, or, as a result of the patient's psychiatric condition, there is considered reason to assume that the healthcare cannot be provided with his or her consent.

Involuntary treatment may not be given if the patient's psychiatric disorder, within the meaning of the first subparagraph, is merely a mental retardation.

In the assessment of need for care as referred to in the first subparagraph shall also be taken into account, if the patient due to his psychiatric disorder is dangerous to another's personal safety or physical or psychiatric health. *Law (2008:415)*.

Definition of "severe psychiatric disorder" in the Government's legislative proposition regarding the Swedish Mental Health Act, <http://data.riksdagen.se/dokument/GE0358>, page 86:

"Severe psychiatric disorder", should primarily signify conditions of psychotic character, such as conditions with a disturbed perception of reality with symptoms like delusions, hallucinations and confusion. Following brain injury, a severe mental impairment (dementia) with disturbed perception of reality and decreased global orientation, can manifest itself. Severe depression with suicidal ideation should also count as a severe psychiatric disorder. Furthermore, severe character disorders, for example some disabling neuroses and personality disorders with impulsive breakthroughs of psychotic character. Compulsory care could also be applied when a stress reaction affects the mental ability to such extent as to be of psychotic character. Alcohol-related psychoses, like delirium tremens, alcohol-related hallucinoses and obvious dementia-like states, should also be categorized as severe psychiatric disorders. The same goes for psychotic states that can affect drug abusers. [...] [I]t is imperative to stress that a mental disability caused by ageing, expressed as a behavioural disorder related to senile dementia, could be as severe as to be referred to as a severe psychiatric disorder. When it comes to mentally retarded patients, solely the mental impairment is not grounds for compulsory care.

Quotes from the Government's legislative proposition regarding the Swedish Mental Health Act, <http://data.riksdagen.se/dokument/GE0358>, page 239–240:

"It is deserves to be stressed that a person may not be subjected to compulsory care merely for social reasons. For practising compulsory care, the patient must be suffering from a severe psychiatric disorder."

"In principle, the patient's own need for care shall be decisive when making an assessment under the Mental Health Act."

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?

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