ABSTRACT

Background: Informal coercion, i.e. situations where caregivers use subtle coercive measures to impose their will on patients, is common in adult psychiatric inpatient care. It has been described as "a necessary evil", confronting nurses with an ethical dilemma where they need to balance between a wish to do good, and the risk of violating patients' dignity and autonomy. **Aim**: To describe nurses' experiences of being involved in informal coercion in adult psychiatric inpatient care. **Research design:** The study has a qualitative, inductive design. **Participants and research context:** Semi-structured interviews with ten Swedish psychiatric nurses were analysed with qualitative content analysis. **Ethical considerations:** The study was performed in accordance with the Declaration of Helsinki. **Findings:** Four domains comprise informal coercion as a process over time. These domains contain eleven categories focusing on different experiences involved in the process: *Striving to connect, involving others, adjusting to the caring culture, dealing with laws, justifying coercion, waiting for the patient, persuading the patient, negotiating with the patient, using professional power, scrutinizing one's actions and learning together.* **Discussion:** Informal coercion is associated with moral stress as nurses might find themselves torn between a wish to do good for the patient, general practices and "house rules" in the caring culture. In addition, nurses need to be aware of the asymmetry of the caring relationship, in order to avoid compliance becoming a consequence of patients subordinating to nurse power, rather than a result of mutual understanding. Reflections are thus necessary through the process to promote mutual learning and to avoid violations of patients' dignity and autonomy. **Conclusions:** If there is a need for coercion, i.e. if the coercion is found to be an "unpleasant good", rather than "necessary evil" considering the consequences for the *patient*, it should be subject to reflecting and learning together with the patient.

Keywords: Autonomy, dignity, informal coercion, nurses' perspective, power, psychiatric inpatient care

Introduction

Following Szmukler and Appelbaum[1] coercion ranges from softer to harder types. The latter are regulated by laws. Even though laws differ between countries, a common premise is that coercion is justified when a person suffering from mental health problems is considered to be unable to make adequate decisions and is perceived as dangerous for self and/or others. When subject to formal coercive care, patients might be forced to take medication against their will, or subject to seclusion or physically restrain.[2, 3] During such circumstances, coercion is explicit, and clearly documented in patients' records. However, as reported by Lützen[4] more than two decades ago, there is also a subtle coercion that is less obvious. Since then, other researchers have described that patients who are voluntarily cared for experience the care as coercive.[5, 6] Examples of such subtle coercion are different actions where caregivers use their power to put pressure on patients to behave in a certain way and comply with treatment plans. This kind of coercion, which has also been described as "softer coercion", [7] is more implicit. As it is not subject to formal decisions and documentation it could also be described in terms of informal coercion[8, 9] which is the term we will use.

In line with O'Brien and Golding's[10] definition we understand coercion as "any use of authority to override the choice of another" (p. 168). This means that subtle and informal practices in nurse-patient interactions might also be considered as coercive. Hence, as is the case with formal coercion, this is also an ethical challenge, associated with the asymmetry of the nurse-patient relationship and basic nursing values.[11, 12]

Background and aim

Nurses usually consider coercive measures as necessary and only to be used as a last resort when other alternatives have failed.[13-15] Like formal coercion, informal coercion is likely to affect nurse-patient interactions negatively, undermining patients' autonomy and dignity as well as their trust in caregivers.[4, 7, 16] However, when the caring-relationship is trustful and the nurses know the patient, it is possible to make use of coercion in a more gentle way, thus reducing patients' experiences of inferiority.[17] One example can be to let the patient choose which nurse should

administer a medication that the patient does not want to have. If patients perceive that professionals are acting in their best interest and coercion is administered in a transparent, fair and respectful way the negative impact on the relationship can be reduced.[18] Nurses also describe that during such circumstances coercion can strengthen the alliance with the patients when they become aware that the nurses took responsibility and acted in the best interest of the patients when the patients themselves were not able to.[13, 19]

When coercion is used, formally as well as informally, nurses report experiences of guilt and uneasiness[20], and strive to justify their actions.[4, 12, 19, 21] This is understood as an ethical awareness. However, there are also situations where nurses are less reflective in relation to ethical issues and appear to put pragmatic reasoning before ethical reflection.[2] For example it has been suggested that informal coercion should be considered a treatment preventing the patient from developing more severe symptoms, rather than as coercion.[8, 9] In the worst case scenario, informal coercion is also used as a punishment rather than for the best of the patient.[16]

Even though harder types of coercion are often traumatic for both patients and caregivers, the fact that these are preceded by a thorough assessment, regulated by laws and documented in patients' records, also makes them visible. Thus, hard coercion is also easier to conceptualize and reflect on, while soft, subtle coercion is often informal, and not always documented explicitly. Yet, informal coercion exists, and mental health professionals tend to underestimate their use of it.[8] One reason might be that they fail to distinguish between their view of what justifies coercive practice and what counts as such practices,[10] and that practitioners' opinions about coercion overrule legislation.[22] This is indeed troublesome and in contrast to nursing ethics and profound values regarding respect for patients' autonomy and dignity. This study aims at describing nurses' experiences of being involved in informal coercion in adult psychiatric inpatient care.

Method

Participants and settings

Written information about the study was distributed to all nurses at a psychiatric clinic in central Sweden. The only inclusion criterion was having at least six months

experience as a nurse. Nurses who considered participation were given the same information verbally from the researchers and could ask further questions if needed. Ten participants representing three different wards with focus on general psychiatric care, acute psychosis, intensive and addiction care volunteered. Eight participants were women, which is representative compared to the distribution between male and female nurses at the clinic. All wards had locked doors, as patients might be either involuntarily or voluntarily admitted to the hospital. Participants were between 25-65 years old and their experiences from psychiatric care varied between six months and 30 years. Six participants had an MSc in mental health and psychiatric nursing, while four where registered nurses.

Data collection and analysis

Data were collected by semi-structured interviews in January 2019. The interviews were conducted by either author one or author two in a room at the hospital. As we wanted to avoid imposing our understanding of informal coercion on participants, they were asked to describe in what kind of situations they had experienced that informal coercion was used and why. To understand the ethical challenges associated with informal coercion they were also encouraged to narrate about a situation where they had been doubtful about their decisions. They also described how they approached the patient, as well as their own reflections regarding ethics. Additional questions, such as "can you give me an example or "what was that like for you" were posed in order to support participants in elaborating their descriptions.[23] The interviews lasted between 38 and 65 minutes and were transcribed verbatim. Following Graneheim and Lundman's[24] description of manifest content analysis, the transcribed interviews were read in order to get a first grasp of the data as a whole and identify domains. These are rough structures, describing explicit areas of content. In the following steps, meaning-units, i.e. i.e. words, sentences and paragraphs that comprised information related to the aim of the study, were identified and then condensed. The latter is a matter of describing the content of the meaning-unit in fewer words, thus making data more manageable before labelling each meaning-unit with codes. The codes were compared, and similar codes abstracted into sub-categories and categories within the domains. The process from condensation to categorization is illustrated in Table 1.

Table 1: Example of the analytic process

Meaning unit	Condensed meaning unit	Code	Sub-category	Category
When the patient is in a bad mental health state I think it is reasonable to get him medicated in order to recover faster, and hopefully be discharged earlier, without formal coercion	Patients will recover faster, and formal coercion can be avoided	Best for the patient	For the good of the patient	Striving to justify informal coercion
Some colleagues has expectations on me, that I shall do it…that I will succeed in (what we have decided), mainly getting the medication into the patient	Colleagues expects that one shall follow what has been decided	Expectations from others	Adjusting to peoples' expectations	
You have to do it to avoid formal coercion, like forced injections or physical restrain	To avoid other forms of coercion	Avoiding formal coercion	Avoiding formal coercion	

Methodological considerations

In qualitative content analysis, concepts used to describe different aspects of trustworthiness are intertwined and interrelated.[24] Participants' wide range of experiences are related to credibility as well as transferability. Even though the number of participants is limited, and their practices might be influenced by the local culture, it is rather the experiences of being involved in such practices that are in focus, not the kind of practices. Thus, there might be differences between this hospital and other units in the way informal coercion is practiced, but also similarities in experiences related to how it is to be involved in those practices. Hence, transferability is a matter of whether the findings shed light on experiences that other nurses could identify with. Dependability is related to data as co-created, i.e. that data is not only a matter of participants' experiences but of the interaction between

interviewer and participants, and to the stability of data. The latter is related to the consistency during data collection. We consider data as fairly stable as similar codes were found in the interviews, regardless of who had performed the interview. In other words, the interviewers' positions, which differed based on their occupational and cultural backgrounds, were probably not imposed on participants and their narration during the interviews. In addition, credibility is also related to the interpretive procedures, and the researcher's ability to reduce the impact their own pre-understandings might have on the analysis. Therefore, a preliminary analysis was made by the person who had made the interview. Each step was then jointly reflected on in order to refine the analysis.

Ethical considerations

The study was conducted in line with the declaration of Helsinki[25] and the university policies. Hence, participants were given written as well as verbal information about the purpose of the study, the procedures around the interview and their right to withdraw at any time as well as about confidentiality. Confidentiality was protected as the interviewers transcribed their own interviews. Hence, nobody else knew who had participated and who had said what. Confidentiality was also protected as characteristics of the participants are described on a group level. Participants were also informed about how the researchers planned to disseminate the results. In line with Swedish legislation the study was also subject to discussions at an ethical seminar at the university and approved by the management of the psychiatric clinic.

Findings

In qualitative content analysis the domains may be used as analytic tools. Hence, they are not always accounted for in the presentation of findings. However, in this study the domains are related to informal coercion as a process rather than as an event. Hence, we have used the domains as a means to structure the presentation of findings, which are summarized in Figure 1. Three domains contain categories and subcategories describing experiences of how the coercion is initiated, the coercive event, and the aftermath. There is also one domain, pervading factors, containing categories and subcategories describing aspects of informal coercion that influence the process, from beginning to end. Domains and categories are presented as

subheadings, while sub-categories are marked with *italics* in the text. (P1-10) are used after quotes to distinguish between participants.

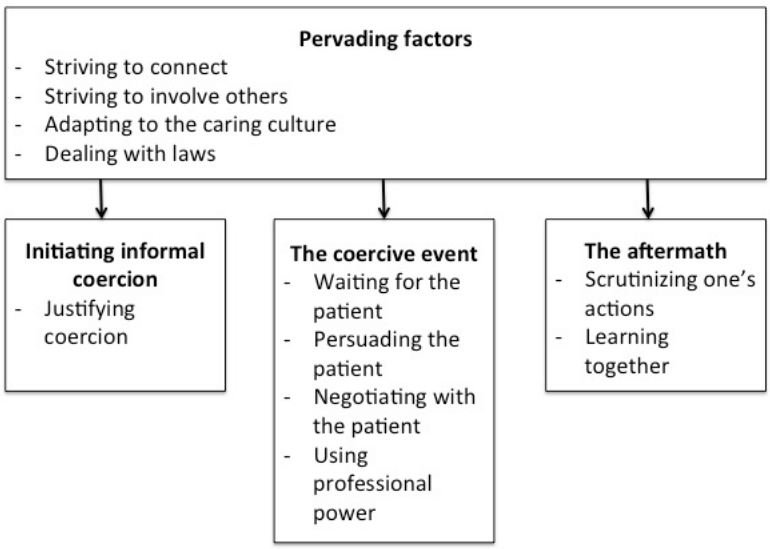

Figure 1: Summary of findings

Pervading factors

This domain consisted of four categories. These are understood as a sounding board throughout the process.

Striving to connect Communication is pivotal in nurse-patient interaction to obtain a mutual understanding. Patients' psychiatric symptoms such as cognitive impairment and lack of initiative are experienced as obstacles for communication, thus making it hard to establish a mutual connection and to understand patients' intentions. This can contribute to informal coercion as it "is always easier to decide over a person who is passive than one who is able to articulate his will" (P10). Gender aspects, especially in combination with cultural customs regarding gender interaction and different native language might complicate this even further. In contrast, similarities facilitate communication and reduce differences in perceived power.

> If it is a younger patient and a younger nurse…they might feel more equal (P6).

This calls for nurses' ability to be responsive to non-verbal communication as well, and to reflect on previous encounters with the person to avoid violating the patient's dignity. Striving to connect to the patient is a way of ensuring good nursing care and minimizing coercive interventions. When this fails informal coercion is more likely to occur.

Striving to involve others. When making decisions regarding informal coercion, nurses can perceive themselves as standing alone. The complexity of the situation calls for multiple perspectives, not only from other nurses but also from other professionals. By involving other people, the situations become more manageable, and the nurse does not stand alone left to take full responsibility.

> I always take help because I am so new at work and new as a nurse ... I always ask some colleague before going to a patient, even if I am the one who shall have the first contact (5).

Nurses with more experience are less dependent on their colleagues, especially if they have previous knowledge about the patient. When the knowledge about the patient is sparse, they tend to rely on the group's knowledge and prefer to transfer responsibilities for decisions and actions to colleagues who know the patient.

Adapting to the caring culture. The third category comprises three sub-categories related to different dimensions of the caring culture. *Being restricted by the physical environment* is perceived as a contributing factor to informal coercion, as the milieu is perceived as obstructing and as a source to coercion.

> They have a restricted autonomy just by being here. They are locked in. We close the door behind them (2).

Nurses need to consider not only limitations in the physical environment, such as locked doors, but also need *to balance professional power* as patients are dependent and need to rely on them. This is not only in relation to their mental health problems but also so they are able to get out for a walk, smoke or other activities that are part of the person's ordinary life outside the hospital. This is a double-edged sword as nurses might use this power to influence patients and get them to do things they might be

reluctant to do, such as taking their medicine. There are also power issues in relation to other professionals that need to be balanced to provide good care. When this fails and nurses experience themselves as inferior to, for example, psychiatrists they might resign and adapt to the informal coercion.

> But perhaps I don't agree with the doctor's decisions. But I must conform to it. And I am the one who has to face the patient with it, and to bear it (the metaphoric headache as the problem is described as) (P7).

If nurses perceive that there is no evidence for psychiatrists' decisions, they are less likely to subordinate. In such cases they strive to act according to their own values, thus pushing the limits and taking the consequences. When informal coercion is considered as a plausible solution, the execution of it is facilitated just by *following the routines* on the ward. In these routines, which can be described as "our way of doing things" involuntary coercion is implicit and taken for granted.

> The routines affect our decisions about informal coercion. When following them you don't take the opportunity to think differently in a way that might benefit the patients (P8).

Hence patients who are subject to voluntary care, may also suffer from informal coercion by, for example, not being allowed to leave the ward as they please.

Dealing with laws Involuntary coercion is also a silent coercion and there are no laws regulating it. However, from the nurses' perspective it is easier to use informal coercion if the patient is admitted to psychiatric care against his/her will.

> I think you get blinded by the coercive care (…) when they are hospitalized in this way it's like it becomes more acceptable also with the informal coercion (P9).

Furthermore, nurses might experience themselves as powerless when patients who are voluntarily cared for act out and informal coercion is insufficient to calm the patient down. This calls for formal coercion, which is considered a setback as it would also mean that the care is no longer voluntary.

Initiating informal coercion

This domain focuses on nurses' experiences of initiating informal coercion. These experiences were understood as striving to justify the informal coercion, i.e. the category, by describing different motives, the subcategories.

Justifying informal coercion. A common motive was doing it *for the good of the patient.* Informal coercion is considered as a "necessary evil" if the patient is considered as incapable of knowing his/her own good.

> They can't determine things and make decisions when they are in such a mental state. You must lead them to the right track (P7).

Sometimes informal coercion is also a way *of adjusting to peoples' expectations.* This meant that nurses sometimes acted against their own consciousness and assessment of what the patient needed to please colleagues, or act as they were supposed to act according to routines and the caring culture. For example, they might "not agree with what a doctor prescribes, but must act accordingly anyway" (P4) even if it means that they need to use informal coercion to execute "doctor's orders".

The use of informal coercion contributes to nurses remaining in control of the situation and is considered necessary *to cope with the demands of everyday work.* Thus, informal coercion makes things easier, as it might save time as well as contribute to stability at the unit.

> If a patient becomes noisy or starts fussing with another patient or a member of staff it is easy to…., it is the easiest thing to do (P9).

As formal coercion is considered as more traumatic for the patients and involves more emotional stress for the nurses, informal coercion is also a means of *avoiding formal coercion.* Participants describe it as "fairly reasonable to get the medication into the patient as soon as possible" (P1) to avoid informal coercion.

The coercive event

This domain involves four categories describing nurses' experiences during the coercive act. These descriptions include how nurses strive to make informal coercion as gentle as possible as well as how they exert it.

Waiting for the patient. When possible, nurses strive to avoid informal coercion by not rushing things. If it is not acute "it is better to let it be for a while instead of having the whole ward on its feet" (3). Then nurses just give information about what is planned and return on a later occasion.

Persuading the patient. Based on striving to do good, *using professional power* is used by nurses to persuade the patient to accept interventions s/he disagrees with. As nurses they "know what's best" and argue to convince the patient. The professional power is related to the asymmetry in the relationship and knowledge. However, they could also argue that it is based on other professionals' knowledge and power (most commonly the doctor), by saying for example "The doctor has said that this is the best for you" (P2). *Appealing to the patient's sense and reasons* is a way of provoking an emotional response. By letting the patient know that "this is made from concern" they hope that the patient will adjust to please the caregivers. Nurses might also manipulate patients by *omitting information*.

> If you want to give a medicine or an injection to someone who is reluctant, I do not deliver information about convulsions … head ache... what might happen, as they are already negative about it. Rather you try to tone that down, or just exclude the information about side effects (P7).

In other situations, nurses give detailed information about negative consequences, such as risks associated with non-compliance, as well as threatening the patient that s/he will experience more psychiatric symptoms or become subject to informal coercion "if you don't take this injection" (P8), thus *scaring the patient to comply.*

Negotiating with the patient. When persuasion fails, for example if the patient is knowledgeable and argumentative, nurses use different methods to negotiate with the patients. These methods allude to patients' wishes, but might place nurses in a doubtful position, for example by *using carrot and stick,* telling patients things like "If you want to have a leave of absence (or smoke or anything else desirable) you must take your pills (or go to the shower, or behave in a certain way)" (P8). Other ways of negotiating become visible by *giving patients respect* or *kindly coaxing.*

> We try to coax a bit, in a nice, cute way, while a male colleague might be more direct…this is how it is, so there might be a difference there (P4).

As illustrated by the quote, nurses use different strategies with the intention of inviting the patient to be involved in the care that is basically dictated by professionals. Coax and respect are considered a way to come to an agreement about patients' behaviour. Hence, patients can influence the care within certain limits as a response to compliance.

Using professional power. There are also situations where professional power is used to emphasise professionals' perspective, and the necessity of patients' compliance. This could be done very obviously, for example if the patient is perceived as aggressive and the intervention as necessary in the moment, by *joining forces.* In such cases several professionals approach the patient. If this succeeds, nurses can impose their will on the patient just by making up the majority. However, "sometimes the situation with the patient becomes worse if you come in as a group" (P1). Such a situation might also escalate to formal coercion.

Professional power could also be used in a subtler way, when *communicating power* verbally or nonverbally in a way that communicates to the patients that there are no alternatives.

> "So, I am very resolute, I feel that too. And the patient submits, and there is no more fuss about it" (P9).

Nurses might also use their power *to obstruct dysfunctional behaviours*. This might be the case when nurses perceive that patients have dysfunctional habits that they should not have, especially when not being cared for at the hospital. Then "you have to intervene to shape a healthy behaviour". In these cases, they might obstruct patients from unhealthy eating, smoking etc.

The aftermath

The final domain focus nurses' experiences after an event where informal coercion has been used. At the core of this domain, nurses strive to make sense of the event and their own actions.

Scrutinizing one's actions. Nurses are aware that they are moving in a grey zone regarding whether their actions are ethically sound or not. When the informal coercion is soft it is easier to accept, and when the intentions fail nurses tend to become more self-critical. When uncertainties arise nurses struggle *to justify* the use of informal coercion for themselves by considering the actions "as the best for the patient from a long term perspective" (P9), and they also claim that as the patient finally accepted it, meaning that it could not be defined as coercion. Despite striving to excuse their own behaviours, they also reflect on whether their decisions and actions were right in relation to profound values.

> But nursing ethics must nevertheless still characterize my actions so that I sometimes pause, considering what is my mission and such things (P9).

These reflections can be painful, and cause feelings of guilt, shame and self-accusations. Blaming yourself by asking questions such as "why did I do this? Even if they in a way agreed they should have been entitled to refuse?" (P10) is also part of nurses scrutinizing. When experiencing that one's action was doubtful, nurses might also blame the doctor or the organization to avoid a bad conscience. This could be part of striving *to search validation from others,* peers as well as patients. When in doubt peers could reassure that the nurse's actions were necessary. Nurses also experience that "talking to the patient when he has recovered might strengthen the relationship" (P10), as the patient can understand that the coercion was helpful and "actually thank us for intervening" (P9).

Learning together. Other people are not only important for relieving experiences of guilt and blame. Joint reflections are also opportunities to learn. *Reflecting with peers* can contribute with other perspectives and different ways of understanding the situation and one's own actions. Even though such reflections are not part of the routine they are considered as important as they make the informal coercion visible and contribute to an awareness of different alternatives. Nurses also describe *sharing with the patient* as a source of mutual respect and learning.

> I always describe why I did as I did, and of course patients are encouraged to narrate their experiences. And I do think that you need to do this to retain the caring relationship (P4).

These reflections can work well for nurses and patients alike. By sharing their experiences, it is possible to regain trust, and find out what can be done differently.

Discussion

We have described informal coercion as a process affected by different factors. This contrasts to previous research focusing on informal coercion as a phenomenon, or describing decisions, feelings or actions associated with it. Not surprisingly, we found that nurses constantly struggle to balance between a wish to do good and the demands of others. We will discuss this struggle from an understanding of the nurse-patient interactions and the caring relationship as simultaneously reciprocal and asymmetric.[26]

In line with Hem et al.[12] we found that nurses experience that patients' ill health and/or communication difficulties can make it hard to connect to patients and understand their caring needs. This is a dilemma, as nurses' wishes to do good in these situations can create difficulties to remain in what has been described as a "not knowing" position, i.e. striving to care for the person based on an understanding and respect for his/her unique experience[27]. Instead they position themselves in a power-position, using their knowledge to decide what the patient needs. As described by Muir-Cochrane et al.[15], in such cases nurses might base their decisions on their intuition rather than on what the patient says. But intuition might fail, and they might feel alone in an ethically demanding situation. As described by other researchers, nurses can believe that they are expected to manage such situations independently.[16, 28] Torn between insecurity about the patients' perspective and a desire to get support and acknowledgement from colleagues, nurses might choose to comply with other professionals whose perspectives are easier to grasp than the patient's.

Even if nurses strive to wait for patients, one could ask why they give up waiting and precede to being more active in their efforts to make patients comply. As in earlier research[2] this is sometimes done by withdrawing information, a behaviour which has been described as deceptive.[1] Negotiating with the patient might be a subtler way to do this. In Sweden the expression "carrot and stick" is commonly used in everyday language and is seen as part of negotiations. However, as the relationship is

asymmetric, patients are inferior in such discussions, as nurses are the ones with the power to open the door, provide cigarettes or other things the patient desires in exchange for compliance. Exchanging this everyday expression to Szmuckler and Appelbaum's[1] "threats and offers" illuminates the ethical problem with such a strategy, as being scared or tempted to act in a certain way is far from shared decision-making as well as un-dignifying. In addition, research shows that even if patients adjust, it should not be taken for granted that they comply. As concluded by Lorem et.al.[18] passivity is not the same as acceptance. Rather it might be a sign of resignation related to an experience that resistance is futile. Hence, patient autonomy is put at stake, and resignation is likely to increase power differences.

Nurses strive to justify the coercive measures by claiming that it will avoid formal, and thus also harder, coercion. As described by Vuckovich and Artinian[21] this is supposed to be more humane. This is an understandable standpoint. However, this also gives rise to reflections on the humanness in using professional power in order to make the patient comply with different interventions in situations where neither the patient nor other people are at obvious risk for harm. If such immediate risks do not exist, there might be another hidden agenda that needs to be subject to reflections before acting. As described by Enarsson, Sandman and Hellzén[29] professionals tend to set up house rules not only for the good of the patient, but also to preserve general order. From this perspective, informal coercion might be understood as a way to create control. As we interpret our data, nurses continue to struggle with the rightness of coercion by scrutinizing their actions in the aftermath of the coercive event. This could be understood as moral stress, or stress of conscience.[12, 30]

Nurses' efforts to balance between an ethical sensitivity in the situation, and demands and expectations from others, has been verbalised in terms of having a vulnerable inside and a strong and professional outside.[17] From our perspective the vulnerable inside is related to the nurse as an individual, and the caring relationship as reciprocal. Doubting one's own actions as unethical is part of this reciprocity. However, such doubts could also be understood as an expression of nurses' fear to be judged as incompetent by their colleagues.[13] Adapting to house rules rather than acting out of an understanding of the patient, could thus be understood as strengthening the

professional outside to preserve relations with peers.

Conclusion

Informal coercion is a complex phenomenon. It has been described as a necessary evil,[3] and without doubt it is experienced as challenging for the involved nurses who struggle between a wish to do good, and a desire to stay within the norms of the caring culture. Avoiding acting for the sake of the other in order to escape own experiences of unease and guilt could be just as unethical as using subtle coercion in order to protect the patient and avoid harder coercion. We conclude that these issues can't be resolved by adapting general principles about what is the right or wrong thing to do. Nor can they be solved by focusing solely on the coercive event as an intervention, as this might reduce nursing care to the coercive measure rather than understanding it as an on going process. Hence, reflections need to include considerations about when and how such interventions should be executed, and how this could be done with respect for patients' dignity and autonomy. The asymmetry in the nurse-patient relationship means risking that patients adjust to nurses' requests in a subordinate way in order to please them rather than because of a mutual understanding of what needs to be done. On the other hand, the asymmetry also means that nurses have a unique opportunity to use their authority in a way that is perceived as good rather than evil by the patient. Hence, even though coercion could not be considered as good in the light of profound ethical values, it could be perceived as helpful when it is used based on a concern for the person's health and dignity, for example when avoiding formal and harder forms of coercion such as forced injections or seclusion. This is also in line with research focusing on patients' experiences of coercion as "good" when they trust the staff and evaluation as helpful.[18]

Still, reflections on how coercion, informal as well as formal, could be avoided are necessary. Such reflections could benefit from being preceded by ethical reflections focusing on whether the coercion is necessary *right now.* If there is a chance that it could wait while trying to resolve whatever the matter is in a non-coercive way, nurses need to reflect on this with other professionals rather than resign to existing practices even if those are subtle. If there is a need for coercion, i.e. if the coercion is found to be an "unpleasant good", rather than a "necessary evil" considering the

consequences for the *patient*, it should be subject to reflecting and learning together with the patient.

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