Influence and coercion: relational and rights-based ethical approaches to forced psychiatric treatment

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The dominant rights-based approach to the ethics of coercion in psychiatric treatment guides clinicians in deciding whether treatment should be compelled or the patient's autonomy respected, but provides no guidance across the remaining broad continuum of influence that clinicians exert with patients. The assumptions of the rights-based approach lead to three dichotomous decisions: (1) ‘Is the treatment voluntary?’; (2) ‘Is the patient competent?’ and (3) ‘Are the consequences of no treatment dangerous?’. The assumptions of a relational approach lead to ethical guidance across the full range in the intensity and types of influence which may be ethically justified or required in psychiatric treatment. These assumptions are: (1) influence is inherent in the clinical relationship; (2) the relevant factors are continuous and (3) all decisions are subjective. While the rights-based approach emphasizes defining competence and developing techniques to predict future patient dangerousness, the relational approach emphasizes patient–clinician responsibilities in ethical relationships and understanding all factors which legitimately bear on the use of influence. An initial list of such factors is offered.

Keywords: coercion, ethics, influence, relationship, responsibility, rights

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Introduction

A rights-based approach is dominant in both ethical discussion of force or coercion in psychiatric treatment and in its regulation through statutory and institutional policy. Rights-based justification of coercion focuses on those specific acts by clinicians that breach the assumed obligation to respect patient autonomy and liberty. Such acts include restraint, seclusion, civil commitment and forced medication. This article seeks to shift the emphasis of the discussion away from isolated breaches of patient rights towards the identification of parameters for the ethical use of the influence within clinical relationships, thus expanding the discourse to provide ethical guidance across a full range of influence-wielding in clinical situations rather than simply drawing a line beyond which is an abuse of the clinician's power. This creates the possibility for consideration of positive moral action in treatment that is stifled by a rights-based approach focused on transgression.

The rights-based approach to ethics in psychiatric treatment has given rise to the present climate where consumers clamour for reductions in the forced treatment techniques of seclusion, restraint, forced medication and commitment (Ahern et al. 2000, National Council on Disability 2000, Olofsson & Jacobsson 2001), and clinicians argue that their power to compel treatment should be increased for those identified as disordered (Perr 1978, Bachrach 1980, Committee on Government Policy, Group for the Advancement of Psychiatry 1994, Talbott 2000, Appelbaum 2001). The discussion of ethical treatment in psychiatry is expanded beyond rights and their transgression by conceptualizing treatment as a relationship where influence is
inherent, factors under consideration occur on a continuum and decisions are subjective. Exploring the implications of a relational approach to influence and coercion in psychiatric treatment requires that the assumptions and application of both the rights-based and relational approaches be contrasted.

The rights-based approach to ethical justification

The rights-based approach is grounded on three *prima facie* assumptions:

1. persons are autonomous, that is, self-governing;
2. personhood, that is, humanity, has primary value; and
3. no individual's personhood has more or less intrinsic value than the personhood of any other individual, and so every individual’s humanity should be respected equally.

Liberty as the right to pursue one's own ends without interference is derived from these assumptions.

In health care, a fundamental expression of respect for the humanity of patients is to give priority to the patients' treatment goals, summarized as the principle of respect for autonomy. Therefore, coercing patients is unacceptable under normal circumstances. The decisions of properly informed, uncoerced competent patients are to be honoured (Beauchamp & Childress 2001). Acts of coercion must be justified as exceptions to the clinician's obligation to respect patient autonomy. Although many philosophers, most notably Kant (1989, 1993) and Rawls (1971), play a role in explicating the ethical theory forming the basis of the rights-based approach, the form of currently accepted standards for forcing treatment in psychiatry can be found in John Stuart Mill's *On Liberty* (first published in 1859).

The two justifications for denying a patient's choice of treatment are that the patient lacks competence to make a decision or that the patient's choice could result in harm, either to the patient or others. Mill (1985) gives an example which invokes both criteria. A man is about to walk over a bridge that will collapse under his weight sending him to his death. A bystander does not have time to warn him and so pushes him out of the way. At first the walker is angry, but when fully informed of the situation, he concurs that pushing him was the proper action.

The legal justification of forced psychiatric treatment in all 50 US states requires the presence of mental illness, which serves as a presumption of impaired competence, coupled with potential danger, either to oneself or others (Tasman et al. 1997). The commitment criterion of 'gravely disabled' is conceptually grounded as an extension of potential danger to self providing ethical justification of the forced treatment. While advocates of legal assisted suicide have argued that deliberate and rational suicide is a right of liberty, the presence of mental illness is considered a sufficient impairment of competence to negate this right (Benrubi 1992, Baile et al. 1993). There is an implied connection of mental illness with incompetence in the law which serves to remove the need for a more overt demonstration of incompetence.

In Mill's case, the bystander's assumption that the walker lacked competence is confirmed by the walker's approval of pushing him when he is fully informing of the bridge's condition. This information restores his competence. Thus the walker's liberty was not violated. The analogy in psychiatric treatment is that the non-competent, that is, mentally ill patient who is restrained, committed or force-medicated will concur after a course of treatment has restored the patient to a competent mental state. Allen Stone has labelled this the ‘thank you’ theory of civil commitment (Alexander et al. 1991).

However, empirical research shows that many patients do not concur with the need for their forced treatment when asked retrospectively. In an interview study of 15 involuntarily committed patients after discharge, 40% said they would never commit another person (Joseph-Kinzelman et al. 1994). In a study of 24 patients interviewed within 1 week of seclusion, only half agreed that seclusion was necessary (Binder & McCoy 1983). Another study of 84 committed and voluntary patients suggested that patient-reported improvement was related to the perception that patient autonomy was respected (Kjellin et al. 1997). So either a ‘thank you’ can not be counted on to provide the ethical justification for forced treatment or much current forced treatment is unethical.

Further, the actual situation of seeking concordance or a ‘thank you’ regarding an act of forced treatment presents two problems likely to result in the clinician having an inflated sense of the patient's agreement with the necessity of forcing treatment. First, as clinicians believe that they act in a patient's best interest, they will be biased towards interpreting the patient's discussion of an incident as agreement. The second barrier to assessing the patient's retrospective endorsement of forced treatment is that asking from the position of the treating clinician is inherently coercive. Patients expecting to continue in treatment or gain institutional privileges are likely to feel that their endorsement of the forced treatment demonstrates cooperativeness and improved 'health'. One study by Soliday (1985) which found that patients endorsed the need for seclusion provoked this response: 'Many patients after an episode of solitary confinement will learn that the best way to avoid another is to acknowledge therapeutic benefit, even if this is not how they really feel.' (Chamberlain 1985, p. 290).
The second justification for overruling a patient’s stated wishes is to prevent harm to the patient or another. In most cases, this entails a patient’s refusal of treatment being ignored. An example is when a homicidal patient refuses inpatient admission and is civilly committed rather than left at liberty in the community.

The determination of ethical treatment within a rights-based approach begins with the conceptualization of the individual as a bearer of rights. Thus, respect for the individual is ensured by surrounding each person with an independent and inviolable autonomy. Rules are then structured to maintain that shell or to justify violations. These rules require careful distinctions regarding the nature of autonomy because criteria for denial follow from autonomy’s definition. Thus the rights-based approach must address the occurrence of influence and coercion in treatment by defining which specific acts are transgressions against the obligation to respect autonomy and then developing criteria for when the patient is to be considered non-competent and dangerous. This leads the ethical discussion into the consideration of a series of sharp dichotomies.

Voluntary vs. forced or coerced treatment

A distinction between coercion and other therapeutic interactions that exert influence on a patient is essential in a rights-based approach to ethical justification. Beauchamp & Childress (2001) define coercion as when ‘one person intentionally uses a credible and severe threat of harm or force to control another’ (p. 94). Lovell (1996) says, ‘In coercion, force is used to compel the person labeled mentally ill to act or refrain from acting in a certain way’ (p. 152). Both definitions set criterion for when influence is to be considered coercion: in the Beauchamp and Childress definition, it is the threat of harm or force, and in the Lovell definition, the use of force. Both follow a common sense understanding of coercion but do little to draw a practical distinction as both replace the term coercion with the term force.

Both authors recognize that influence takes many forms with differing intensities. Beauchamp & Childress (2001) distinguish coercion from manipulation and persuasion, while Lovell (1996) places coercion at the far end of a continuum of social control methods used in psychiatry. Beauchamp & Childress (2001) specify the need to distinguish coercion from other types of influence because coercion ‘voids an act of autonomy’ (p. 94). Thus in the rights-based approach, the distinction between voluntary and coerced treatment is critical because coerced or forced treatment violates the patient’s fundamental right to liberty, and the clinician’s obligation to respect patient autonomy.

When cases involve forced or coerced treatment, there is a need for ethical justification. The Beauchamp and Childress and Lovell definitions attempt to dichotomize clinical interventions into the coercive and non-coercive to identify those situations requiring ethical justification.

Competent vs. incompetent

Compelling a rational person into treatment against his or her will is a considerable breach of the right to liberty and the clinician’s obligation to respect patient autonomy. Therefore, rights-based justification of forced treatment emphasizes distinguishing competent from incompetent patients.

Autonomy is generally conceived as an ability to self-govern. Frankena (1973) says: ‘a self or person is a unique agent capable of a kind of self-determination that is not a function of previous causes and yet is not a matter of chance but of choice, intent and purpose’ (p. 76). In defining autonomy for bioethics, Beauchamp & Childress (2001) say: ‘Virtually all theories of autonomy agree that two conditions are essential: (1) liberty (independence from controlling influences) and (2) agency (capacity for intentional action)’ (p. 58). The first condition of the Beauchamp and Childress formulation is environmental, requiring a lack of coercion, and is addressed under the first dichotomy between coerced vs. voluntary action. While the second Beauchamp and Childress condition is internal, putting requirements on the patient’s mental condition, which draw from an understanding of human nature as specified in Frankena’s definition of autonomy.

Thus under the rights-based approach showing that a patient lacks the critical faculty of self-governance, that is, autonomy, is a key to justifying forced treatment. There are several implications for using this criterion to guide ethical decisions. First, an underlying assumption of this perspective is that autonomy or self-governance is a defining feature of humanity hence the value given to preserving and respecting it. Therefore, the incompetent person is considered somewhat less human than a competent person. Second, for a person to be considered self-governing within the Beauchamp and Childress formulation, the influence being exerted must be distinguished as controlling or not controlling. An ethically optimum situation would be the complete lack of influence, demonstrating an inherent absurdity in that decision-making by definition is the sorting through of various influences to determine the most salient and act accordingly. Finally, mental processes must be sharply distinguished between those conferring a capacity for intentional action and those that do not. Beauchamp & Childress (2001) stress this saying: ‘For practical and policy reasons, we need threshold levels below which a person with a certain level of abilities is incompetent’ (p. 72). Such sharp distinctions blur the normative aspect of valuing cer-


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taint forms of mentation and ways of making a decision over other giving competence the appearance of being an objective clinical decision.

In mental health, the competent/incompetent dichotomy merges with the distinction between mentally ill vs. mentally well, placing great emphasis on the ability to define mental illness objectively. That all 50 US states require a person be identified as mentally ill as a necessary, but not sufficient, condition of civil commitment illustrates the critical nature of the distinction between being well and ill (Tasman et al. 1997).

Another manifestation of dichotomizing mental phenomena into well and ill are the medical necessity criteria used to decide whose treatment is covered. This extend the problems of dichotomizing mental processes in the opposite direction; forcing patients out of treatment they feel they is needed and beneficial, but does not meet the criteria of medical necessity.

In the context of both commitment and coverage, the issue of whether the patient has a disease or not bypasses considerations of the patient’s suffering and the clinician’s ability to alleviate that suffering. Sabin & Daniels (1994) endorse this error by asking the question: ‘Which kinds of mental suffering create a legitimate claim for assistance from others through health insurance?’ (p. 5), and then providing the answer, ‘... health care insurance coverage should be restricted to disadvantages caused by disease ... ’ (p. 11, emphasis added).

**Dangerous vs. non-dangerous**

Following Mill’s criteria for denying liberty commitment, statutes in all 50 US states also require that the committed person be dangerous to self or others or to be gravely disabled (Tasman et al. 1997). In defining ‘danger’, most statutes require the potential for imminent harm (Alexander et al. 1991). Similarly, most states require the documentation of some form of danger as the potential for harm in other types of forced treatment, including seclusion, restraint and forced medication. The assessment of danger as potential harm includes the concept of grave disability, which is generally defined in terms of the person’s ability to meet basic needs. The notion of danger as potential for harm is also often extended to the likelihood that the person’s mental disorder or overall condition will deteriorate without intervention (Tardiff 1996).

In all cases, the clinician is required to predict the likelihood of harm to justify acts of forced psychiatric treatment. One practical problem is that suicide and homicide have a low probability of occurring in the ‘imminent’ time frame required by most US state statutes, even in individuals who can be predicted to exhibit these behaviours at some point over the course of a lifetime (Maris 2002). It is inherently difficult to predict single instances of events that have a low probability of occurring at any single point in time (Maris 2002). This places the clinician in a difficult situation as the justification of the forced treatment hinges on this prediction.

The need to determine the degree of danger shifts emphasis from the intention to do well for the patient towards the need to prevent harm. Mills (1986) refers to this as the ‘commitment/treatment discontinuity’ which separates the need for treatment from the decision to treat because the decision must be based on an assessment of the potential for harm and not the need for treatment.

In many cases where clinicians rely on the distinction between dangerous and non-dangerous to justify commitment, the assessment of potential danger is actually made by the patient. In assessing suicide potential, a patient’s self-report of self-destructive impulses or desires can be a crucial determinant (Shea 1998). While other factors are used to assess a patient’s suicide potential, principally current behaviour and history, self-report is a primary component of the assessment and sometimes the first indicator that suicidality is an immediate concern. Thus, the clinician’s decision appears paradoxical from a rights-based perspective where the situation becomes adversarial with patients being forced into treatment against their will while being asked to provide a justification that they could conceivably withhold. This paradox highlights the divergence between the justification of forced treatment and caring concern for the patient.

**The relational approach to ethical justification**

The relational approach starts with three assumptions:

1. influence is inherent in the clinical relationship. The patient cannot be without influence from the clinician;
2. the factors relevant to treatment decisions and the intensity of influence are continuous, not dichotomous; and
3. all decisions are subjective, and so the clinician, as a person, is a fundamental component of the situation.

**Influence**

If influence is accorded a straightforward meaning: ‘the power to have an effect on people’ (Proctor 2000), then not only is it intrinsic to the clinical relationship but is desirable. Influence defines treatment – patients seek treatment to be influenced, either directly or by learning better self-control. Locus and desirability are two parameters in exerting influence. The locus of influence can be internal or external. Influence may be wanted or unwanted. Mental disorder can be thought of as an unwanted internal influence (Com-
Continuous variation

The parameters dichotomized in order to apply the rights-based view are also essential in the relational view, but are considered to occur across a broad continuum. Thus patient competence, potential for danger and the intensity of influence being exerted vary by degree. These parameters have always been recognized to occur continuously in clinical situations as well as in clinicians’ assessments and treatments. The dichotomization of danger, influence and competence required for the justification of forced treatment in the rights-based system creates an artificial situation.

Subjectivity

Decisions using rights-based approach have the character of being objective, arising from the model’s roots in deontological philosophy, which requires that ethical decisions be universalizable. In the relational approach, the application of influence in clinical relations arises from a particular relationship between that provider and that patient. Thus determining ethical action is connected to the personhood of the clinician in the context of each unique relationship.

Summary

The change from the rights-based to the relational approach is a change in emphasis and perspective rather than a change in content. Much of the content needed for a clinician to decide the appropriate use of influence remains the same, for example, the patient’s mental state and potential for danger. These three assumptions of the relational approach combine to change the way the application of specific factors is understood. When influence is considered inevitable, neither good or bad in itself, and continuous in the degree of intensity, then the label ‘coercion’ applies to that point at which the use of influence creates moral discomfort. The term coercion no longer carries the connotation of an objective label based on universal criterion, but becomes a subjectively applied term based in the particularity of the clinician, the patient and the relationship. As an emotive term describing a sense of moral discomfort, the application of the term ‘coercion’ would seem to be less distinct. However, its use may be more congruent with the clinician’s and patient’s experience of the situation than as a label applied legalistically according to a set of criteria. The relational usage may also be more accurate in that it is applied specifically as a moral indicator whereas in a legalistic application one must justify or condemn its use. Further, in the rights-based approach, criteria for use of the term coercion is distinct and objective in appearance only. Recall that both the Beauchamp & Childress (2001) and Lovell (1996) definitions of coercion rely on the term force, which simply moves the subjective judgement from coercion to force.

The relational approach shifts concern away from the justification of acts of force to the maintenance of an ethical relationship within a web of influence. For example, regarding the use of restraints, the question is not ‘Is the act of restraint justified?’, but ‘How in the context of an ethical relationship does one person put another in physical restraints?’ Many activists are quick to use the language of rights, but the justification of acts of force is facile within a rights-based framework. The clinician only needs to demonstrate the patient incompetent and dangerous. With patient refusing treatment, the clinician already has the advantage in that the person is acting outside the social norm by declining the authoritative advice of the clinician. Forced and coerced psychiatric treatment is an everyday occurrence indicating the ease with which rights-based justification is made. From a relational perspective, the use of strong influence must be justified as the act of one person exerting his or her will over another within the context of an ethical relationship.

In a rights-based approach, the justification of an act like restraint can give the perception of an isolated event. The patient is restrained, the clinician reflects on the act and finds it justified, moral sensibility and legal requirement are satisfied. The law requires that the patient be released when the restraint is no longer required, but this simply extends the event, continuing to involve the need for dichotomous decisions.

Within a relational perspective, the clinician may find the restraint justified, but the moral weight of that act is ongoing throughout the relationship. The patient cannot be restrained and thoughts of the act cast aside because it was justified, even after the restraint is discontinued; the fact of its occurrence will continue to carry moral weight for the duration of the clinical relationship. While the relationship continues, the clinician and patient can work together to find shared meanings for events. Only when the relationship is over does each act within the relationship become solidified in its moral meaning.
In contrast to the work of sharpening dichotomous distinctions implied by the rights-based approach, the relational approach spurs inquiry in two directions:
1. understanding the ethical relationship between the nurse and patient; and
2. defining, describing and understanding the factors relevant to determining what is ethical in the type and intensity of influence used in clinical practice.

Ethical relationships

The philosopher David Seedhouse (Seedhouse 2000) describes the ethics myth as the assumption that clinical care proceeds as dictated by objective clinical parameters and occasionally encounters difficult situations entailing a clash of values; these anomalous situations are then labelled ethical. This is inaccurate, according to Seedhouse (2000), who holds that all the choices made as part of nursing practice are grounded in values. The provision of treatment puts value into practice; one gives nursing care to others to enhance functioning, ease or alleviate suffering for subjective moral reasons not objective clinical reasons. The concept that health care and nursing in particular is at its heart a moral pursuit is not new (Benner & Wrubel 1989, Gadow 1990). However, despite acknowledging the moral basis of practice, we often treat ethics as the specialized discipline to work out rules for narrowly specified situations rather than searching for ethical modes of practice to cover both easy and difficult situations.

As the assumptions of the relational approach remove emphasis from defining objective rules for the application of forced treatment, moral appraisal of situation turns to an assessment of how the available choices serve to value and enhance the human dignity of the particular patient in the specific situation. This leads to three potential areas of inquiry that currently receive little attention:
1. moral development, particularly the way in which the nurse comes to understand and value the personhood of patients;
2. the extent and nature of the clinician’s responsibility to the patient; and
3. ways to assess situations for ethical outcome.

Under the rights-based approach, forced treatment is ethical or unethical, that is, the patient’s rights are honoured or not, depending on how three dichotomous criteria are met – features of a situation’s outcome other than the status of the patient’s rights are fortunate or unfortunate. A clinician’s efforts to bring about more fortunate outcomes may be considered supererogatory acts, not ethical obligations. While in the relational approach, the ‘good’ of the situation’s outcome, like the variables defining the situation, will occur on a broad continuum. Currently, there is no rigorous way to assess that while one set of actions led to an acceptable outcome, that is, no rights were violated, another set lead to a better outcome in the moral sense.

Factors ethically relevant in determining the type and intensity of influence

Another direction of inquiry implied in a relational approach is to examine the factors that ought to be used to determine the nature and level of the influence. While most of the factors discussed here are familiar under the rights-based approach, there are substantial differences in emphasis and development of factors under the relational approach. The relational approach is open to a wide consideration of many factors and one only needs to demonstrate their relevance, while under a rights-based approach, theory limits ethical relevance to certain specific criteria. In the relational approach, the factors represent items of consideration occurring on a continuum while in the rights-based specific criteria are either met or unmet. Perhaps the key intrinsic difference in the approaches is in the breadth of application. In the rights-based approach, ethical consideration is only needed when acts of coercion or force are considered. However, because of the relational approach’s basic assumption that all clinical situations involve influence, the clinician is ethically obliged to consider the level and type of influence brought to bear on patients. In this way, ethics is not brought into the clinical situation as needed, the parameters of the clinical situation are inherently values-based. This maintains and strengthens the concept of nursing as a moral practice. Further, the obligation to assess and apply the morally appropriate level of influence runs in both directions, refraining from overuse of influence and the application of increased amounts of influence.

Keeping with the nature of the relational approach, the following list of factors bearing the use of influence is offered as an initial listing. All these factors have been considered in some form within a rights-based approach, but are reviewed under the relational approach assumption that these represent continuous variables essential to the nurse’s determination of the nature and level of influence that is ethical in a given situation.

Strength and nature of clinical relationship

This provides the context within which all other factors are evaluated. Decisions made in an emergency department by a clinician who has spent an hour with the patient are going to be considered differently from those made by a therapist who knows the patient intimately. In the relational approach, all decisions are embedded in the context of the actual relationship, while in a rights-based approach,
the differences in relationships may be acknowledged but the criteria to apply forced treatment remain essentially the same. So in the rights-based approach, the difference between the emergency department clinician and therapist is in how well they discern an ‘objective truth’ as to whether or not the patient meets the dichotomous criteria for the application of forced treatment.

The patient's willingness to participate

More intensive interventions are justified when patients are willing recipients. Even the most restrictive interventions of seclusion and restraint can be applied with little ethical conflict if the patient desires the intervention, excluding cases where the intervention is clinically inappropriate or the patient’s motives are incongruent with the therapeutic use of the intervention. However, assessing willingness must be an ongoing, open process because the existing and inherent influence a clinician exerts on the patient affects on the perception of willingness. The clinician will be inherently biased in perceiving the patient as willing.

Potential for harm if a treatment is not instituted

A greater potential for harm justifies more intensive influence. This includes harm to the patient and to others. As with other factors, the potential danger of harm does not occur in a dichotomy but on a continuum. A hierarchy in degree of harm might range from property damage to assault or self-harm to death.

Likelihood of the harm's occurrence

With a higher probability of harm comes more justification for coercion. However, this factor is notoriously unreliable, because violence and suicide, as low probability events, are inherently difficult to predict.

Degree of benefit from an intervention

Greater benefit justifies more intense influence. It is legitimate for mental health clinicians to consider their judgement of potential benefits to the patient, to specific others, such as family members, and to society at large in assessing the use of influence.

Intensity of restriction or intrusion from the intervention

More intrusive treatment requires stronger justification. A rough hierarchy of intensity of influence follows:

1. movement in space (e.g. seclusion rooms, ward restriction);
2. decisions of daily life (e.g. food, television, when to smoke, with whom to socialize);
3. meaningful activities (e.g. housing, work);
4. treatment choice (e.g. court-mandated treatment, unwanted social work intervention);
5. control of resources (e.g. use of money); and
6. emotional or verbal expression (e.g. censorship, social expectation; Olsen 1998).

Restraint and seclusion are the most intensely restrictive and intrusive interventions available to the clinician, it therefore requires the highest level of justification.

Intensity of the method used to exert influence

Most intense influence requires greater justification, either by patient need, the potential for harm or some other factor or combination of factors. A rough hierarchy of intensity in the method used to influence a patient might be:

1. physical force (e.g. restraint, seclusion rooms);
2. manipulation of resources (e.g. when patients are told that their place in a group home will be held if they agree to a voluntary admission, or when compliance with medication is tied to disability entitlements);
3. manipulation of social forces [e.g. compliance with treatment reflects well in a custody struggle (medication of children in custody cases)];
4. social pressure [e.g. social clubs, men wear neck ties and not skirts (some mental disorder might be seen as an insensitivity to this influence)]; and
5. advice (e.g. psychotherapy; Olsen 1998).

Degree of confidence in the intervention efficacy

Less influence is justified if the intervention is unlikely to have the intended effect.

Patient's mental state and competence

Greater impairment in the patient’s thought process justifies the clinician in substituting his or her own judgement. There is controversy over what constitutes impaired judgement as opposed to different judgement. This is one area where clinician’s with closer relationships to a patient have an advantage. The greatest ethical error regarding this factor is to equate sound judgement with agreement with treatment plan.

Conclusion

The relational approach to influence in psychiatric treatment brings ethical guidance to clinical decision-making
across a wide spectrum of situations and provides guidance in way that more closely matches the experience of clinical encounters. In contrast to the rights-based approach that provides only single points of guidance and requires the clinician to distort the situation to fit predetermined criteria, the relational approach is congruent with the lived experience of clinical situations – the clinician and patient are considered as distinct and specific persons, the clinician’s moral intuition is honoured, all parameters of the situations are available for consideration across a continuum and the power relationship between a clinician and patient is acknowledged. The relational approach encourages clinicians to assess every use of influence as an ethical decision providing a real method for bringing values into everyday clinical practice. Further, assessment and research of clinical practice can be conducted to provide conclusions on a continuum of moral good rather than the dichotomous conclusions of honoured vs. abused rights predicated by the rights-based approach. So with a relational perspective, the oft-stated dictum that nursing is a value-based discipline becomes more than a slogan.

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