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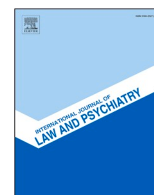

Can coercion in psychiatry be justified? A theoretical adversarial collaboration approach

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ABSTRACT

The use of coercion in psychiatry is one of the most controversial issues in modern healthcare. There are clinical, legal and ethical arguments in favour of both the abolition and justification of coercion in psychiatry. The two lines of argument are often diametrically opposed, so further development of the discussion seems difficult. To address this unsatisfactory situation, we have applied the approach of adversarial collaboration to this issue. The two authors represent fundamentally different points of view on the question of the legitimisation of coercion in psychiatry. Through a methodically guided exchange of arguments, numerous consensus hypotheses, dissent hypotheses and general consensus hypotheses with dissent in detail were developed. The main findings include the fact that the antagonists argue from completely different starting points at the core of the argument, namely, general arguments vs. individual clinical cases. In addition, antagonists hold consistent positions on many topics. It can therefore be concluded that both those in favour and those against the abolition of coercion in psychiatry are arguing with good intentions.

The myth of the beginning of modern psychiatry is symbolised by the picture of the French physician Philippe Pinel, removing the chains from mentally ill people detained in asylums during the French revolution. Since then, there have been repeated movements aiming to abolish coercion in the new medical specialty of psychiatry, but ultimately, this has never been achieved. In the 19th century, the 'no restraint concept', initiated by John Conolly in England, offered much promise across Europe (Shorter, 1997). The first anti-psychiatric movement emerged at the end of the 19th century amid public concerns about involuntary hospitalisation in several European countries (Haack & Kumbier, 2012). While these early movements were inspired by a sense of charity and humanity and a new consciousness of civil rights, without questioning the basic ideas of psychiatry, the psychiatrist and psychoanalyst Thomas S. Szasz in the U.S. was the first to formulate critique on the basis of scientific considerations against the current psychiatric paradigm in the 1960s and 1970s. Szasz rejected the use of restrictive practices for fundamental reasons. According to Szasz, mental disorders were not illnesses in the strict sense because of the lack of physical correlates; he argued that there were no essential arguments for legitimising measures against a person's will (Szasz, 1997, 2007)). Together with scholars such as the French philosopher Michel Foucault (Foucault, 1961), Szasz formed the second anti-psychiatric movement in the 1960s and 1970s. His views were sharply rejected by leading clinicians. These included, for example, Paul Appelbaum (1994), who for decades cited the diagnosis of a mental disorder as one of the clinical and ethical justifications for the legitimisation of coercion. Subsequently, a longstanding discussion on the 'right to refuse treatment' arose within psychiatry in the last two decades of the 20th century, mainly in the U.S. At that time, the idea emerged that the use of coercion could be justified on the basis of whether a person had mental capacity (Stone, 1981).

With the development and publication of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD hereafter) in 2006 (United Nations, 2006), the discussion about the permissibility of coercion in psychiatric care flared again. The UN CRPD was drawn up with the significant involvement of service user organisations. The Convention contains several articles that were regarded by

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some legal scholars as the basis for the abolition of coercion in the international legal context (Wilson, 2022). This applies particularly to Article 12, which suggests that persons with disabilities "…have full legal capacity" even in the absence of mental capacity. Both clinicians (Appelbaum, 2016; Zinkler & von Peter, 2019) and legal scholars (Nilsson, 2024; Wilson, 2021) have argued about the relevance of the UN CRPD. Owing to the legal significance of the Convention, there was a debate in the United Kingdom, for example, as to whether the British state should revoke its ratification of the Convention (Gosney & Bartlett, 2020). The German Supreme Court also agreed with the sceptical reasoning and rejected the interpretation that coercion should be abolished on the basis of the UN CRPD.

The debate about the permissibility or abolition of psychiatric coercion has still not been resolved. Even at the level of legally binding conventions within the United Nations, there is no consensus. In the legal literature, the term 'Geneva impasse' has emerged in this context (Martin & Gurbai, 2019). This means that there are conventions that justify the use of psychiatric coercion under certain circumstances (e.g., the International Covenant on Civil and Political Rights) as well as conventions that, like the UN CRPD, suggest the abolition of restrictive practices.

In the current state of the debate, coercion in mental health care can be both justified and rejected at different levels. In the clinical context, reference can be made to the lack of mental capacity in connection with a mental disorder and a causal association with violence against others or self or to the psychological consequences of coercion for the person concerned. Legally, the UN CRPD can be cited as the human rights basis for the abolition of coercion, whereas mental health laws or judgements by national supreme courts reject this. Ethically, both the benefits of coercion for the person concerned can be cited and denied.

The authors of this paper have spoken on different sides of the debate on the issues of the justification or abolition of psychiatric coercion in scientific papers and have appeared as opponents in several conferences. Dirk Richter is a proponent of the abolition of coercion in mental health care (Richter, 2025a; Richter, 2025b), whereas Tilman Steinert is an opponent of the abolition of coercion (Steinert, 2017, 2019). Both authors consider the current state of the debate to be unsuitable for further development of the issue, let alone a solution. As is so often the case with ethical problems, silo formation can also be recognised here, in which the antagonists engage in a debate with the same arguments without any potential for a solution.

To address this unsatisfactory situation to some extent, we propose applying the method of adversarial collaboration to answer the question of the justification of psychiatric coercion. We hope that this method will clarify our differences with the aim of developing further discussions and scientific questions.

The published literature has thus far limited itself to collecting arguments for and against the justification of coercion (Chieze et al., 2021). We are aware of only one publication in which the controversial positions (World Psychiatric Association, WPA, and World Health Organisation; WHO) on dealing with coercion were compared with the aim of reconciliation (Gill et al., 2024). Our project differs from this publication in its methodologically guided approach, which is not aimed primarily at reconciliation but rather at finding consensus and dissent on one of the most difficult questions in modern psychiatry.

1. Method

The adversarial collaboration method was developed with the aim of resolving controversial scientific positions through a joint project carried out by the opposing parties. The term 'adversarial collaboration' originates from the psychologist and Nobel Prize winner Daniel Kahneman (Kahneman, 2003). However, the method has already been described elsewhere under the terminology of 'Joint Design of Experiments by Antagonists' (Latham et al., 1988). As this terminology suggests, the core of the method consists of an empirical experiment to be developed jointly by the antagonists, which is intended to answer the question under discussion.

In the current methodological literature, experimental adversarial collaboration is described as an essential building block for the further development of research (Ceci et al., 2024; Clark & Tetlock, 2023; Nature, 2025; Peters et al., 2025), even as an extension of Open Science (Clark et al., 2022). Yet, for the question to be answered here, an empirical experiment is out of the question. However, adversarial collaborations have also been propagated for non-empirical questions, for example, in the bioethical field (Parker, 2024). For non-empirical topics, however, the procedure is not as clear-cut as for empirical experiments. In the context of a philosophical discussion, for example, the opponents worked largely independently of each other and produced only a joint publication at the end (Leal & Marraud, 2022).

We worked together from the outset and harmonised both the methodology and the content in an iterative process. Each author had the opportunity to formulate hypotheses that were important to him, and the other author had to comment on them. Initially, we agreed to fill two larger blocks with statements, namely, one block with consensus statements and one block with dissent statements. As we progressed, however, we came across a third area. We were able to identify numerous topics on which we had a consensus in principle but then disagreed in detail. This step is not unusual in the method; it is also called 'mixed agreement' (Ariely et al., 2000).

2. Results

2.1. Consensus hypotheses

The opponents fundamentally agree on many aspects. The consensus ranges from empirical observations to clinical considerations and human rights issues.

- Many countries and regions in Europe are experiencing an increase in coercive measures in psychiatric hospitals. This is a cause for concern as well as for research and development to achieve a reduction.
- In certain situations, coercion can be experienced as helpful in retrospect by people with severe mental illness.
- In certain situations, coercion can also be experienced as unhelpful and rather harmful in retrospect by people with severe mental illnesses.
- Mental health services in which coercion was completely prohibited would fulfil the wishes of many of those working there.
- Mental health services in which coercion was completely prohibited would fulfil the wishes of many patients and users.
- Coercion purely to avert danger to others is not a primary medical task.
- When weighing the harm and benefit of an intervention, the use of coercion must always be included as harm, depending on its duration, form and intensity.
- The criteria for the use of coercion should not differ legally and ethically between general medicine and psychiatry.
- To date, there is a lack of plausible and/or realistic proposals as to how people with acute suicidal tendencies or who are at risk to others in connection with a severe mental illness should be cared for elsewhere than they are in psychiatric hospitals.
- Owing to the inconsistent and, in some cases, contradictory legal interpretations, human rights cannot be cited in the question of the legitimisation or non-legitimisation of psychiatric coercion.

2.2. Dissent hypotheses

There has been a clear dissent in various hypotheses. The respective arguments in favour and against are shown in Table 1.

Table 1
Dissent hypotheses on the justification of coercion in psychiatry.

There is disagreement about whether…	Argument against justification (Richter)	Argument in favour of justification (Steinert)
…it is relevant for the general justification of coercion as an option that the majority of people affected by coercion experience the measure as unhelpful.	This removes the legitimisation.	The circumstances of the individual case are always decisive for all ethical and legal considerations.
…the benefit of coercion can only be assessed by the persons concerned.	Ethical legitimisation requires that the persons concerned would have consented to the measure afterwards.	In the case of incapacity to consent, the persons concerned are not in a position to adequately assess the benefits and harms (otherwise they would be able to consent).
…incapacity to consent is a necessary criterion for the use of coercion in a medical context.	Capacity or incapacity to consent are socio-culturally informed normative constructs that are neither undisputedly defined nor clearly operationalised in the sense of a demarcation line.	In terms of medical ethics, incapacity to consent is the central characteristic for legitimisation; coercion is prohibited in the case of capacity to consent.
…an option for treatment is a necessary criterion for the use of coercion in the medical context.	Without an option for treatment, coercion may not be used at all.	If there is no treatment option, coercion can only be justified for short periods of time for diagnostic evaluation (e.g. in cases of suicidality).
…the discussion about the legitimisation of coercion in psychiatry or medicine should be conducted primarily on the basis of fundamental considerations.	Since coercion in the medical context is a medical measure, general evidence-based criteria must be applied to the purpose and benefit of the measure.	The decisive factor is the consideration of fundamental ethical and legal principles in each individual case.
…the use of coercion in psychiatric facilities can be explained by the construct of path dependency	Historically, coercive practices have been assigned to psychiatry and people working there continue to do so.	The use of coercion in medicine is not unique to psychiatry and is not a result of history but of current ethical considerations and legal frameworks.

2.3. General consensus with dissent in detail

There was a general consensus among the antagonists on various further hypotheses. The subsequent disagreement arose, in particular, with respect to the consequences or the interpretation of the consensus. The respective pro arguments and contra arguments can be seen in Table 2.

3. Discussion

We have presented an adversarial collaboration on the question of the legitimisation of coercion in psychiatric settings. This is a methodologically guided procedure that motivates antagonists to work together. The central limitation of our approach should be emphasised at the outset. The most important limitation is that the controversial positions of only two people were used here. It can be assumed that many protagonists in the abolitionist and non-abolitionist camps do not always agree with the details of our respective arguments.

Now to the benefits of our collaboration. Despite the very different attitudes of the antagonists, a surprising amount of consensus was found. There is a common concern that restrictive practices are not applied appropriately in terms of justification and frequency. The human rights aspect of the justification for coercion is also considered

Table 2
General consensus with dissent in detail on the justification of coercion in psychiatry.

Hypothesis (consensus)	Additional hypothesis: There is disagreement about …	Argument against justification (Richter)	Argument in favour of justification (Steinert)
A coercive measure can lead to considerable negative health consequences.	…whether this fundamentally rules out coercive measures.	Possible negative consequences speak against the use of coercive measures	In accordance with principles-based ethics, this does not result in a fundamental delegitimisation, but requires consideration on a case-by-case basis.
The use of coercion in a medical context can only be justified if there is a significant disturbance of brain function in conjunction with a significant risk that is justified by this.	…whether it is possible to determine a functional disorder of the brain with sufficient certainty.	It is not possible to determine a functional disorder of the brain with sufficient certainty.	The decisive factor is the question of capacity to consent, which can be clarified with reasonable certainty.
Psychiatric diagnoses are not valid	…whether coercion is therefore unjustifiable in a medical context	A diagnosis is a necessary prerequisite for a coercive measure in a medical setting.	It is not diagnoses that matter, but the question of capacity to consent.
Capacity to consent is a normative construct.	…whether coercion is therefore unjustifiable in a medical context.	Medical measures against a person's will must be based on scientifically replicable findings.	Many legal regulations, including in social law as a whole, are inevitably based on such normative constructs.
According to available meta-analyses, psychiatric treatments are on average less than "moderately" effective.	…whether this prohibits coercive treatments.	If the therapies associated with the coercive measure are not even moderately effective on average, this does not correspond to the usual evidence criteria that are to be applied in particular to measures against a person's will.	An assessment is required taking into account the available evidence and the particular circumstances of the individual case.
The omission of a coercive measure can lead to significant negative health consequences for the person concerned or other persons.	…whether this is a problem.	According to current research, the consequences of the measure are more serious for the person concerned than the omission. In the case of consequences for other persons, law enforcement authorities are responsible.	In the case of people who are incapable of giving consent, this is the core responsibility of psychiatry.

(continued on next page)

Table 2 (*continued*)

Hypothesis (consensus)	Additional hypothesis: There is disagreement about …	Argument against justification (Richter)	Argument in favour of justification (Steinert)
A ban on coercion in a psychiatric context would lead to a shift in the use of coercion to other institutions.	…whether this is a problem.	The inadequate resources of the police and judiciary cannot be an argument in favour of the non-legitimised use of coercion in a medical context.	Where this happens (e.g. in the U.S.), it is a major problem for the people concerned.
There is no justifiable scientific basis for the use of coercion in a medical context.	…whether this is a problem.	Medical intervention against a person's will requires a sound scientific basis.	Almost all normative decisions have no scientific basis in a strict sense.
The use of coercion in a psychiatric setting does not correspond to the usual understanding of torture.	…whether certain characteristics of psychiatric coercion, such as the humiliating and punishing behaviour experienced by those affected, can be classified as torture.	Both the perception of some of those affected and the current legal assessment of humiliating and punishing behaviour suggest that psychiatric coercion can be considered torture.	The conceptual equation discredits in an intolerable way not only the employees in psychiatric clinics but also the actual victims of torture. However, humiliation and punishment are absolutely unjustifiable.

equally implausible by antagonists (Richter, 2024). There is further agreement that there are no relevant practical alternatives for averting coercion in psychiatry. Both antagonists agree in principle on the problems that the use of coercion causes in terms of justification but also with regard to the consequences for the people affected by it. Additionally, there is an agreement on the sometimes problematic ethical arguments used to legitimise coercion. The antagonists agreed that psychiatric diagnoses and the assessment of capacity are based on normative constructs and have no solid scientific evidence.

Many of these arguments, such as that coercion must benefit the person concerned or that restrictive practices may be applied only in the context of effective therapeutic procedures, cannot be empirically proven (Chieze et al., 2019; Richter, 2025a). Nevertheless, clinicians and psychiatric institutions must deal with people who pose a danger to themselves or others in the context of a mental disorder. Although the legal legitimisation of the measure against the person's will is generally ethically justified, not all ethical criteria, such as beneficence or non-maleficence, are always weighed up in individual cases. Given the pressure on admission practice and the expectation from the social environment that psychiatry will fulfil its dual function as a treating and controlling authority (Steinert, 2021), this is obviously difficult to achieve in many cases. We interpret this broad consensus to mean that both the abolitionist side and the non-abolitionist side are arguing with good intentions and with the aim of benefiting the people affected. We see this consensus and the recognizable good intentions behind it as core findings from our adversarial collaboration.

Disagreement exists in principle but also in detail, predominantly with regard to the ethical and medical conditions for the legitimisation of coercion. This reveals a fundamental difference in the question of whether legitimisation has lost its validity due to fundamental considerations or whether the individual case should be considered. While Dirk Richter favours the fundamental argument, Tilman Steinert argues against it argues against it, suggesting consideration of the special circumstances of the individual case (Steinert, 2024). This difference can be seen as another main insight of our adversarial collaboration approach.

The WPA and WHO paper cited in the introduction concluded with a joint call for reforms in the handling of coercion in psychiatry (Gill et al., 2024). However, in view of the increasing number of restrictive practices in many countries (e.g., Sweden (Nilsson, 2024), France (Ouliaris et al., 2025), the Netherlands (Alexandrov & Schuck, 2021) or Switzerland (Richter et al., 2023)), more is needed than calls for reform. One approach is the implementation of evidence-based guidelines (Steinert et al., 2023). A second approach is improved prevention, for example, the expansion of outpatient acute treatments such as home treatment/crisis resolution (Holgersen et al., 2022) or supported housing (Adamus, Mötteli, et al., 2022; Adamus, Zürcher, & Richter, 2022), which contributes to the reduction of inpatient treatment and thus reduces the risk of coercive measures. A third approach can be derived from our adversarial collaboration, namely, the cooperation of individuals and organisations that pursue the common goal of psychiatric care with less coercion despite different starting positions. In our view, maximalist positions are not helpful but rather the development of consensus arguments that can be used to develop steps toward reducing measures against a person's will.

4. Conclusions

In our judgement, the adversarial collaboration methodology is able to detail both consensus and dissent in relation to the justification of restrictive practices in mental health care. In contrast to a non-simultaneous methodology (e.g., Leal & Marraud, 2022), in our approach, the antagonists were forced to explicitly address each argument of the other side, formulate their opinion and justify it. We believe that this approach has led to new insights, as suggested by the amount of consensus. It remains to be seen whether initiatives such as adversarial collaboration can lead to a better understanding of all the perspectives and stakeholders involved and to collaborative efforts to minimise the burden of coercive measures on the persons affected. At the same time, we can imagine an extension of the fields of application to other empirical, ethical and clinical issues in psychiatry.

CRediT authorship contribution statement

Dirk Richter: Writing – original draft, Methodology, Investigation, Formal analysis, Conceptualization. **Tilman Steinert:** Writing – review & editing, Methodology, Formal analysis, Conceptualization.

Declaration of competing interest

None.

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