

# Awareness of the Need for Change: A Constructivist Grounded Theory of Medical Students' Understanding of Human Rights in Mental Health

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## Abstract

Traditionally, teaching in psychiatry has had a passing focus on human rights. Against this backdrop, the aim of this study was to construct a theory of the learning value of a service user-led human rights-focused teaching program for final-year medical students. We used descriptive qualitative analysis based on constructivist grounded theory to examine final-year medical students' understandings of human rights following a formal teaching program. The overarching theory that emerged focuses on an awareness of the need for change within student learning. This involves both a need for understanding the mental health care system and a need for self-reflection. These two processes appear to interact, promoting learning about the value of a human rights focus. While acknowledging the difficulties in securing such a change, students felt that doing so would be valuable to the practice of mental health. This service user-led human rights teaching program produced new awareness in medical students, both in terms of their understanding of their own biases and in terms of understanding the influence of systemic and structural elements of the psychiatric system on the protection of service users' human rights. Teaching human rights in psychiatry is likely to enrich their future self-reflective practice.

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## Introduction

The teaching of bioethics is a core component of most medical school curricula, though poorly evidenced and assessed.<sup>1</sup> Within psychiatry specifically, there are critical issues related to human rights that are often overlooked or neglected, despite calls for action for over two decades.<sup>2</sup> Mental health legislation allowing for patients to be detained is the most obvious issue; however, the routine use of informal coercion, the rights to accept or refuse treatment, the right to full participation in society, and even such basic rights as housing remain relevant. While no medical curricula can cover all the elements that future doctors will need, the issue of human rights in relation to psychiatry is key to future good practice, particularly in light of international legal obligations and growing rates of mental distress in communities.<sup>3</sup>

Since the Convention on the Rights of Persons with Disabilities (CRPD) entered into force in 2006, its committee and other human rights bodies have provided comment on, and interpretation of, the CRPD as it applies to people who experience psychosocial disability.<sup>4</sup> Of particular note in terms of medical education are resolutions from the United Nations Human Rights Council and reports of the Special Rapporteur on the right to health. For example, in 2019, the Special Rapporteur noted:

*Psychiatrists and users of services both become the hostages of an ineffective system in which decisions to override human rights are based on unsound arguments about danger and medical necessity. It is well accepted in the profession that psychiatrists will often make decisions to deprive persons with certain mental health conditions of liberty to avoid legal action against them “if something happens,” and this leads to misuse and overuse of coercion. Changes in medical education that significantly reduced those power asymmetries and incentives to use coercion would be beneficial for users of services and psychiatrists.<sup>5</sup>*

In this report, psychiatric teaching in this area was identified to be lagging behind medical and surgical services.<sup>6</sup> A resolution adopted by the Human Rights Council in 2020 strongly encouraged states

to provide human rights education and training for health workers and urged universities to consider the integration of human rights teaching into medical curricula.<sup>7</sup>

Such structural and legal changes need the adaptation of medical school teaching to ensure that future doctors are able to understand the individual and societal implications of their actions. This requires a focus on human rights within psychiatric teaching programs that recognizes the unique implication of these changes to psychiatric practice. In order to appropriately consider these rights, coproduced teaching that recognizes the importance of the service user's experience is critical, albeit in its infancy.<sup>8</sup>

With this in mind, the University of Otago, Wellington, reformed its teaching for medical students by developing a variety of modules—all coproduced and delivered with service users—to counter stigma, reduce discrimination, promote recovery, and improve human rights. Coproduction involved equal contributions by academics responsible for the delivery of the psychological medicine module of the medical program, the head of department, a service user academic, and those with lived experience. Initial minimalist interventions were found to have no impact on student attitudes.<sup>9</sup> Progressively more interventions were added, including placements with service user-led and recovery-focused organizations, and assessment of learning.<sup>10</sup> In 2017, the content was extended to include a specific focus on human rights. A comparative cohort study found that while the intervention group had significantly more positive attitudes toward recovery than the control group, there was no significant between-cohort differences in terms of stigmatizing attitudes.<sup>11</sup> We have not to date specifically examined the human rights component of teaching, and to our knowledge there is no clear concept of how this learning is incorporated into medical student thinking or what is gained by this approach within the context of the teaching of psychiatry to medical students.

The aim of this study was therefore to develop a theoretical understanding of the value of a service user-led human rights-focused teach-

ing program within the psychiatric module of a final-year teaching program for medical students. There is no clear agreement as to what paradigm is accepted, and the field is evolving rapidly, so developing such a conceptual theory could enable a clearer understanding of the possible utility of this teaching approach. Given that our primary interest was in the theoretical experience of learning, we considered a grounded theory approach not based on preconceived concepts to be most appropriate.

## Methods

### *Setting*

Teaching in mental health at our medical school spans two clinical years, with a five-week block in the first year and a four-week block in the second. Within the service user-led component of the teaching program, the emphasis in year one is on the impact of stigma and discrimination on outcomes and promoting recovery and well-being, while the emphasis in year two is on the impact of the denial of human rights on recovery and well-being and respecting and protecting people's human rights. It is the year-two program that was of interest in the development of learning theory in this instance.

The six-hour workshop in year two is fully delivered by users of mental health services who have lived experience of mental distress and human rights breaches and is based on key anti-discrimination methods and messages, including repeated, positive interpersonal contact with service users over time and context-specific education targeted at a key group—in this instance, medical students.<sup>12</sup> The workshop first introduces the CRPD and presents its application in practice. This is followed by discussion of the use of the Mental Health Act and human rights breaches inherent in the use of seclusion and restraint, as well as strategies to reduce the use of such practices. The workshop proposes a shift from substituted decision-making to supported decision-making and the use of advanced care planning in protecting the rights of service users. The content is supported by the facilitators' personal narratives about their experiences with mental

distress and subsequent human rights breaches while engaged with mental health services.

### *Data collection*

As part of the program, students were required to write a brief human rights-focused personal reflection at the end of the second year of the course. These reflections were to be drawn from their experiences with the service user-led teaching and clinical service exposure. Students were asked to reflect on what individuals and services can do to promote respect and protect people's human rights. In order to pass, students were instructed to demonstrate their understanding of concepts such as the relationship between the denial of rights and recovery and well-being, how individuals and services can respect and protect people's human rights, and consideration of Indigenous health models. Assignments were marked based on the level of critical engagement that students showed with each of these concepts. The requirement was open ended, which enabled us to use a constant comparative approach to the data, as is necessary for a grounded theoretical approach.<sup>13</sup>

Reflections were marked for course progression before the medical students were then invited to take part in this study by submitting their reflections for our separate analysis. They were given assurance of no disadvantage if they chose not to participate. Participant reflections were then de-identified and submitted to qualitative analysis. Although we were unable to theoretically sample the reflections for the whole cohort (not every student gave written informed consent to participate), we sampled from the reflections available and coded to saturation (see below).

### *Analysis*

To guide the analysis of our data, we used qualitative description based on grounded theory.<sup>14</sup> Given the paucity of understanding as to how medical students experience the nexus between mental health and human rights, the inductive nature of this methodology allowed new insights to come forward from the data, with less imposition of our own preexisting views and expectations. Guided

by this constructivist form of grounded theory, we used constant comparative methods to capture the key experiences of students and remain grounded in the data. Acknowledging the social constructionist view that theory can offer an interpretation rather than an exact picture, our theory in this case can be defined as a conceptual understanding of a social process situated in a particular context.

Initial coding of all included reflections was undertaken by PM and TG separately, with GNH coding selected samples. Researchers met regularly to compare and contrast findings, explore differing viewpoints, and identify recurring themes. This allowed the creation of a set of focused codes that were compared with one another as well as against coded and uncoded reflections. Memos, exploratory diagramming, and tabling formalized the capturing of thoughts, development of ideas, and identification of gaps where more review was needed. As coding and recoding of reflections progressed, theoretical sensitivity began to develop in the researchers. The different backgrounds of the research team enabled a coproduced approach, adding triangulation and reflexivity to the data.

## Results

A total of 38 participants, from a class size of 93, consented to analysis of their reflections, which ranged between 400 and 600 words in length. Although this was a limited number of reflections, it was considered sufficient to analyze and provided reassurance that students in no way felt coerced or obliged to consent to engaging with this project.<sup>15</sup> Additionally, the methods used looked for content saturation as opposed to a review of all information, and for this reason we recognized a priori that it was unlikely that even 38 reflections would be needed to reach saturation.<sup>16</sup>

Six of the 38 participants provided no demographic data. Of the remainder, 53% were women, and 47% were men, with a mean age of 24. Sixty six percent were New Zealand European, and 22% were Asian, with Māori (the Indigenous population) making up less than 10% and other ethnicities making up 12.5%.

Theoretical saturation was reached after 20 reflections, as no new codes, themes, or major perspectives were emerging from the data. The underlying concepts from the data were considered to have formed. Consideration of conceptual density suggested that the analysis was robust, as iteration and recoding did not redefine the conceptual categories. The constant comparative process elevated the data through higher levels of abstraction, with two major categories emerging: *understanding the system* and *self-reflection*.

### *Understanding the system*

Clinical, legal, and ethical issues were among those appraised through learning interactions during attachments. Participants highlighted what they saw as challenges and opportunities. Three elements in the data made up this category: appreciating advocacy, appreciating complexity, and developing a personal perspective.

**Appreciating advocacy.** As participants went about understanding the system around them, they experienced a sensitivity to the narratives of the service users they encountered. They considered service users and their rights as vulnerable to a range of pressures, including stigma, power imbalance, and a professional tendency toward paternalism:

*This difference comes from the philosophy of our health professionals and what we are taught in our training. Almost all health professionals are aware that people with disabilities and mental illness are a largely marginalised and vulnerable group, often with worse health outcomes than other populations. With this in mind it is a natural reaction to try and compensate, to become more concerned over their health difficulties and become very rigid in our thinking that we must deliver our “best practice” of healthcare to this group. This may even come at the cost of their disagreement, but we are OK with that as health professionals because “that’s just a part of the illness.” (P20)*

This sensitivity established a rationale for advocacy. The role of the medical professional in supporting this also became clear. Some reflections expressed the need for a more active debate regarding the

place of advocacy. Overall, this element of how the system worked appeared to have a sensitizing effect and marked the topic as one for further exploration during medical learning.

**Appreciating complexity.** The awareness of nuance within the topic was not lost on participants who appreciated the different opinions and pressures at play. Participants' experience with this complexity emerged from the data in three forms: that the denial of rights was harmful, that there were justifications for the denial of rights at times, and that reconciling this ethical conflict was very difficult.

Participants came to understand that when rights were restricted, longer-term effects could run counter to therapeutic intention:

*They told us how this [compulsory treatment] had made them feel powerless, and led to a distrust of mental health workers, and thus they were less likely to seek help in future. This was a very clear illustration of how denying the human rights of a mental health patient can hinder their recovery by directly reducing their future contact with mental health and other medical services, potentially also putting them at risk of worse health outcomes in regards to other health issues. (P3)*

Experienced as challenging influences on decision-making, society's expectation of beneficence and its tolerance for risk were presented as ethico-legal limitations on an otherwise general promotion of rights in mental health. This experience of "finding it difficult" seemed to help participants appreciate the complexity of the area of inquiry. This awareness of conflicting views and practices shaped participants' perspectives based on what they had encountered:

*[What] I have found most difficult to come to any conclusion on is the dilemma of treating a patient in their "best interests" versus respecting their autonomy and their right to make decisions. In the complex area of mental health, I feel this can sometimes be an impossible conundrum. It is incredibly difficult because I can see both sides of this dilemma and they both have good reasons behind them ... I am still unsure of the answer, and I don't think there is a "right" answer as such. (P8)*

**Developing a personal perspective.** This process of shaping and clarifying opinion followed from the earlier sensitization to the subject and assimilation of knowledge described above. The common factors in this process included participants' understanding of the protection of human rights as a moral imperative, and the idea that services and society need to adapt to achieve this protection:

*Instinctively I feel that it [protecting rights] is what is what will lead to the best patient experiences of mental health care and ultimately better patient outcomes than a more paternalistic, coercive manner of treatment. And potentially more importantly, it's the just thing to do. (P2)*

Participants developed the perspective that addressing the social determinants of health was necessary if substantial reform in rights protection was to be realized. This was in tandem with a view that coercive practices were symptomatic of overburdened systems and underfunded systems:

*I believe these seclusion rates are more likely to represent the underlying foundational and functional issues that are present within the mental health system. These are where I believe the focus needs to be, with the trickle-down effect leading to reducing seclusion. (P17)*

### Self-reflection

This describes a process of participants examining their own backgrounds, attitudes, and biases as related to human rights. Participants experienced a personalization of the issues by viewing them through the lens of future clinicians. This opportunity to review their comfort with the issues appeared to be welcomed. It helped foster a mind-set that was open to different opinions. The data demonstrated three key elements that helped explain this process: realizing naïveté, the power of lived experience, and thought-provoking teaching.

**Realizing naïveté.** Participants described becoming aware of the contrast between previously held assumptions and newly acquired information after their attachment. Many experienced surprise and

unease upon learning that the services they could soon work in were considered in breach of human rights by the United Nations. On being exposed to different perspectives, some looked back on their accepted narrative and saw it as one-sided:

*I had only been exposed to the point-of-view of my psychiatry team, who are not on the receiving end of treatment, so this was really insightful for me. (P6)*

*It initially seemed to me as if we were only discussing this as a result of a continued hangover from the old way of practicing psychiatry. (P2)*

While acknowledged as uncomfortable for participants, the realization of naïveté was largely embraced as a motivating factor to engage in the clinical and teaching experiences that followed. This likely helped participants be aware of their own background and bias when viewing scenarios that they would previously have not questioned.

**Power of lived experience.** Participants experienced strong internal reactions to hearing lived experience directly from service users, which led to a humanizing effect. The relational empathy that was evoked allowed greater salience to be allocated to the issue and helped stimulate the reflection process. This novel experience was reflected on as a turning point and a motivator to seek change:

*It was devastating to hear the stories of many of the individuals I came across, and it opened my eyes to true suffering and conflict. It was very clear to see how denial of their human rights, through belittlement and prejudice, had a large detrimental impact on their recovery. (P18)*

These narratives prompted participants to examine their own moral comfort with being part of such practices. The concept of a lived experience gap between staff and service users was felt by some to be difficult to bridge:

*I don't think that this is something that the traditional mental health service can ever give to the people they care for. (P7)*

**Thought-provoking teaching.** It emerged from the data that concurrent exposure to service user experiences alongside the usual clinical attachment made participants feel more open to the rights issues they came across. The teaching program seemed to act as a framework of experiences that prompted participants to question and rethink their comfort with current practice:

*These placements ... and the tutorial, have helped me to be more self-aware—including being able to recognize unconscious stigma held by myself and others ... This was a huge learning point for me regarding the challenges service users face on a daily basis. (P18)*

*I am seriously considering a career in psychiatry, and because of this service user-led component of the modules I can say my attitudes towards compulsory treatment have been challenged. I think that the use of compulsory treatment needs to be more carefully considered in each circumstance. (P16)*

### *Grounded theory of “awareness of the need for change”*

Our theory of awareness of the need for change encompasses two key components: *understanding the system* and *self-reflection*. These two components can be thought of as distinct but synergistic processes. *Understanding the system* entails how participants went on to comprehend the issues of human rights in the context of mental health services, appraising experiences during their attachment and identifying the challenges and opportunities. *Self-reflection* describes the process of how participants examined their own backgrounds, attitudes, and biases regarding human rights.

First, the distinction between the categories appears to be in their origin. As part of their academic course, participants set about collecting observational and interactional information to understand the system and how rights were managed within it. This process appeared learned and automatic to participants. This contrasted with the more elusive, internal processes involved in self-reflection, which were initiated by emotive triggers

encountered through the clinical attachment.

Second, a relationship between the categories emerged as one of synergy. As participants began the process of understanding the system, they encountered practices and heard reports that made them uncomfortable. Their general understanding was that services should face a high bar to justify the harms from denial of rights, but that this was not always happening. This was a surprise to many and prompted self-reflection to reappraise how their own background could affect what they had assumed was good practice. Envisioning themselves as nearly clinicians, they pondered how they would justify clinical decision-making within the tension created between the duty of care and the protection of rights. Establishing a cycle, this self-reflection then prompted a need to understand the system more deeply.

The interplay between the two processes continued for participants. Renewed information gathering unearthed more areas of conflict, which served to further the questioning of accepted practice and increase openness to narratives from outside the medical realm. The cycle of understanding the system and self-reflection was thus established and gathered momentum.

This momentum would ultimately manifest in participants as a drive for change. This drive included motives of advocacy on behalf of disadvantaged groups, a moral imperative to protect service users' autonomy, and unease with the injustices in current health outcomes. Their combined effect was sufficient for the realization of a change-seeking stance. While acknowledging some of the legal and practical challenges to making change in this direction, participants struggled to accept the status quo as good enough and wanted to practice in a system that better upholds the rights of service users. Thus, an awareness of the need for change was created. We theorize this awareness around change as explaining how participants qualitatively experience human rights in mental health.

## Discussion

This study aimed to develop a conceptual under-

standing of the impact of service user-led human rights teaching for final-year medical students in the psychiatric context. The findings make clear that such learning is challenging, engages deep thinking, and in some cases leads to a reappraisal of the context of psychiatric practice by the medical students involved. This study is, to our knowledge, the first of its kind in this area and supports the inclusion of such programs in psychiatric medical school teaching given that they align with a human rights ethic and the requirements of conformity to CRPD obligations.

Two major concepts of learning underlie the teaching program explored here: (1) a clearer understanding of the impact of psychiatric systems as it affects human rights and (2) the importance of self-reflection in practice. There is a face validity to these findings, and it is not hard to see the importance of these factors for people who, within less than a year, will be delivering health care as doctors. It is also not hard to speculate that such learning could generalize to other areas of health care, and indeed both of these concepts may be critical to becoming a good doctor irrespective of one's field of expertise. Although the teaching program was designed to be specific to psychiatry, and the content of responses was psychiatrically informed, our research highlights the relative benefits that may be felt across many areas of specialty.

The subthemes describe a process of internalizing this learning and using it as scaffolding for the understanding of clinical placements. This process of internalization enabled issues such as advocacy and complexity to add richness to concepts of medical systems and encouraged a transition away from the didactic learning of facts toward the forming of personal understandings of human rights in the health care context. In a similar vein, this personalization of values required self-reflection and the uncomfortable reality of naïveté in those so close to completing a six-year medical degree.

This research project has limitations that need to be considered. In all qualitative research, it is important to acknowledge the difficulty of generalization. Nonetheless, this project facilitates an understanding of the benefits garnered from such

a program and the possibility of similar benefits being uncovered in other domains. Further, to our knowledge, there is no formal quantitative tool for examining human rights teaching, and this study identifies domains to be quantified in future research. Another limitation is the constraints of the data collection. In a more classic grounded theory approach, tailored data collection, with iteration of questioning, allows for greater detail and nuance to be gathered within the accruing data. We were unable to do this due to the nature of our dataset. Moreover, the prescriptive nature and contained word limit of the assignments, in addition to the necessity of obtaining a passing grade, may preclude students from airing views that could be at odds with the teaching objectives. That said, students were remarkably frank in their reports. We have acknowledged this limitation in the description of our methodology and were cognizant of it during data analysis. We aimed for both data saturation and conceptual density in our analysis to minimize the impact of this limitation. Nonetheless, it is possible that following a more classical grounded theory approach would enable greater nuance and possibly an overarching theory of this teaching frame to become apparent.<sup>17</sup> Finally, only a proportion of those who completed these reflections consented for them to be used in our research. For ethical reasons, we are unable to provide demographic data for those who did not consent to participate. It is possible that divergent concepts exist among the non-consenting group, and we are unable to ascertain what these may be, if any. This is, however, a minor limitation offset by the reality of reaching saturation prior to analyzing all 38 reflections.

## Conclusion

Based on this research, we are confident that a co-produced human rights-based teaching program for medical students enables growth and learning within the medical teaching paradigm. Such a program meets the needs of modern human rights ethics and the obligations of nations-states that are signatories of the CRPD. We encourage the quan-

titative development of tools to further assess such teaching and the development of research alongside innovations in psychiatric teaching and learning.

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## Ethics approval

The study was approved by the University of Otago Human Ethics Committee (D17/386; 18/082).

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