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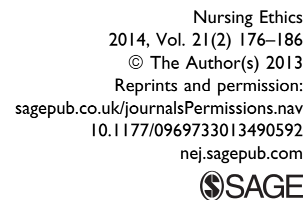

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Undignified care: Violation of patient dignity in involuntary psychiatric hospital care from a nurse's perspective

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Abstract

Patient dignity in involuntary psychiatric hospital care is a complex yet central phenomenon. Research is needed on the concept of dignity's specific contextual attributes since nurses are responsible for providing dignified care in psychiatric care. The *aim* was to describe nurses' experiences of violation of patient dignity in clinical caring situations in involuntary psychiatric hospital care. A qualitative design with a hermeneutic approach was used to analyze and interpret data collected from group interviews. Findings reveal seven tentative themes of nurses' experiences of violations of patient dignity: patients not taken seriously, patients ignored, patients uncovered and exposed, patients physically violated, patients becoming the victims of others' superiority, patients being betrayed, and patients being predefined. Understanding the contextual experiences of nurses can shed light on the care of patients in involuntary psychiatric hospital care.

Keywords

Caring, dignity, group interviews, hermeneutics, psychiatric forensic care, violations

Introduction

Caring and caring ethics are pushed to their limits in involuntary psychiatric hospital care, where patients have not reached out for help but are treated without informed consent. Violation of patient dignity under these circumstances can be understood as far more offensive since patients do not have the ability to protect themselves and their own well-being by, for example, discharging themselves from the clinic or declining to receive treatment. As Kogstad[1] claims, these patients are in a vulnerable situation where professionals traditionally take action on their behalf. Jacobson[2] teaches us that if given the choice, patients avoid people and places they know to be violating their dignity—even if it means being without the service. The

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importance of respecting and preserving human dignity has to be seen universally, and the need appears in nearly every healthcare experience,[2] as dignity is one of the most important attributes in involuntary psychiatric hospital care. The aspect of compulsion is one of the things that distinguish psychiatric care from somatic care with respect to dignity.[3]

Background

In previous research as well as in political discussion, the topic dignity has been highlighted as one of the most important ethical concerns in nursing care. There are studies pointing out that people who experienced respect for dignity during healthcare encounters received optimal care and found more satisfaction in the care provided.[4] Thus, one should see dignity as important not only for nursing but also for the pragmatic outcomes of provided care. Protection and respect of patient dignity are both described as an ethos in professional nursing care.[5,6] Jacobson[2] claimed that violations of patient dignity are more common when the relation between two people becomes asymmetric. When one actor has more power, wealth, strength, and authority, one is more likely to see violations of dignity. In the hierarchical environments people meet when they become patients, there is always a risk that this asymmetry becomes the first step toward violations of dignity. Nearly every situation where people come into contact with healthcare, they are put in situations that can be embarrassing, humiliating, or shameful.[7] Kogstad's[1] research shows that patients treated without informed consent often experience humiliating situations that even contribute further harm and trauma to their already-wounded souls. There is research in this type of context showing patients feeling offended because of the nurse's abuse of their power, use of constraint, and lack of support.[8] Further to this, Hem and Heggen's[9] research shows that many psychiatric nurses feel frustrated at not managing to realize their own professional and ethical ideals and that this grows into insurmountable ethical dilemmas arising from their working conditions. Lindwall et al.[10] show that human dignity in psychiatric care can be preserved when nurses act on their ethical responsibility. This can be violated if there are value conflicts in the situation. This can happen even when the psychiatric patient is vulnerable, dependent, trusting, and confronts the nurse with a constant "ethical demand" to take good care of him or her.[9]

A large amount of research has been performed exploring dignity in different praxis;[7] yet there is still a need for research that focuses on the concept's specific contextual attributes since nurses are responsible for providing care that respects the dignity and individuality of each patient.[11] Such research can support the understanding of the psychiatric patient's dignity and can be used as a foundation for strategies, programs, and caring cultures building on the awareness of these patients' vulnerable situation. This knowledge can be used as a part of nurses' self-conscious control and can help them regarding questions such as: What is good, what is esthetic and ethical in this situation, and what is not?[9]

The area of interest in this study is nurses' experiences of violation of patient dignity in clinical caring situations in involuntary psychiatric hospital care. The following research question was posed: How do nurses in involuntary psychiatric hospital care express their experiences of own as well as others' violation of patient dignity in their daily work?

Method/design

An explorative and interpretative design with a hermeneutic approach inspired by the philosophy of Ricoeur[12] and Gadamer[13] was used in order to gain in-depth understanding of nurse's experiences of violation of patient dignity in clinical caring situations in involuntary psychiatric hospital care. Gadamer[13] focuses on pre-understanding and fusion of horizons and emphasizes that those who express themselves and are connected by a common human consciousness make understanding possible. Ricoeur[12] helped us with

the de-contextualization, which is a question about distancing to gain a new understanding of the phenomenon.

Participants and data collection

Nurses and enrolled nurses from two different hospitals providing involuntary psychiatric hospital care in the south of Sweden were invited to take part in the study. The nurses received an invitation letter after approval from the chief administrative officer. A total of 15 nurses, 10 women and 5 men, answered and took part in the study and represented 7 different psychiatric wards providing involuntary care. The participants were between 27 and 52 years of age. These nurses were divided into two different interview groups and were interviewed once a month for 9 months, which resulted in 17 audio-recorded group interviews ranging from 60 to 90 min. The first interview was a pilot one and was not tape-recorded.

Bradbury-Jones et al.[14] suggest that individual experiences can be preserved within a group context and that it can even be beneficial because it stimulates discussion and opens up greater understanding of the phenomena. The hermeneutical circle means that the researcher is involved in the process of interpretation as well as the research persons, which is not seen as a contamination but as a resource leading to new understanding. The group approach helps to maintain focus on the phenomena and stimulates discussion. A group interview allows the participants to hear each other's stories and add their own perspective and similar experience. This would not come up in individual interviews, which can be useful as a part of the interpretive approach.[14] The interviews took place in the two hospitals where the nurses were working. The informants were informed in advance that they would be asked to speak about specific caring situations where they experienced that patient dignity was violated.

Ethical approval

The study was approved by a local ethical university committee. All participants were informed that participation was voluntary and that data collected would be handled confidentially. Further ethical aspects were considered based on the World Medical Association Declaration of Helsinki.[15]

Analysis

A hermeneutic method for analysis and interpretation of the text inspired by Ricoeur[12] and Gadamer[13] was used. A similar analysis procedure was previously described by Nyström and Svensson.[16] The phases of the hermeneutic analysis were as follows: (a) An *open reading*, according to Gadamer,[13] was conducted in order to obtain a sense of the text as a whole. (b) *Tentative interpretations* were expressed. In this phase, Gadamer's thoughts about open reading to gain interpretations for deeper understanding and Ricoeur's[12] thoughts about critical reading to gain explanatory interpretations were matched. At this stage, caring theory about human dignity described by Eriksson[17] and Lindström et al.[18] became useful. Dignity in this theoretical view is partly absolute, partly relative, where absolute dignity is given to humans at the time of creation and involves the right to be confirmed as unique. On the contrary, relative dignity is influenced by the world the person meets.[19] The interpretation process was also guided by knowledge about dignity expressed by Nordenfelt[20] as four varieties of dignity: dignity of merit, dignity of moral or existential stature, dignity of identity, and finally, the universal dignity, which pertains to all humans and cannot be diminished or lost in any circumstance. A third theoretical guide was Eriksson[17] and Lindström et al.'s[18] theory of caring that claims the caring act as an affirmation of the other in order to safeguard the individual patient's dignity. This appropriation is able to restore the human being and make him or her a more genuine human in an ontological sense. (c) At the third phase of interpretation, different and opposite interpretations were searched for

and the authors went back between the parts and whole of the text in order to search for discrepancies between understandings of the parts and the more overall interpretation. Finally, a *comprehensive interpretation (interpreted whole)* was formulated that was able to widen and deepen the understanding in order to promote a deeper understanding of nurses' experiences of violation of patient's dignity in clinical caring situations in involuntary psychiatric hospital care.

Findings

When identifying the thematic pattern that illuminates the nurses' experiences of violation of patients' dignity in clinical caring situations in involuntary psychiatric hospital care, analysis resulted in seven tentative themes; *when patients are not taken seriously, when patients are ignored, when patients are uncovered and exposed, when patients are physically violated, when patients become the victim of another's superiority, when patients are betrayed,* and *when patients are predefined*. These themes were completed in a comprehensive interpretation.

When patients are not taken seriously

The nurses experienced situations when patients were not taken seriously by staff as violation of patients' dignity. It could concern situations when the staff discount a patient's credibility expressing their dreams or thoughts about the future. This doubting attitude was sometimes expressed in words, but more often shown by the staff's body language, with sighs, gestures, and so on. Occasionally, staff seemed to feel a responsibility to express the expected prejudgment of the community—that, for example, the police, social counselors, judges, and so on would not believe the patient's side of their story about what really happened:

> A patient said to me that someone on the staff had told her it was unnecessary to report the abuse to the police. They said, "Do you think they will believe you? It would be dismissed anyway."

The nurses also experienced that patients were not considered sane regarding physical symptoms. Patients often complained about not being taken seriously when they were trying to express physical pain or other symptoms regarding the body:

> He has not been believed regarding his somatic problems before because everyone claimed that they were psychological.

Patient dignity was violated by not taking their expressions about physical sensations seriously as symptoms originating from the body and rejecting them as delusions or as a mark of mental affliction. In these situations, patients were not being met as credible adults having the ability to describe their own experiences.

When patients are ignored

The theme about being ignored differs from the above-mentioned theme, from not being taken seriously to not being involved at all in an encounter. Patients could receive important decisions made by physicians or other staff without any explanations whatsoever. Nurses often experienced that patients received answers without any room for communication:

> One violation regards medicine. They often receive the answer—There is nothing to discuss! They have to receive medication that they don't want and they just want to know why? But the only answer they get is—End of discussion!

Some nurses experienced that this type of answer often seemed to be an indication that the staff did not have the energy to engage themselves in the patient's problems or suffering. Often, no one had the will to take time off and listen to the patient's story or complaints, and it was humiliating for the patients to badger and beg for attention. The nurses also expressed that the more the patients begged for attention, the more they were ignored. Nurses found that being ignored caused more and more anxiety to patients, which could lead to them being ignored even more:

> He didn't just want people to sit and stare at him. Then he had to make the next move . . . and the next, which resulted in them stopping looking at him. It was scary; they didn't look at him. It was like he didn't exist.

To be ignored seemed to be a subtle kind of violation but one of the violations mentioned by the nurses that awakened most anxiety for the patients. Still it seemed to be mentioned as the most common mistreatment made by tired or overwrought staff.

When patients are uncovered and exposed

Being exposed could be regarding the patient's physical body but could also refer to uncovering a patient's life as a whole during different kinds of meetings on the ward that nearly always included a lot of people the patient did not really know, or had not chosen to tell his or her life story to. Just being in involuntary care gave a lot of people access to sensitive information about the patient's life. The patient could not limit this access to sensitive information:

> When we sat there at a network meeting, there were a lot of people there that steered the meeting and he sat in the middle. I thought about being that patient and being exposed to this kind of scrutiny. You know, they don't sit there in a relaxed way. They sit there to review/criticize the patient.

Nurses experienced that the patient had no power to control the situation or the flow of information regarding his life, health, past, or future and had to totally trust the good intentions of every single person involved in the meetings. Few human beings outside the world of involuntary hospital care have had to endure this phenomenon. Even in the ward, patient health often seemed to be exposed in front of other fellow patients:

> Then there are those patients that are ashamed of receiving this kind of medicine. I think a lot about that: When they sit down eating breakfast the nurse comes out with the medicine wagon and stops at X. She gives him his medicine pot with 4 different pills and every fellow patient can see how many pills = how crazy the patient is thought to be.

A nurse said that there were a lot of patients trying to preempt this violation by knocking on the nurses' door 10 min before medicine time. Patients often tried to avoid the violation of dignity caused by being exposed and were treated as demanding or as seeking "special" attention, which in turn made them victims of another violation mentioned in the above-mentioned theme—*when patients are ignored*.

When patients are physically violated

The violation of a patient's physical body was experienced as a violation of patient dignity in situations where different kinds of restraints were used. Touching or holding parts of the patient's body against the patient's will became one of many other violations committed at the same time and was often impossible for the staff to totally avoid, although there was a consensus in the interview groups that the violation could be diminished if the restraint was well planned and discussed beforehand. The statements regarding

physical violations of patient dignity were often filled with anxiety from the nurses themselves in the interview groups and seemed to be the hardest component of working in this context. In the narratives, there were numerous testimonies of violent situations that stayed in the nurses' minds as traumas, but there was also an overall understanding that violence cannot be totally avoided in this type of care:

> The thing with forcing someone you never come to terms with it being nothing but a violation, but it is well-meant—That it is done to protect both the patient, staff and other fellow patients.

Physical violence or restraint is in its character a violation of dignity and becomes even more violating in situations where the conditions and parties involved are obviously asymmetrical.

When patients become the victim of others' superiority

The caring relation is asymmetrical in its foundation, and it becomes especially visible in involuntary psychiatric hospital care. Patients end up in an inferior position when compared with the staff with power over the patients' life in the ward as well as their future. Administrative routines often support these power positions, and patients have to subordinate to effectual circumstances during involuntary care and treatment. One of these circumstances that violate patient dignity is the juridical boards patients have to visit regularly:

> If they could they should get off going there! I mean, they are totally different human beings. The lawyers and the experts are from a whole different world. One is in an inferior position all the time. Even the clothes show that you're below them. You have to defer to these people to get something or somewhere you want. If you are cocky or try to hold your head up high—you get nothing!

This quotation illuminates nurses' experience that patients have to put aside all personal dignity to get somewhere they want or something they want. The nurses also illuminated the violation of being treated in a hierarchical system and being treated like a child when you are an adult. The care takes place in conditions where it is common for staff to rebuke, lecture, and reprimand the patient and his actions in ways that no other adults are exposed to. Although the nurses were well aware of this problematic position, they could identify the phenomena even in well-meant actions:

> When I was going home after one working day I said—Have a nice time everyone! . . . That was a violation itself. I went home; I was going to have a nice time. But to say it to a group of patients can be incredibly violating—For god's sake, we will be sitting here in this hell! What are you talking about?

Although the staff constantly tried to diminish this asymmetric relation, they recognized time and again how hard it was to create a fellowship when their human conditions were so completely different and when the patient was still a victim of the superiority of others.

When patients are betrayed

During involuntary psychiatric hospital care, the patient can be betrayed in many different ways, and it is always at the cost of the patient's human dignity. In the asymmetric relation to staff, the patient becomes vulnerable and depends on staff promises. It is not uncommon that the staff break their promises deliberately or unconsciously. This could concern not only very explicit promises but also promises the patient had read into a situation themselves. However, this is always a violation that hurts the patient to the core:

> I remember when we planned to go to a barbeque. We had promised him that he could join us. And then the physician said no! The patient took a knife and threatened X. He was removed from our ward because of that. It was so wrong! He had managed to care for himself in a good way and everything he had worked for was destroyed in that moment.

This quotation elucidates deception by broken promises, but it also illuminates a betrayal letting the patient fail and collapse. This was beyond the control of the nurses, although the nurses in the interview groups had many suggestions of how to avoid these violating situations. Thus, actions can violate patient dignity, but neglecting actions are also violating:

> The home community wasn't especially interested in taking responsibility for the patient. Then they deliberately let the patient go out and fail getting it on paper that the patient is not capable of living out in their community.

Although the nurses recognized how they betrayed patients in their daily work, this was often not reflected upon but it was very hard to see patients blatantly betrayed by others in society who destroyed the patient's future dreams.

One other deceiving action that was brought up as patient dignity violation was abandoning or not taking the role as the patient's only spokesman. This spokesman saw the patient all day long having the power to advocate and, to defend patient dignity, perhaps not totally, in this vulnerable situation.

When patients are predefined

To be predefined was brought up as a violation of patient dignity. This concerns the depersonalization of the patient as an involuntary psychiatric patient. The nurses experienced that the patient's right to be a human being in society was often taken away. The patient was being denied not only his or her previous role but also potential role as an adult. Psychiatric illness also awakens prejudgment of how unpredictable or even dangerous psychiatric patients could be. This branding affects the society's judgment of the patients or their relation to staff:

> When x came in to the dayroom, I said "Hi." But I waited to see how he would react. I knew his diagnosis.

The nurses experienced that staff went on their guard if there were new patients with a diagnosis that was known to be potentially violent. This is a natural reaction among staff and can be seen as a prerequisite for safe care, but still, it adds to patient depersonalization and can lead to the patient experiencing dignity violation. This definition as a psychiatric patient could be visible in the ward and also became very obvious when patients came in contact with other caregivers outside the specific psychiatric context:

> On the medical ward no one came in and wanted to nurse him. They wanted us to do it though we had no knowledge about cancer care. There was a fear of him being schizophrenic. He was so sick with cancer and couldn't make a move but still they saw him as a dangerous "psychiatric patient."

According to the nurses, branding patients in this way only added more suffering and prevented the process toward health and self-esteem. Diagnosis or the fact that they had been cared for on an involuntary psychiatric ward became a burden and often had lifelong consequences.

Comprehensive interpretation (interpreted whole)

The nurse's experiences of violation of patient's dignity in clinical caring situations in involuntary psychiatric hospital care appears in this study as seven illuminations in the form of tentative themes that can be

interpreted as different aspects of dignity. None of these tentative themes can be seen as a violation related only to one dimension of the human being but affect the patient's whole existence. Looking at Nordenfelt's[20] mentioned varieties, dignity of identity became most visible in the text. Dignity of identity grows in relationship to others and becomes the basis for self-respect. The phenomenon describes an adult as not being taken seriously, being ignored, or betrayed by another human being in a situation where one does not have the option of leaving the people who treat or humiliate you. This situation is unique for this context. In relation to Eriksson,[17] Lindström et al.,[18] and Edlund's[19] explanation of dignity, even the absolute dignity, which involves every human's right to be confirmed as unique, was experienced as violated by predefining the patients according to their diagnosis. The lack of confirmation as a unique human being could also be seen by the ignorant attitude of the staff that seemed to be the component that awakened most anxiety among patients in involuntary psychiatric hospital care. Nurses illuminated the violation caused by the stigmatization of the patients as causing more suffering than physical violation, although the latter violation at first sight seemed more dramatic. In one way, the nurses seemed to think that the patients more or less had some understanding that this may be inevitable. The dramatic situations where patient dignity was violated were discussed, and the patient achieved some sort of comfort or apology. However, it was the subtle acts of staff that included carelessness on the part of the caregiver that violated patient dignity in the deepest way. This kind of violation can be seen in relation to Eriksson[17] and Lindström et al.'s[18] theory of caring as the staff's failure to affirm the other and safeguard the individual patient's dignity. There seemed to be a contrast between the more "dramatic" or visible violations of patients' dignity (when patients are uncovered and exposed and when patients are physically violated) and violations that were more subtle (when patients are not taken seriously, when patients are ignored, when patients become the victim of another's superiority, when patients are deceived or betrayed, and when patients are predefined). Nurses' experiences predominantly indicated that the more subtle violations caused more harm to patients' health than the "dramatic" ones. The more dramatic violations of dignity often also put the nurse as a victim of circumstances, and therefore could more easily confirm the patient's experience of being violated.

Discussion

Our intention was to illuminate nurse's experiences of violation of patient dignity in clinical caring situations in involuntary psychiatric hospital care. We want to claim the importance of continually focusing on these kinds of ethical problems in the care of vulnerable groups of patients, especially groups who have not chosen care voluntarily but are treated without informed consent, as well as earlier research in the area[1,3,6] has done. As Kogstad[1] claims, nurses have the right to take action on behalf of the patients, which makes patients especially vulnerable. The researchers in this study were well aware of the fact that patient dignity was violated on their wards every day, but they did not have an overall view of the patterns of these violations. More and more of these patterns became visible during the 9 months of group interviews, both to the researchers as well as to the nurses involved in the study. As Rytterström et al.[21] describe, often nurses' ambition to follow ward routines can explain why nursing loses its humanity and instead violates patient dignity. Sometimes caring acts become "common sense." It is not considered that routines can be experienced by patients as violating and as an indignity. As Gustafsson et al.[6] claim, protection and respect of patient dignity is an ethos in professional nursing care, and violation must always be seen as failure. In this specific context, however, it seemed to be next to impossible to totally reduce the violations, as violations of dignity are more common in asymmetric relations, as Jacobson[2] claims. Since these patients are involuntarily held behind locked doors, the relation between the nurse and patient can never be symmetric, and it is very hard to avoid these kinds of violations. One can ask in line with Wainwright and Gallagher[7] whether this is not the case in all healthcare where patients are put in situations that can be embarrassing,

humiliating, and shameful, and therefore, look at the results of this study as an extreme variant but nevertheless in some way transferable to other healthcare contexts.

Even if ward staff do all they can to minimize the violation of patient dignity, there are some violations that are very hard to totally eradicate. These violations threaten the restoration and self-respect of patients as human beings as well as reconciliation with health.[22,23] Failure to safeguard the individual patient's dignity and the more obvious violations can be avoided. Being a nurse in involuntary psychiatric hospital care often includes situations where patients are exposed, are physically violated, or become the victims of others' superiority, no matter how hard they try to safeguard patient dignity. These situations are often built into the involuntary psychiatric hospital care institution. Stigmatization is connected to society's prejudgment and is therefore beyond the control of the single nurse. Violations like not taking the patient seriously, ignoring, or deceiving the patient can be seen as something nurses could do a lot to minimize on their ward. Hopefully, this illumination can serve as a tool to discuss patient dignity violation and improve the planning of involuntary patient care.

Methodological issues

There is always a question of how to collect data to illuminate phenomena that are hard to talk about or even hard to understand in depth. Here, we chose to invite nurses to talk about their experiences of patient dignity violation. In one way, this could be considered as a detour around the patient's own narrative about the subject. On the contrary, patients in involuntary psychiatric care are in such a vulnerable situation and are totally dependent on the goodwill of the staff, and therefore, they have a hard time being completely truthful and honest in the presentation of their experience of violations. Thus, this method was considered too hard to handle ethically at this point in the research. There is another point that illustrates the nurse's experience of patients' dignity while witnessing un dignifying acts; it is that it would affect the way they will keep on relating to their patients. Since according to Eriksson,[17] the way we perceive the human being is the way we treat him or her. This study is based on a limited number of participating nurses, thus they were interviewed a number of times (9 to 10 times) and represented seven different involuntary psychiatric wards. This provided us with a lot of caring situations and narratives told by the nurses involved. This limitation could be seen in the light of Ricoeur,[12] who meant that it is not the experiences themselves we are looking for, but the best interpretation of the common meaning. In that case, the number of participants is not of interest but the understanding that can be lifted from the text narrated by the nurses.

Conclusion

Findings from this study illuminate nurses' experiences of violations of patients' dignity in involuntary psychiatric hospital care in Sweden. Bearing in mind differences in culture and politics, these findings could serve as a starting point for discussions and reflection in other countries. The violation of patient dignity in clinical caring situations is not only a problem for nurses in involuntary psychiatric care nor is it just a national problem. Nurses face many challenges related to ethical issues in everyday interaction with those patients most sensitive to violations due to the asymmetric nature of the relationships. This should be guided by supportive environments where nurses can openly reflect and build a conscious awareness of their actions, and results of acting or not acting, related to patient care. The findings could also provide grounds for discussion and suggestions about structural changes toward preventing violation of patient dignity.

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Conflict of interest

The authors declare that there is no conflict of interest.

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