Caring With Dignity: A Q-Methodological Study of Staff Members' Experiences in a Psychiatric Context

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Abstract: *We undertook three independent, but related, Q-methodological studies on views of "dignity" from the perspectives of patients, relatives, and staff in the context of a hospital-based mental-health setting. This article discusses the results from the study among staff, focusing on their interpretation of the term* dignity *in patient encounters. The following research question was asked: "Based on your experiences, what does the term* dignity *mean to you when caring for patients in a psychiatric ward?" Based on theory and interviews, a Q sample of 51 statements was drawn from the concourse. Statements were sorted on a most agree to most disagree scale. Twenty-five staff members responded and post-interviews took place with all participants. Results were analyzed using the PQMethod program. Two different viewpoints emerged. In Viewpoint One, the focus is on the patient and on overarching values that promote an idea that we are all unique and equal individuals but also that, as humans, we are vulnerable. Viewpoint Two focuses on challenges staff face in maintaining patient dignity during patient encounters. An increased awareness of the opinions raised through both viewpoints may help increase understanding among staff, and thereby form the foundation for upholding patients' dignity.*

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"Dignity" is a term encountered in a number of contexts. In the context of health care, it is often used with reference to loss of dignity. However, Macklin (2003) argues that the vagueness of the term makes it unusable and he proposes using "respect" in its place. Wainright and Gallagher (2008) concur that respect is a more appropriate term, on the grounds that dignity is such a complex term. At the same time, dignity is cited as a core concept within both the Universal Declaration on Human Rights (UDHR, 1948) and nursing ethical guidelines (ICN, 2006). Alvsvåg (2010) describes respect and dignity as compensatory terms, where respect relates to our actions or attitude to others, and dignity is associated with something we possess. Lindholm (2009) states that a major principle within the UDHR (1948) is that the term should be independent and free from any cultural, religious or political ties in order for it to be accepted as a concept in different countries and cultures. Lysaker (2008) views the link between vulnerability, violation and dignity from a human rights perspective, and describes humans' innate vulnerability and inviolability as being the inalienable mandate of human dignity.

Different Considerations About Dignity

From a Christian creationist perspective, the absolute dignity of humans is linked to man being created in God's image (Lindborg, 1974). Alternatively, humans, according to Kant, have innate dignity because they are rational, autonomous beings with intrinsic values, and are capable of creating and determining their own future (Burns, 2008).

Dignity is a core concept of the caring sciences, and it is through the caring staff–patient relationship that care of patients' dignity is expressed (Eriksson, 1988). Dignity can then be seen as a culturally and socially changeable dimension of care (Edlund, 2002). Jacobs (2001) argues that dignity is the key phenomenon within the discipline of nursing and should be the goal and end result of all caring. However, what is most important is maintaining patient dignity in every staff–patient encounter. Alvsvåg (2010) discusses the role of the German concept "bildung" in the health services. Bildung may be described as knowing what it is to be a good person and acting accordingly (Alvsvåg, 2010).

Previous studies within psychiatric health care—from both staff and patient perspectives—found patient dignity to be a core value (Hopkins, Loeb, & Fick, 2009). Treating patients with respect was described as being important in several studies (Austin, Bergum, & Goldberg, 2003; Sanna & Granerud, 2009; Karlsson, 2007). Staff attitudes were important in terms of staff viewing persons with mental illness as equal, competent partners and using language and behavior consistent with maintaining patient dignity (Coursey et al., 2000). Sanna and Granerud (2009)

found that respect, humanity and empathy were important values that challenged relationships between health-care professionals and patients, values which gave the caring relationship a therapeutic power. Respect is also a matter of engaging with patients and regarding them holistically. However, lack of resources made this difficult (Austin, Bergum, & Goldberg, 2003; Sanna & Granerud, 2009). Karlsson (2007) found honesty and sincerity to be preconditions for creating a relationship of respect.

There is also a difference between theoretical understanding and experience in caring for those with mental illness. Some staff may have natural talent, while others may have to work harder to achieve such skills (Karlsson, 2007). Sensitivity to the patient's vulnerability, such as the ability of staff to put themselves in the patient's situation and be emotionally affected by it, was considered important (Karlsson, 2007). How staff treat their patients appears to be based on personal qualities and fundamental values (Austin et al., 2003; Sanna & Granerud, 2009).

Patients sometimes experience lack of respect and stigmatization due to having a mental illness, which affects their dignity (Granerud & Severinsson, 2003). Being accepted as a unique individual, being seen like everyone else, being understood, and being helped to feel like everyone else reduce feelings of shame and impact on the patient's experience of dignity (Schröder, Ahlström, & Larsson, 2006). Nurses' lack of knowledge was also a threat to patient dignity (Hem & Heggen, 2004).

Threats to dignity occur more often when there is an imbalance in the staff–patient relationship (Hem & Heggen, 2004; Jacobson, 2007). Nurses who do not take patients' experiences seriously are a threat to patients' dignity (Hem & Heggen, 2004). Conversely, staff who trust in patients' ability to make their own decisions are pivotal to their motivation and development. Patients who experience health problems should define what the problem is. Where the nurses considered themselves superior, patients did not feel respected (Svedberg, Jormfeldt, & Arvidsson, 2003). Control over one's own life, including one's life history, is a protection against violation of human dignity (Granerud & Severinsson, 2003).

Hence, dignity may be described as something inherent, belonging to all of us (human dignity), or as something cultural and socially changeable. Staff in the mental-health field want to take care of patients' dignity. However, how they achieve this depends not only on the personalities of staff, but also on their basic values, and willingness to engage with patients. Patient-focused research has revealed that patients with mental health problems experience a lack of dignity from their contact with the mental health service.

Research Method and Design

The Purpose of this Study

The aim of this study was to gain deeper understanding of how staff in a psychiatric hospital perceive the dignity in encounters with patients, and therefore to gain a better insight into staff perspectives and their understanding of the concept. The research question was:

> Based on your experiences, what does the term *dignity* mean to you when caring for patients in a psychiatric ward?

The choice of Q methodology as the scientific approach is based on its explorative qualities, since the purpose of the study is to get a deeper understanding of what dignity means for staff working with patients experiencing psychosis in Norwegian psychiatric hospitals. The strength of the Q methodology approach is in how it reveals people's subjective views, feelings, and values in respect of a specific domain (Brown, 1980; Stephenson, 1953), which in this case is dignity. This is based not only on past and present experiences, wishes, and dreams, but also on expectations for the future (Stephenson, 1978).

Dignity may be viewed as part of a number of such experiences, about which individuals form their own conscious and unconscious subjective interpretations. Wolf (2010) pointed out that Q methodology focuses on opinions and not specific facts, and called attention to the possibility to identify the meaning about a specific topic through communication. According to Watts (2011), Q methodology gives us an opportunity to deliver first-person science at precisely the same standard one might achieve using a more conventional third-person science. Hence, it is those shared viewpoints, identified through person-to-person factor analysis, upon which the present study sheds light.

The logic behind the scientific approach of Q methodology is often described as *abduction* (Brown & Robyn, 2004). When using this kind of approach, researchers are able not only to test knowledge, but also to discover new patterns of viewpoints. Råholm (2010) described abduction as being about how we look at reality and try to find meaningful deep structures in the fields we research.

Developing the Q Sample

Even if this particular study is about staff viewpoints, when developing the Q sample we decided that it should be used by patients, staff, and relatives in three independent, but similar, studies. Consequently, we decided to develop an instrument based on qualitative interviews conducted with all three groups. Seven staff, six patients, and five relatives were interviewed face-to-face and asked the following: "When you hear a world like dignity, could you please tell me what you think about?" and "What influences your/ the patients' experience of dignity?"

The interviews lasted from 50 to 150 minutes. According to McKeown and Thomas (1988), the statements could be described as *naturalistic.* Qualitative interviews were chosen in order to identify "concourse" and to discover discussions, thoughts and feelings connected to the substantive theme of dignity.

The interview participants were recruited from five units in a psychiatric hospital. The inclusion criteria were as follows: for patients, their mental status had manifested in the form of one or more psychotic episodes. "Relatives" were a patient's relatives or others the patient defined as immediate family. "Staff" included nursing assistants, nurses, social workers, occupational therapists, untrained personnel, doctors and psychologists. The staff worked on units caring for patients with a history of psychotic episodes. Patients and staff were interviewed in various psychiatric units with the exception of one patient interviewed at the patient's home. Relatives were interviewed in their own homes or at one of the researcher's workplaces.

All interviews where taped and transcriptions made, with particular focus on getting the wording exactly right so that the subjects' viewpoints would come across clearly in the transcription. Some of the statements were expressed as patient viewpoints and others as relative and staff viewpoints.

Sample statements follow:

Statement 3: Everyone is entitled to be equally valued. Whether one is mentally ill, a drug addict or murderer, we are all equally valuable (expressed by a relative).

Statement 49: Time pressure today creates a greater divide between the ideal and the reality (expressed by a staff member).

Statement 26: Staff should listen to what the patient says, since the patient is the one having the experience (patient statement).

Based on the qualitative interviews, 1751 statements were identified. Initially the statements were grouped in order to gain an overview of the various themes obtained, which resulted in 15 provisional categories: primary statements, experiences, staff–patient encounters, situations, suffering, self-esteem, autonomy, staff competence and personality, attitude, understanding, time, relatives and important others, health-care system, economy, and medication.

After trying several ways to reduce the 15 categories, we ultimately decided on four main categories to classify statements as ontological, existential, ethical, or caring–cultural. Each main category was also divided into dignity-preserving statements and dignity-inhibitory statements. Ontological statements concern how we generally value ourselves and others as human beings (statements 1–12), existential statements are about self and self-in-relation to others (statements 13–

24), ethical statements focus primarily on interpersonal relationships (statements 25–36), and caring-cultural statements (statements 37–48) concern patient experiences within the health care system. A miscellaneous category (statements 49–51) was also created, comprising three statements. As Ellingsen (2010) pointed out, one statement may sometimes be placed under several categories, and some choices had to be made.

The process of reducing the number of categories from 15 to four was performed by three of the researchers. On several occasions the primary author sent the statements to the other researchers, asking for their viewpoints and comments in respect of which statements we should retain. The instrument in its final form comprised 51 statements. Six colleagues of one of the researchers piloted the instrument in order to test and clarify the statements. The instrument was developed for use in a Norwegian context, and the English version has been translated by a professional translator, who is also a registered nurse. However, translating this document did present some orthographic challenges. One example is use of the Norwegian word "miljøpersonale" in statement 29, which was translated to health care personnel and, in this context, includes nurses, nursing assistants, mental health nurses, social workers and social educators. Another example is the Norwegian word "behandlingsapparatet," which can have a dual meaning. A literal translation would be "treatment apparatus," but we elected in this context to translate as "health-care system" to align with the intention. The statements are provided in the Appendix.

Participants in this Study

Twenty-five staff members working in the same units and responsible for admitting patients experiencing psychosis were recruited voluntarily into this study. None of these were interviewed in relation to Q-sample construction.

Procedure and Analysis

One researcher was present and instructed the participants. Statements were ranked from positive statement +5, most agree; 0, neutral or non-meaningful statement; and −5, most disagree with the statement. As per the methodological approach the participants were required to prioritize statements using forced-choice distribution as opposed to free-choice distribution (Stephenson, 1953). In line with relevant research recommendations, follow-up interviews were performed with all 25 participants (Stenner, Watts, & Worrell, 2008). All staff members were invited to comment on why they placed the statements under "most agree" (+5, + 4, +3) and "most disagree" (−5, −4, −3). They were also asked if they wished to add other comments.

Information and conditions of instruction given to participants were as follows:

> You will now be presented with 51 statements. Each of these statements contains a message that could be relevant for patients' experience of dignity. Based on your experiences, I would like you to rank the statements from those you most agree with to those you most disagree with.

The sorts were analyzed using the PQMethod 2.11 program (Schmolck, 2002). Numerous analyses were performed, including centroid-factor analysis and hand rotation of the extracted factors. Principal component analysis (PCA) also took place using varimax rotation. For both types of factor analysis we tried 1 to 5 factor solutions, and hand-flagged each solution at a high significance level due to relatively high correlation between factors. After much consideration we chose a two-factor PCA analysis with varimax rotation, which we found produced the clearest result.

Ethical Considerations

The study was approved by the Regional Committee for Medical Research Ethics in Western Norway (reg. no. 2008/13776 CAG), the Norwegian Data Protection Agency (reg. no. 20522/2) and the individual departments within the psychiatric hospital in which data were collected. All participants were informed verbally and in writing that their participation in the study was voluntary, and of their right to withdraw their consent to participate at any time without having to give any form of explanation. All participants gave written consent. Confidentiality was protected by virtue of written consent, and background information on participants was stored separately. Participants were not asked to disclose personal information such as their birthdate and home address.

Results

Although several solutions were explored, we found the two-factor solution using PCA extraction and varimax rotation to be the most meaningful. This explained 54% of the variation. The correlation between the two factors (r=.42) was relatively high, suggesting similarities in views, and that we might have only one factor. At the same time there were differences we felt were worth pursuing and consequently applied a strict significance level of $p<.01$ (hand-flagged at loadings >.37 and with very clear difference between the two factors). The defining sorts that remained allowed us to tease out the differences more easily. Seven staff defined factor 1 while three defined factor 2.

Each factor tells its own story through the essence of meaning, feelings, preferences, values and communicability that flow from the

negative pole through the more neutral area to the positive pole (Stephenson, 1983a; 1983b). Single statements may take on different meanings relating to where they are positioned in the factor array. In the ongoing analysis and interpretation of views that emerged, the focus was on those statements that staff mostly agreed with and those statements they mostly disagreed with, since these represent the strongest psychological weight/affect. However, statements placed in the more neutral area are part of the whole picture, too, and should therefore be given some attention. Interpretation was also influenced by the opinions expressed in the qualitative post interviews. All participants were asked why they most agreed and most disagreed with specific statements. Consensus statements and distinguishing statements were also used in the interpretation process and to help us understand the meanings behind each factor or viewpoint. All these elements are taken into account in presenting and interpreting the results.

Viewpoint One: Patient-Focused Staff

This point of view was expressed by seven staff members: one nurse assistant, one social worker, one mental health nurse and four registered nurses. Table 1 shows the nine statements they most agreed with and Table 2 those they most disagreed with. Refer also to the Appendix.

Table 1: Statements that Viewpoint One Most Agreed With

Statement		*Rank*
3	Everyone is entitled to be equally valued. Whether one is mentally ill, a drug addict or murderer, we are all equally valuable.	+5
4	Dignity is a question of having respect for people's uniqueness, irrespective of what kind of diagnosis or illness they have.	+5
16	It's important to be honest. It's about how staff behave; how they say things.	+4*
1	Seeing oneself as valuable does not mean that you are more or less valuable than others, but are equally valuable.	+4*
30	The patient must be able to trust and feel safe with the personnel.	+4
9	If one takes away the dignity of others, then both parties are affected.	+3
10	If staff does not value patients for who they are, even when they are unwell, then the patient will not be able to value themselves.	+3*
25	It's important that someone asks the patient how he feels.	+3
27	One must be capable of taking others' opinions seriously and accepting that they don't feel the same way you do.	+3

**Distinguishing statement at p<.01*

These staff members seem to mostly agree with the statements that can be seen as expectations of how, as a human being and a health-care professional, one should interact with patients. The staff focus was on equality (3) and respecting people's uniqueness in general (4), on emphasizing how staff should act, and finding it important for staff to be honest (16) and to behave in a manner that makes it possible for patients to trust and feel safe with them (30).

The post interviews substantiated and elaborated staff members' viewpoints. With regard to equality one staff member said that "as a nurse it is important to treat everyone with respect and equality," another, that "one must always show everyone respect irrespectively" and ". . . don't always know the underlying issue. It's hard sometimes, that's something you have to admit." Equality was also commented on as follows: "equal treatment is discrimination; you have to take each patient as your starting point and not compare, which was more commonplace in psychiatry previously." Discussing the unique nature of individuals, one staff member said "to be able to see the resources individuals have, I think is important" and "finding out what they can master—that helps increase their dignity." In relation to honesty one staff member stated that "I automatically think about different values, and honesty is one of several qualities used to explain dignity," and another staff said that "honesty is about your own values, not just in terms of patients but in life in general, people should be able to trust us."

Table 2: Statements that Viewpoint One Most Disagreed With

Statement		***Rank***
2	As human beings, deep inside we are all inviolable.	-5*
43	If the patients want to complain about the treatment they won't get far, because the health care system has its back completely covered.	-5
44	User participation is non-existent, no one asks the patients.	-4*
50	Money is no obstacle to one, as a patient, living as you want to live.	-4*
32	The staff are nice, but experienced as superficial.	-4
17	As a patient, being given a diagnosis means nothing, because you know there's something wrong with you.	-3
45	As a patient you are passed here and there, just like on a conveyor belt!	-3
29	It's the nursing staff the patient talks to if there's something he wants to talk about.	-3*
19	As a patient it is degrading not to look well-groomed.	-3*

**Distinguishing statement at p<.01*

Staff's responsibility was underlined as follows: "They [patients] should be respected irrespective of their behavior—that's their right" and "It is important to have respect and value them . . . and to build up their belief that one day they will be better."

The statements staff most disagreed with communicate several things. First of all staff appear to be aware of the patients' vulnerability. They feel that anyone can be violated (2), that being given a diagnosis is significant (17), and that finance is an obstacle to one living as one wants (50). However, if patients are willing to complain about treatment they do have options, one example of which is user participation (43 and 44). Respondents do not agree that they [the staff] are nice, but superficial (32), or that the patients are sent *from pillar to post* (45), which may indicate a deep concern for patients. Statement 29 is a bit puzzling but, as one staff member said; "some patients prefer to go to doctors with their needs instead of nursing staff." Among the nine statements presented here, five were distinguishing for Viewpoint One at $p<.01$ (statements 2, 44, 50 29, and 19).

Staff most disagreed about statement 2 which is also a distinguishing statement. One staff member said about vulnerability that "we are all vulnerable, and if you look hard enough it is probably possible to hurt any of us," and another said, "Everyone is vulnerable and violable, depending on their circumstances." A third staff member said that "I do not agree with it—it's the opposite I believe because we are all vulnerable, for example, in relation to coercion."

A couple of statements from the more neutral area are (8): "One has dignity until it is taken away. If you are strong, no one can take it from you. If you are vulnerable and downtrodden, it doesn't take much" and (6): "As a patient one finds comfort and peace in one's faith."

Taking a holistic look at Viewpoint One, a main essence seems to be staff having a focus on the patient's vulnerability, their uniqueness, and about how staff should behave when communicating with patients, hence this view is termed *Patient-Focused Staff.*

Viewpoint Two: Challenges for Staff

This point of view was expressed by three staff members: one nursing assistant and two mental health nurses. All three staff members were over 50 years of age. Table 3 shows the nine statements they most agreed with and Table 4 the nine statements they most disagreed with.

In Viewpoint Two staff members also flag equality (3, 5), and respect for people's uniqueness (4) as being important. However, the focus largely seems to concern how staff should behave when dealing with patients, for example, asking the patient how they feel something (25), creating a good atmosphere (40), ensuring patients are able to trust and feel safe with staff (30), being knowledgeable as staff (38), being there

for patients to talk to (29), and listening to the patients' experiences (26). Four of these nine statements were distinguishing at p<.01 (statement 5, 29, 38 and 40).

Table 3: Statements that Viewpoint Two Most Agreed With:

Statement		*Rank*
3	Everyone is entitled to be equally valued. Whether one is mentally ill, a drug addict or murderer, we are all equally valuable.	5
25	It's important that someone asks the patient how he feels.	5
40	The fact that there's a good atmosphere when the patient is admitted onto a unit, that's important.	4*
5	All people are equally valuable, and everyone has the opportunity and potential to change things, and make things better.	4*
4	Dignity is a question of having respect for people's uniqueness, irrespective of what kind of diagnosis or illness they have.	4
30	The patient must be able to trust and feel safe with the personnel.	3
38	The staff's level of knowledge is important. Knowledge is always important.	3*
29	It's the nursing staff the patient talks to if there's something he wants to talk about.	3*
26	Staff should listen to what the patient says, since the patient is the one having the experience.	3

**Distinguishing statement at p<.01*

Viewpoint Two is also elaborated in the post-interviews, where staff highlight challenges in encounters with patients. Speaking about statement 25 one staff member said that "We can see they're having a difficult time, but it is after all a judgment depending on how we [as staff] feel that day" and about statement 4, "I, as a person have so much personal baggage, and in some encounters with patients I react in a completely different way, so I feel I have to sit down and think over why I react as I do."

The statements staff members seem to mostly disagree with are critical statements directed toward staff and the health care system. They strongly disagree that it does not help complaining (43), that staff exercise authority (34), and that there is not enough time for patients (49). They also disagree that staff are superficial (32), that staff feel they know what is best for the patients (36), or that the patients are treated "as if they were on a production line" (45). Generally speaking, staff seem to communicate that they take the patients seriously and treat them individually. Among the nine statements, six of them were distinguishing at p<.01 (statement 34, 49, 41, 36, 11, and 15).

Even if staff communicate disagreement (e.g. statements 43 and 34), the post-interviews reveal other reflections as well: "yet, so I feel that this could be a form of self-defense, and that patient's experience may be different," and about authority: "I believe that might be some people's experience of it, but most staff are aware of it and feel that it belongs to the past."

Table 4: Statements that Viewpoint Two Most Disagreed With

Statement		*Rank*
43	If you want to complain about the treatment you won't get far, because the health care system has its back completely covered.	-5
34	Staff may unconsciously exercise authority, for example, by walking through the corridor jangling their keys.	-5*
49	Time pressure today creates a greater divide between the ideal and the reality.	-4*
41	Education can never replace staff's individual suitability.	-4*
36	Staff show over and over that they don't think the patients know what's best for them.	-4*
32	The staff are nice, but experienced as superficial.	-3
11	No one views mental illness as being the same as breaking your foot.	-3*
15	Sometimes the experience of violation can be a wake-up call; something good can come of it.	-3*
45	As a patient you are passed here and there, just like on a conveyor belt!	-3

**Distinguishing statement at p<.01*

The relation between personality and education is emphasized on both sides of the sorting grid. Staff agree that knowledge is important (38) and they disagree that education cannot replace individual suitability (41). One staff member elaborated on it and said "I believe there is some development that takes place during one's education, but that we also have something inside which we can never change, no matter what kind of education we have."

A couple of statements from the more neutral area will be presented here, one of which is 35: "As a patient, every time you want to talk to someone, there's a new therapist," and 42) "Professional knowledge and user-experience must be given equal worth."

Taken as a whole, staff communicate the existence of numerous challenges in interactions with patients. On the other hand, they seem to believe they are taking good care of the patients, although some express concern that staff and patient experiences may differ. Viewpoint Two is therefore labeled *Challenges for Staff.*

Both characteristic and distinguishing statements have been presented for each viewpoint, pointing out the differences between them. There are also consensus statements demonstrating the similarities between viewpoints and these may also account for the relatively high correlation. A few examples are the right to dignity (3), respect for uniqueness (4), not being superficial (32) and that complaining about treatment will not help (43).

Discussion

Patient-Focused Staff

The *Patient-Focused Viewpoint* could be interpreted as staff's self-expectations in terms of interactions with patients. Staff putting forward this viewpoint seem to espouse interacting with patients as equals, being honest with them and treating them with respect. Earlier research has emphasized equality (Coursey et al., 2000), and staff who help patients feel "like everyone else" (Schröder et al., 2006), as dignity promoting. Honesty is another of the concepts staff felt was important for patients' dignity. Karlsson (2007) found honesty to be a prerequisite for creating a therapeutic relationship. In the post interviews honesty was described as one of several qualities contributing to treating people with dignity, and that honesty is about the individual and their personal values.

Although staff express that patients are taken good care of, previous research has shown that patients experience not being treated as equal (Svedberg et al., 2003), not being taken seriously, with an imbalance in the relationship between patients and staff (Hem & Heggen, 2004), and that patients experience lack of respect and stigmatization. All these factors impact on patients' experience of dignity. One way of understanding this discrepancy between patients' experiences and the viewpoint of staff members in respect of how care should be given, could be that staff are idealizing their way of behaving towards patients. If so, further research is necessary in order to explore why there is such a discrepancy.

Another explanation could be that the patients are in a vulnerable position. Historically we know that patients with mental illness, and in particular those with psychotic disorders, have been stigmatized by society, a situation still experienced by many today. Patients have described it as a threat to their experience of dignity (Granerud & Severinsson, 2003).

Even when focusing on idealizing behavior of staff in encounters with patients, it is important to have ideals. Austin et al. (2003) found that staff's personal qualities and values influence their interactions with patients. Hence, values such as equality, honesty and respect for the

unique nature of individuals are not only personal issues, but also impact on how patients are dealt with.

Staff defining the Patient-Focused Viewpoint seem also to communicate an awareness of patients' vulnerability. Earlier research among staff has highlighted the importance of having an awareness of patients' vulnerability (Karlsson, 2007). Use of diagnosis (17), being treated as if one were on a conveyor belt (45), and the way staff value patients' influence on their own self-worth (10) could all be seen as placing patients in a vulnerable position, that is, dependent on other people's judgments and decisions. Jacobson (2007) found that when there is an imbalance in the relation between the involved parties, such as staff and patients, there is a higher risk of violating the dignity of the weakest party. In the psychiatric-hospital setting staff are the stronger group and patients the weaker. Consequently, there is a risk of violating patient dignity.

Staff totally disagreed that we deep inside are all inviolable (2). Several staff members used the word "vulnerable" when explaining why they disagreed. One staff member said: "We are all vulnerable, and if you look hard enough it is probably possible to hurt any of us." One possible explanation for why staff disagreed with this statement is that on the one hand it may be viewed as an ideal (Lysaker, 2008), whereas on the other hand it may be seen in the context of concrete patient situations, and staff interacting with patients experience them as vulnerable. The ideal of human inviolability, based on the view that we as human beings are born with dignity, is not the experience of staff at mental health institutions in their daily encounters with patients. Statement 8 from the more neutral area could be understood to mean that we all are vulnerable, and that it is possible to take dignity away from us, but since it is placed in the neutral area, it does not represent the most significant statements, but could be seen to support the interpretation of staff experiencing patients as vulnerable. Statement 6, which is about one finding support in one's belief, is also interesting. If one takes as a starting point the view that innate human dignity stems from humans being created in the image of God (Lindborg, 1974), one explanation could be that staff perhaps experience this as being true for some patients, but not for all, or conversely, see no connection between dignity and faith.

It has been suggested that "respect" is a better term to use than dignity in a research context (Macklin, 2003; Wainright & Gallagher, 2008), since dignity is too vague and unclear a concept. Both this particular study and earlier studies, however, do not appear to support such a view. Dignity seems in fact to be a part of people's shared communication. Should one not then study dignity because one's research instruments or methodological approaches are not suitable?

The answer seems to be no. One should instead develop new methods and instruments. This study could be one such contribution. Hopkins, Loeb, and Fick (2009) found that respect for patient dignity was highlighted as an important attribute for staff to have. Respect was mentioned twice in the Q sample, but emphasized several times in the post-interviews. Other concepts, too, such as honesty and equality seem to be important in explaining dignity. In agreement with Alvsvåg (2010), respect cannot replace dignity, but can be an element of it. One way of understanding it is that dignity is a more universal concept than respect, and appears to comprise internalized values guiding staff both personally and professionally (Eriksson, 1988; ICN, 2006; UDHR, 1948). Dignity seems to include respect, equality and honesty.

Jacobs (2001) highlighted the importance of having ideals, and suggested that dignity could be one such unifying goal. If each individual staff member involved in patient care believed in tenets of equality, honesty, and respect, and strived to achieve this in his or her own life, then naturally this would impact positively on those in his or her care. Ideals would then be a prerequisite for actions.

Challenges for Staff

In the view *Challenges for Staff*, it seems that the staff also promote values such as equality and respect (3, 5, and 4) but the focus seems to be on staff's own challenges in interacting with patients in a way that promotes dignity. Statement 3, which states that everyone is entitled to be treated as being of equal worth, is the statement staff defining this view most agreed with. One staff member relates equality to what he describes as "the golden rule," found in virtually all religions and beliefs, and which relates to how one should act towards other people, not only as a caregiver, but also as a fellow human being. Kant's categorical imperative is one example of such a virtue rule.

Statement 4 concerns seeing each individual's uniqueness, irrespective of diagnosis. One could believe that there is no contradiction between giving a person a diagnosis, seeing the uniqueness of every single individual, and caring for his or her dignity. When diagnosing people one looks for a person's behavior and how the person communicates thoughts and feelings. In this categorization and identification process one compares these observations with established criteria (Karlsson, 2007).

Nonetheless, patients feel stigmatized (Granerud & Severinsson, 2003), and staff's perspectives about individual patients may be lost in such a categorization and identification process (Karlsson, 2007). One staff member, remarking on this process, stated, "I feel I have to sit down and think about why I react as I do." Hence, self-reflection and an awareness of personal reactions when interacting with patients seem to

be important in terms of protecting patients' dignity. One way of achieving this kind of self-reflection could be in line with what Karlsson (2007) proposed as a professional milieu that recognizes the necessity for self-reflection. A milieu that facilitates self-reflection encourages staff to see patients as unique individuals, rather than as a diagnosis.

Staff responsibility also appears to be communicated through several statements, for example, asking the patient how he or she feels, listening to the patient, creating a good atmosphere and building a trusting relationship, although they might be considered basic skills in terms of staff–patient encounters. Eriksson (1988) pointed out that patient dignity is expressed through the caring relationship between patient and staff, but as one staff member elaborated: "We can see they're having a difficult time, but it is after all a judgment depending on how we [as staff] feel that day" (statement 25). Staff might be emotionally affected by their dealings with patients (Karlsson, 2007). However, being aware of the possibility of being affected by patients is not the same as avoiding being affected. Staff should be touched by interactions with patients, that is, when they are listening to them and creating a good atmosphere. If staff are not affected then they are not listening to the whole person and trusting relationships cannot be created. However, the challenges are to be aware of, and to recognize, how this influences staff members' own thoughts and feelings. Only then may one be in a position to help the patient.

Even if staff appear to have acknowledged some of the challenges patients encounter, those statements they most disagree about are critical statements against staff. Most staff disagree with statements which assert that it was not possible to complain about the treatment, or that staff demonstrate authority. Yet earlier research makes it clear that there is an inequality between patients and staff, which contributes to patients' loss of dignity (Granerud & Severinsson, 2003; Hem & Heggen, 2004; Svedberg et al., 2003). One staff member said that this view "belongs in the past," but here too, one can see a kind of self-critical thinking and one staff member expressed that "it could be a form of self-defense."

This study tells us nothing of patients' experiences of these staff views, but it would be interesting to see if increased focus on self-reflection among staff leads to increased experience of dignity among patients. Worthy of consideration, too, is the fact that all three staff members defining this viewpoint were more than fifty years old. Perhaps critical self-thinking is a kind of skill one develops as a result of experience. No previous studies looking into this area were identified.

These staff members found knowledge and education important, not only because of the knowledge and skills one develops, but also because

education has an impact on personality. One staff member said that "I believe there is some development that takes place during one's education, but that we also have something inside which we can never change." Karlsson (2007) reports similar findings, and said that some staff had natural empathy towards patients, while others took time to develop these skills. Alvsvåg (2010) has promoted the role of "bildung" in health care education, and suggests that bildung relates to knowing what it takes to be a good person, and acting accordingly. Perhaps what should be promoted when discussing the personal challenges faced by staff when addressing patients' dignity is not only the relationship between personal suitability and education, but also what types of skills and excellence staff should possess. The capacity for critical self-reflection seems to be one such important skill when upholding patient dignity.

Consensus

There were several consensus statements highlighting similarities among the participants. These included the statements about equality (3) and respect for the uniqueness of individuals (4), in respect of which there was significant agreement. There may be many explanations behind the high level of concord among staff in respect of these statements. One is that we asked them to consider patients in general and not one particular patient. It is possible that if we had asked them about one particular patient more differences might have come to light. Most staff have gone through a personal educational process, also described as bildung (Alvsvåg, 2010). In this personal process, staff's own values meet with professional ethical guidelines which have their origins in basic values in western countries. Staff also strongly disagreed that staff were superficial (32), and that complaining about treatment would not help (43). One way of understanding this is that staff feel they do take patients seriously. Earlier research has shown the importance of taking patients' experience seriously (Hem & Heggen, 2004), trusting patients (Svedberg et al., 2003) and allowing them to retain control over their own lives (Granerud & Severinsson, 2003). All these factors influence patients' experience of dignity.

Being in agreement on the importance of such values should be a positive factor for the health care profession. As discussed previously, staff's personal values and attitudes impact on their actions in respect of patients. This is not a guarantee of patients' experience of being treated in step with such values. Staff awareness of this is a first step.

Methodological Considerations

The aim of the study was to increase understanding of how staff in a psychiatric setting perceive the term "dignity" in their interactions with patients. Q methodology was chosen because of its explorative nature

and potential to make tacit knowledge more explicit, and where both similarities and differences in views emerge. The statements used in this study are a selection collected from the spectrum of opinions existing between patients, staff and relatives within mental health care. Each Q statement has been valued by the sorters in relation to all the other statements as a whole in order to express their personal views (Stephenson, 1953). Significant agreement among staff may be interpreted based on the general answers relating to admitted patients and not in relation to individual patients. The fact that staff are trained within the same care culture may also have impacted on the results. The results say little about the 15 staff who loaded on both factors, but one possible interpretation is that they contain a "little of both," that is, they are focused on challenges facing both patients and staff.

Another explanation could be that staff members are in fact sharing one viewpoint, and that instead of a two-factor solution one could have chosen a one-factor solution. Yet this would have hidden subtle nuances that seem important in helping staff gain more competence in their work by enabling them to become more aware of different perspectives and consequences of their views in relation to patient care. In interpreting the findings, significant weight was placed on the post-interviews, which help give a better sense of the participants' "voices" in interpreting the results.

Conclusion

Two different perspectives came to light in this study. For those defining Viewpoint One, the patient is the focus. Staff promote superior values, in terms of people being unique and equal individuals, values which are in full accordance with both the Declaration on Human Rights, and ethical guidelines within the nursing profession. But at the same time, staff working in mental health care do not consider it meaningful to talk about the inviolability of individuals. Within mental health care staff encounter patients who are vulnerable, and consequently this results in an increased risk of staff violating their rights. Nor can the term "respect" replace dignity, but it is seen as a means of addressing dignity.

In Viewpoint Two, personnel were focused on their own challenges in patient encounters in respect of maintaining patient dignity. This related to various aspects such as present day and prior experiences, but also about how personal suitability and education had an impact on how patient dignity was addressed.

Implications for Practice

In psychiatric units, dignity as a term and phenomenon should be put on the agenda, which requires discussion in respect of several factors, such as what are the overarching values prevailing among staff. There should also be a focus on developing critical thinking and interpersonal skills in

health care training with regard to upholding patient dignity and awareness and openness regarding the challenges faced by both individual staff members and units they belong to in respect of maintaining patient dignity. One should also continue developing theory on several levels relating to dignity, in particular, with a view to applying it to practice.

Increased awareness of the opinions raised in respect of both viewpoints may contribute to increased understanding among staff, and thereby form the foundation for upholding patient dignity.

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Appendix: The Dignity Q Instrument and Factor Array

	Statement	*View 1*	*View 2*
1	Seeing oneself as valuable does not mean that you are more or less valuable than others, but are equally valuable.	4	0
2	As human beings, deep inside we are all inviolable.	-5	-1
3	Everyone is entitled to be equally valued. Whether one is mentally ill, a drug addict or murderer, we are all equally valuable.	5	5
4	Dignity is a question of having respect for people's uniqueness, irrespective of what kind of diagnosis or illness they have.	5	4
5	All people are equally valuable, and everyone has the opportunity and potential to change things, and make things better.	2	4
6	As a patient one finds comfort and peace in one's faith**	0	-2
7	When you treat everyone alike, then you don't necessarily address individuals' dignity.	1	-1
8	One has dignity until it is taken away. If you are strong, no one can take it from you. If you are vulnerable and downtrodden, it doesn't take much.	0	0
9	If one takes away the dignity of others, then both parties are affected.	3	1
10	If staff do not value patients for who they are, even when they are unwell, then the patient will not be able to value themselves.	3	-1
11	No one views mental illness as being the same as breaking your foot.	1	-3
12	Patients have an intrinsic dignity, that can be trampled on in the health service.	1	-1
13	After encounters with the mental health service I have more respect for difference.	-2	1
14	Humor is important.	2	0
15	Sometimes the experience of violation can be a wake-up call; something good can come of it.	-1	-3
16	It's important to be honest. It's about how staff behave; how they say things.	4	0
17	As a patient, being given a diagnosis means nothing, because you know there's something wrong with you.	-3	-2

	Statement	*View 1*	*View 2*
18	There is a link between how one feels physically and how one feels mentally.	-2	1
19	As a patient it is degrading not to look well-groomed.	-3	0
20	Sometimes you feel forced and then you feel that your dignity has not been upheld.	1	1
21	When you feel inferior it is easy to have your dignity taken away. It doesn't happen in psychiatry, it has happened before.	1	-1
22	I'm not against coercion, but I am against unnecessary coercion.	0	2
23	Most people understand that wrong can be done, but they don't understand when things are not dealt with or when no justification or apology is given.	-1	0
24	No one thinks using medicine is good, if it's to treat blood pressure or diabetes. But sometimes it's necessary and that's how it is with psychiatric disorders too.	-1	1
25	It's important that someone asks the patient how he feels.	3	5
26	Staff should listen to what the patient says, since the patient is the one having the experience.	0	3
27	One must be capable of taking others' opinions seriously and accepting that they don't feel the same way you do.	3	2
28	People have to talk normally to you and not put on airs.	2	-2
29	It's the nursing staff the patient talks to if there's something he wants to talk about.	-3	3
30	The patient must be able to trust and feel safe with the personnel.	4	3
31	Not being able to talk with others about the illness is a very isolating experience.	2	2
32	The staff are nice, but experienced as superficial.	-4	-3
33	One should talk to the patient not patronize them. Staff may not think they patronize patients, but they do.	0	-2
34	Staff may unconsciously exercise authority, for example, by walking through the corridor jangling their keys.	0	-5
35	As a patient, every time you want to talk to someone, there's a new therapist. It's tiresome, because then you can't build up any form of trusting relationship.	1	1
36	Staff show over and over that they don't think the patients know what's best for them.	-1	-4

	Statement	View 1	View 2
37	Attitudes, particularly amongst managers, are important. This has a trickle-down effect in the units.	1	2
38	The staff's level of knowledge is important. Knowledge is always important.	−1	3
39	When the patients were discharged, they were the ones who had to report how their stay had been.	0	1
40	The fact that there's a good atmosphere when the patient is admitted onto a unit, that's important.	0	4
41	Education can never replace staff's individual suitability.	2	−4
42	Professional knowledge and user-experience must be given equal worth.	−2	0
43	If the patients want to complain about the treatment they won't get far, because the health care system has its back completely covered.	−5	−5
44	User participation is non-existent, no one asks the patients.	−4	−2
45	As a patient you are passed here and there, just like on a conveyor belt!	−3	−3
46	The health service has a long way to go in terms of including relatives to a greater extent in the treatment.	0	0
47	The standard of things in Norway has been so high, that as soon as people fall below the standard, they think there's a crisis when there's not.	2	−1
48	Many people, once they come out of psychosis, are frightened that so much time has passed before someone intervened. It's a form of state neglect.	−1	−1
49	Time pressure today creates a greater divide between the ideal and the reality.	−1	−4
50	Money is no obstacle to one, as a patient, living as you want to live.	−4	0
51	Housing issues are important.	−2	2