On Dignity

in Inpatient Psychiatric Care

A thesis submitted to

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for the degree of

Doctor in Medicine

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Declaration

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Date: 30/09/21
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Dedication

This thesis is dedicated to my late uncle, Kevin Plunkett. He devoted his professional life to working for others, first as a psychiatric nurse and later as area director of psychiatric nursing. Having worked in the old asylum system, before helping to dismantle it in the 1990s, he had many insights into the importance of dignity in patient care in psychiatric settings. I miss our conversations and am grateful to have shared this common interest.

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Publications and presentations arising from this work


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Table of Contents

Declaration i

Acknowledgements ii

Dedication iii

Publications and conference proceedings arising from this work iv

Table of Contents v

List of Figures and Tables ix

Abstract x

Lay Abstract xii

Aims and Hypothesis xiv

Value of Research xiv

Chapter 1: Introduction and overview

1.1 Overview of chapter 1 1

1.2 Introduction 1

1.3 Dignity origin and meanings 2

1.4 Dignity in legislation 5

1.5 Dignity in medical practice 7

1.6 Criticisms of dignity 11

1.7 Duality of dignity in legal philosophy 15

1.8 Dignity and the social environment 21

1.9 Dignity and coercion 24

1.9.1 Involuntary admission under the Mental Health Act 25

1.9.2 Change of inpatient’s legal status under MHA 27

1.9.3 Correlates of involuntary admission 28

1.10 Dignity in involuntary psychiatric settings 29

1.11 Study aims and objectives 30
Chapter 2: Systematic Review and Thematic Synthesis

2.1 Overview of chapter 2
2.2 Outline of systematic review
2.3 Prospective registration
2.4 Research question for systematic review
2.5 Eligibility
2.6 Information sources
2.7 Search protocol
2.8 Data collection and analysis
2.9 Results
  2.9.1 Study selection
  2.9.2 Characteristics and results of individual studies
2.10 Textual summary of individual studies
  2.10.1 Larsen & Terkelson (2014)
  2.10.2 Sibitz et al. (2011)
  2.10.3 Johansson & Lundman (2002)
  2.10.4 Schroder, Ahlstrom & Larsson (2005)
  2.10.5 Chambers et al. (2014)
  2.10.6 Husum, Legernes & Pedersen (2019)
  2.10.7 Mielau et al. (2018)
  2.10.8 Kjellin et al. (1997)
  2.10.9 Aftab et al. (2019)
2.11 Quality analysis
2.12 Data extraction
2.13 Synthesis of results
2.14 Core themes/subthemes
2.15 Discussion
  2.15.1 Main findings
List of Figures and Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Population, Intervention, Comparison, Outcome (PICO) Grid</td>
<td>35</td>
</tr>
<tr>
<td>2</td>
<td>Full search protocol for Pubmed</td>
<td>38</td>
</tr>
<tr>
<td>3</td>
<td>Synthesis of results of qualitative analysis and risk of bias of primary studies</td>
<td>44</td>
</tr>
<tr>
<td>4</td>
<td>Core themes and subthemes</td>
<td>63, 94</td>
</tr>
<tr>
<td>5</td>
<td>Descriptive statistics for full data set</td>
<td>85</td>
</tr>
<tr>
<td>6</td>
<td>Results of assessment tools with non-parametric distribution</td>
<td>88</td>
</tr>
<tr>
<td>7</td>
<td>Results of assessment tools with parametric distribution</td>
<td>88</td>
</tr>
<tr>
<td>8</td>
<td>Linear regression analysis</td>
<td>91</td>
</tr>
<tr>
<td>1</td>
<td>Flow diagram</td>
<td>42</td>
</tr>
</tbody>
</table>
Abstract

Dignity is an important concept in human rights legislation and medical ethics but is under-studied in psychiatric settings. It is a nuanced concept which is considered difficult to define, but nevertheless has a prominent place in legislation and regulations around the world. Psychiatric care is unusual within medical specialties, in that there typically exists provision for involuntary and coercive treatment. When a patient is involuntarily detained under psychiatric care, their rights to liberty and autonomy are legally restricted and they may be subject to physical restraint, seclusion and/or treatment against their wishes. Patient autonomy is balanced against each individual’s right to treatment, as well as risks to themselves and/or others. Many patients who experienced involuntary treatment agree after the fact that it was necessary and helpful. Nevertheless, maintenance of their human dignity while their freedom and autonomy is restricted is an important human rights issue. In this research, we aim to investigate the experience of voluntary and involuntary psychiatry patients, comparing their experience of dignity in inpatient care.

We conducted a systematic review of the existing literature, and a cross sectional study of inpatients in two psychiatric units in Dublin. We examined their experience of dignity and coercion using validated tools.

There was a dearth of literature looking at differences between voluntary and involuntary patients in terms of dignity. From the literature that did exist, a number of themes emerged as important, namely: Coercion, Powerlessness, Care Environment, Relationship to Staff, Lasting Impact of Involuntary Care and Paradoxes.
Among the 107 patients included in our study, there was no statistically significant difference between voluntary and involuntary patient groups in terms of their subjective dignity scores, after multivariate analysis. Patients with higher levels of perceived coercion on admission, patients with better insight and patients with more severe negative symptoms reported lower levels of subjective dignity. There was no association between dignity and gender, employment status, marital status, diagnosis, working alliance, positive symptoms or cognition.

It is interesting to note that perceived coercion on admission and legal admission status, although theoretically linked, performed as distinct entities and demonstrated different associations with patient dignity in our analysis. Participants who experienced their care as coercive reported lower dignity, but those with involuntary legal status did not. Patients with better insight and those with fewer negative symptoms also reported poorer dignity experience. We consider a number of possible conclusions arising from this evidence on clinical correlates of dignity among psychiatry inpatients.

Dignity is a concept with particular relevance for inpatients in psychiatric care, given the provisions for involuntary and coercive treatment. Respect for and maintenance of patient dignity is especially important in this setting, and requires further investigation if we are to understand and utilise this nuanced concept to improve psychiatric care. Our systematic review provides a potential framework for looking at psychiatry inpatients’ experience of dignity, and our cross-sectional study gives preliminary insights into factors associated with poorer dignity in inpatient care.
To our knowledge, ours is the first study directly investigating the association between legal admission status and subjective experience of dignity. We encourage further investigation into this important area.

Lay Abstract

Dignity is a central concept in human rights legislation and medical ethics but is under-studied in psychiatric settings. Dignity is considered difficult to define, but nevertheless features in legislation and regulations around the world. Psychiatry is unusual within medical specialties, in that there is provision for involuntary and coercive psychiatric treatment in legislation around the world. While a patient is involuntary, their rights to personal freedom and autonomy (or expression of choice) are legally restricted. They may experience physical restraint, seclusion and/or treatment against their wishes. Patient autonomy is balanced against a person’s right to treatment, as well as risks to themselves and/or others. Many patients who experienced involuntary treatment agree afterwards that it was necessary and helpful. Nevertheless, maintenance of their human dignity while their freedom is restricted is an important human rights issue. In this research, we aim to investigate the experience of both involuntary and voluntary psychiatry patients, comparing their experience of dignity in inpatient care.

We conducted a systematic review of the current literature, and a cross sectional study of inpatients in two psychiatric units in Dublin. We examined patients’ experience of dignity and coercion using validated tools.
There was a lack of literature looking at differences between voluntary and involuntary patients in terms of dignity. From the literature that did exist we found a number important themes, namely: Coercion, Powerlessness, Care Environment, Relationship to Staff, Lasting Impact of Involuntary Care and Paradoxes.

Among the 107 patients included in our study, there was no statistically significant difference between voluntary and involuntary patient groups in terms of their subjective dignity scores, after multivariate analysis. Patients with higher levels of perceived coercion on admission, patients with better insight and patients with more severe negative symptoms reported lower levels of dignity. Dignity had no significant association with gender, employment status, marital status, diagnosis, working alliance, psychotic symptoms or cognition.

Those who felt that their admission was forced upon them reported lower dignity. Those who had better understanding of their illness and need for treatment, as well as those who had fewer negative symptoms reported poorer dignity experience. We consider that these two groups of participants may have been better able to identify dignity violations.

Dignity is a concept with particular relevance for inpatient psychiatric patients, given the provisions for involuntary and forced treatment in this setting. Respect for and maintenance of patient dignity is especially important in inpatient psychiatric care. Our systematic review provides a potential framework for looking at psychiatry inpatients’ experience of dignity, and our cross-sectional study gives preliminary insights into factors associated with poorer dignity in inpatient care.
To our knowledge, ours is the first study directly investigating the association between legal admission status and subjective experience of dignity. We encourage further investigation in this important area.

**Aims and Hypothesis of this Research**

This research aims to establish the factors associated with the subjective experience of dignity among psychiatry inpatients. We first wish to interrogate the existing literature in a meaningful way, in order to better understand the experience of psychiatry inpatients in terms of dignity. We further aim to gather data on variables associated with the self-rated dignity of psychiatry inpatients in Dublin. We hypothesise that involuntary patients would have poorer experience of dignity, given the restrictions of liberty and higher proportion of coercive interventions among this patient group. We speculate that variables such as diagnosis, gender, ethnicity, employment status, working alliance, symptom severity, cognition and insight might also have relevance to patients’ experience of dignity in psychiatric inpatient care.

The aims and objectives of this study are described in further detail in the introduction of this thesis.

**Value of this Research**

This research provides, to our knowledge, the first systematic review of the existing literature on dignity in inpatient psychiatric care, as well as a novel quantitative assessment of the clinical correlates of dignity in this setting. It provides an analysis of the factors that patients
identify as important in terms of their experience of dignity, as well as an objective evidence-based appraisal of the variables associated with poorer dignity experience in inpatient care.

Given the provision for coercive and involuntary care in psychiatry settings, and the associated restrictions of liberty and autonomy, consideration of patient dignity in this field is paramount. Psychiatric care has changed significantly over the last 150 years, and there is now widespread acknowledgement of the importance of human rights in inpatient settings. We must continue in our efforts to improve the practice of psychiatric treatment, and to ensure that patient dignity is upheld as a key value in psychiatry inpatient care.
Chapter 1: Introduction

1.1 Overview of chapter 1

This chapter introduces the concept of dignity in general, and the way it relates to inpatient psychiatric care in particular. In this introductory chapter, I outline the meaning, usage and relevance of dignity in psychiatric inpatient settings, and explain the context in which I have developed the aims, objectives and research questions of this thesis.

1.2 Introduction

Dignity, the state or quality of being worthy of honour and respect (Dignity, n.d.) is a concept with ancient roots and international applications. Although distilling the concept of dignity into a single universal understanding is a task which has proved elusive, dignity nevertheless remains an important and often-used term in jurisprudence, medical ethics, national constitutions and international agreements as well as religious and humanistic philosophy. There is already a focus on dignity within some medical specialties, mainly geriatric and palliative medicine. I will argue in this introduction that dignity has especial relevance to inpatient psychiatric care for three main reasons: (1) It is recognised widely as important among regulatory bodies, physicians, philosophers and people generally, with a role in protecting people in a place of vulnerability. (2) It is sufficiently distinct from autonomy to be useful among involuntarily detained inpatients. (3) It has a social component, promoting cooperation and pro-social behaviour in groups and could therefore have a virtuous-cycle effect in inpatient psychiatric settings.
The research I have undertaken for this thesis explores the existing literature on dignity in inpatient psychiatric settings, and examines the factors associated with psychiatric inpatient experience of dignity. In this introductory chapter, I outline some of the ways in which dignity has been defined, understood and utilised, consider some criticisms of the use of the term dignity, and explain its particular relevance to inpatient psychiatric care.

1.3 Dignity origin and meanings

The Latin ‘dignitas’ is related to ‘decus’ (decent, decorous) and ‘dignus’ (worth) in Latin, as well as ‘yasas’, a Sanskrit root denoting fame, honour or glory (Jones, 2010). The word made it in to the English lexicon circa 1200 AD by way of the old French word, ‘dignete’, at a time when French ‘loan-words’ were rapidly changing the English language following the Norman Conquest of 1066 (Baker, 2016).

Roman statesman and philosopher Cicero defined dignity as the ‘honourable authority of a person’, (Di Inventione) and conceptualised dignity as a high honour imbued upon persons of excellence (Johnson 1971). In the Bible and early Christian teachings, dignity is seen as arising from the special relationship between humans and God, mankind having been made in His image (Bayertz, 1996). Stoic philosopher Thomas Hobbes and later metaphysical philosopher Immanuel Kant conceived of dignity as an inherent and inalienable human right, or a worth which has no price (Beck, 1989). This contrasts somewhat with the Roman interpretation of dignity as being a special honour earned by particular status and bestowed only upon those who achieve greatness.
One of the criticisms levelled at the use of the word dignity in medical ethics is that it is too vague to be useful (Macklin, 2003). The fact that two opposing sides of a philosophical or bioethical debate (on topics such as assisted suicide or abortion rights) can both claim to base their arguments on the concept of dignity is seen by some as prima facie evidence that dignity is useless, empty rhetoric (Morrissey, 2016). However, after analysing the 33 published responses to Macklin’s opinion-editorial in the BMJ (which is discussed in more detail later in this chapter), Hofmann (2020) summarised: ‘dignity may be dead, but it won’t lie down’.

Acknowledging the complexity of the origin of the word, bioethicist and academic Daniel Sulmasy proposed a three-part categorisation to the types of human dignity: attributed, inflorescent and intrinsic dignity (Sulmasy, 2008). This taxonomy of dignity does not seek to deny or negate the multiple potential interpretations of the word, but rather to wrangle them into distinct and understandable categorisations.

In his taxonomy, Sulmasy described ‘attributed dignity’ as the honour or worthiness attributed to certain people by others. Attributed dignity indicates a conscious choice made by an individual or group to dignify a person or persons by acts of attribution, such as voting them into office or conferring upon them a certain status or award (Sulmasy, 2013). Elected officials, dignitaries, or Olympic medalists, for example, have attributed dignity. This is analogous to the Ciceran or Roman interpretation of dignity mentioned above.

‘Inflorescent’ dignity, its name deriving from a term meaning to flower or flourish, refers to the dignity of individuals of superlative excellence (Sulmasy, 2013). People who display the very best of human capabilities or talent, and thereby highlight the dignity of all humankind are imbued with inflorescent dignity. Brilliant athletes like Usain Bolt and Serena Williams,
inspirational figures like Malala Yousafzai and Greta Thunberg, or an intellectual giant such as Stephen Hawking would be examples of people who possess inflorescent dignity. It is not a particular prize or position that earns them this status, but rather an overall impression of them as an especially flourishing, and thereby dignified, individual.

Intrinsic dignity, finally, is the dignity possessed of all human beings simply by virtue of their being human (Sulmasy, 2013). It is a worthiness that all human beings have regardless of social status, achievements or even capabilities. Even people who lack the attributes typically said to underlie human dignity, such as conscious or rational thought, maintain intrinsic dignity by virtue of belonging to the human race. A person who is comatose or who has a severe mental illness nevertheless possesses the intrinsic dignity deriving from their humanity. This links to the Confucian view of dignity, namely that every person has moral potential, and thus every person has equal intrinsic dignity (Li, 2021). Intrinsic dignity is, in essence, an extension of one’s humanity (Sulmasy, 2008). It is intrinsic dignity, then, which is the basis of dignity in medical ethics. This sense of the word is unconditional and does not require any particular functional status of a person in order to imbue them with dignity (Parker, 2010). Immanuel Kant wrote that respecting human dignity entails treating each individual as an end in themselves, not as a means to an end (Kant, 2019). This resonates with later human rights doctrines, which I will describe in more detail in the next section on dignity in legislation.

There is debate as to whether dignity is a right, in itself, or the foundation of other more specific rights (O’Mahony, 2012) but it is widely accepted that intrinsic human dignity transcends race, sex, religion and other characteristics. It is even considered to extend beyond life (Hofmann, 2020; Grotius, 1814) and underpins the respect with which human remains
should be treated post-mortem (Schwarz et al., 2021). By virtue of being – or of having been – a member of the human race, one possesses inherent dignity.

1.4 Dignity in legislation

It is the above Kantian or Confucian notion of inherent human dignity, (Sulmasy’s ‘intrinsic’ dignity) which features most commonly as a legal and moral precept around the globe. International human rights charters, legislation and regulations from myriad institutions and governing bodies name dignity as a fundamental principle, including (but certainly not limited to) The Universal Declaration of Human Rights (UDHR) (United Nations, 1948), the International Covenant on Civil and Political Rights (ICCPR) (Office of the High Commissioner of Human Rights (OHCHR), 1976a), and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (OHCHR, 1976b).

A 2014 study of all the sovereign nations comprising the United Nations (UN) member states found that 162 of 193 member nations referenced dignity in their constitution (Schultztiner & Carmi, 2014). Emphasis on dignity in national constitutions has historical roots, with World War II acting as a sort of watershed for the inclusion of dignity in these texts. Prior to 1944, only five countries referenced dignity in their constitution, including the Irish constitution of 1937 which referenced ‘dignity and freedom’ in its preamble. Interestingly, the first countries to introduce dignity into their constitutions following the second world war were the ‘axis powers’ of Japan, Italy and West Germany (Schultziner & Carmi, 2014). The disregard for life and humanity displayed during the Holocaust, and the devastating impact the war had on so many nations, led to the advent of the UN in 1945 and the adoption of the UNDHR by the
UN General Assembly in 1948. The UNDHR states that appreciation of ‘the inherent dignity [...] of all members of the human family’, is the basis of ‘freedom, justice and peace in the world’ (UN General Assembly, 1948). The UN Convention on the Rights of the Child, adopted in 1989, reiterates this statement and continues by saying that children should be brought up ‘in the spirit of peace, dignity, tolerance, freedom, equality and solidarity’ (UN General Assembly, 1989).

In healthcare, dignity is recognised as a fundamental principle in ethical practice. It also frequently features in national and international governing documents regulating the practice of healthcare providers. The Declaration of Helsinki (World Medical Association (WMA) General Assembly, 2013) states that physicians have a duty to ‘protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects.’. Principle 8 of this declaration communicates that while the primary purpose of medical research is to generate new knowledge, that goal can never take precedence over the rights or interests of individual research subjects. This calls to mind Kant’s viewpoint that in order to uphold dignity, human beings must be treated as ends in themselves, never as means to an end (Kant, 2019).

Article 3 of the UNESCO Universal Declaration on Bioethics and Human Rights (2005) states that ‘human dignity, human rights and fundamental freedoms are to be respected’ and specifically state that the wellbeing of an individual should take precedence over the ‘sole interest’ of either science or society as a whole. The WMA International Code of Medical Ethics dictates that a physician shall be ‘dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity’ (WMA,
In Ireland, the Irish Medical Council’s Guide to Professional Conduct and Ethics for Doctors (Irish Medical Council (IMC), 2019) and the Nursing and Midwifery Standards and Guidance (Nursing and Midwifery Board (NMBI), 2021) both state that respecting dignity is a requirement of providing acceptable care to patients.

Clearly, then, inherent human dignity holds an important place in society and in medicine. Its widespread presence as a guiding principle in human rights doctrines, and as a fundamental ethic for medical professionals indicates the significance of dignity to humankind the world over.

1.5 Dignity in medical practice

As described above, dignity has been highlighted as an important principle in national and international guidance documents for many decades and is upheld as a key value in relation to medical care. Within healthcare, dignity is perhaps most studied in relation to palliative medicine and end of life. The concept of dignity frequently arises in relation to physician-assisted death (Back, Wallace, Starks & Pearlman, 1996; Emanuel, Fairclough, Daniels & Clarridge, 1996; Ganzini et al., 2000; Sullivan, Hedberg & Fleming, 2000). Indeed, the phrase ‘death with dignity’ has almost become synonymous with physician-assisted death, including in Ireland where the recently drafted Bill on assisted suicide is titled ‘Dying with Dignity’ (Houses of the Oireachtas, 2020).

However, there is an emerging emphasis on dignity-in-care and dignity therapy for those with terminal illnesses, whether or not they wish to engage with death-hastening measures. The Patient Dignity Inventory (PDI) which will be discussed in more detail later in this thesis,
was originally developed for use in palliative care settings (Chochinov, 2008) based on an empirical model of dignity in the terminally ill (Chochinov, 2002). Despite dignity being a nuanced and multifaceted concept, nevertheless attempts have been made to capture and encapsulate patients’ and carers’ understanding of the term, and to analyse the meaning of dignity in palliative care (Johnson, 1998; Chochinov, 2002).

Johnson’s review distils dignity in death down to three concepts: humanness, humaneness and communication. Each individual may have a different understanding of what a ‘proper’ or dignified death would be for them. The extent to which a person’s individual needs are communicated to, understood and enacted by the people around them determines in great part the dignity of their death (Johnson, 1998).

In attempting to develop a framework for patients’ conceptualisation of dignity in palliative care, Chochinov and colleagues performed latent content analysis on qualitative interviews of 50 patients in a palliative care service in Canada. This analysis revealed three major categories encapsulating dignity in end-of-life patients: illness related concerns, dignity conserving repertoire and social dignity inventory (Chochinov, 2002). Illness related concerns encompass loss of independence, including cognitive acuity and functional capacity; and symptom distress, including physical and psychological suffering. Dignity conserving repertoire includes both dignity conserving perspectives, like role preservation and generativity; and dignity conserving practices, such as living in the moment. The social dignity inventory is made up of five externally-linked subthemes: privacy boundaries, social support, tone of care, burden on others and concerns for after death.
There are parallels to be seen between Johnson’s and Chochinov’s taxonomies of dignity. The social dignity inventory links to humanness, in that it is relational and focused on humans treating each other as connected in their humanity. The dignity conserving repertoire could be thought of as representing humaneness; compassion and consideration for patients’ needs being displayed through dignity conservation and role preservation. Communication underpins the whole process, and may be negatively impacted by illness related concerns such as cognitive or functional difficulties.

Both of these analyses of dignity in palliative care demonstrate that dignity has both internal and external components. That is to say that dignity is experienced both as self-esteem and through the esteem of others. Being seen and treated as a whole individual with needs and wishes, deserving of acknowledgement and respect, generates a sense of dignity. Dignity therapy (DT), developed by Chochinov and colleagues on the basis of this earlier work, derives largely from this idea. Dignity therapy involves recording the patient speaking about their life, the end of their life, and what they wish their legacy to be after they have died. These recordings are transcribed and discussed with the patient, imbuing them with an importance and acknowledging the value of the person and their perspectives (Chochinov et al., 2005). This form of psychotherapy had extremely high rates of patient satisfaction and efficacy, with 91% of participants reporting satisfaction with dignity therapy, 81% reporting it had been or would be helpful for their family and 76% reporting an improved sense of dignity following participation. Efficacy of DT has been demonstrated over control (Rudilla et al., 2016) as well as over treatment as usual (Hall et al., 2011; Juliao et al., 2013) in terms of reduction of anxiety, improvement of subjective dignity and other measures. Recently, systematic reviews on DT
have concluded that the evidence supports the fact that DT is a beneficial intervention (Martinez et al., 2016; Li et al., 2019, Xiao et al., 2019).

Of course, this sort of therapy is, to a large extent, uniquely relevant to palliative care. However, the concept of listening to patients’ unique perspectives and validating their experiences through reflection is certainly well established in other forms of psychotherapy. Psychiatric patient satisfaction is known to be higher on receipt of quality psychotherapy (Stein et al., 2011; McHugh, Whitton, Peckham, Welge, & Otto, 2013). Perhaps the process of engaging with psychotherapy; a human and humane process, deeply rooted in communication, is dignifying, whether the therapy is dignity psychotherapy or another form.

Surprisingly, and despite the fact that dignity is central to ideas of rights and social justice – issues which are clearly engaged in the setting of involuntary care (Kelly, 2014; Feldman, 2002) – the concept of dignity has received little attention in psychiatric literature to date. While there have been considerations of dignity in bioethics and bio-law (Beyleveld & Brownsword, 2001) and theoretical discussions of dignity in psychiatric nursing (Lindwall, Boussaid, Kulzer & Wigerblad, 2012) and forensic psychiatry (Buchanan, 2015), few papers present quantitative data on this topic. This omission is especially remarkable in light of the fact that involuntary admission is a feature of most mental healthcare systems around the world (Stefano, 2008; Chandrasekhar, 2018) and involuntary psychiatric patients are particularly vulnerable to violations of dignity that can occur through restriction of freedom and diagnostic labelling (Jacobson, 2009). Dignity has particular relevance to psychiatric care precisely because of the existence of involuntary care, where respect for autonomy cannot always be upheld. Furthermore, there are potential benefits to be gained from upholding dignity as a key value in
psychiatric inpatient settings, a fact which I will explain in more detail with reference to the
behavioural and social components of dignity in section 1.8, dignity and the social environment.

1.6 Criticisms of dignity

Despite the widespread presence of dignity in medical ethical regulations, there is
disagreement among theorists as to the importance and utility of dignity in healthcare practice
and bioethics. In a somewhat infamous and frequently-cited editorial in the British Medical
Journal, Ruth Macklin (2003) argued that dignity was useless as a concept and could be
eliminated from bioethical philosophy without loss of content.

In that piece, Macklin lists a number of instances where human dignity is mentioned in
legislation and bioethical guidance documents. She condemns its use variously as redundant,
vague and sloganistic. Macklin argues that without clarification of its meaning, the word dignity
is rendered a mere slogan. However where authors have attempted to provide a more detailed
outline of the definition of dignity, Macklin criticizes the term ‘dignity’ as redundant. She draws
parallels between the definitions of dignity offered by the authors and other existing principles
of medical ethics such as autonomy and capacity. Her opinion is that dignity is essentially just a
more ambiguous term denoting respect for persons and autonomy. She concludes that dignity
could be eliminated from the philosophical lexicon without losing any moral substance, and
questions why the term dignity has become so prominent and pervasive in the world of medical
ethics. Macklin acknowledges dignity’s links to religious doctrine and human rights philosophy,
but clearly opines that dignity has no place in secular discussions on bioethics.
Stephen Pinker also challenges the use of the term dignity as a basis for bioethical arguments in his arguably even more incisive opinion piece entitled ‘The Stupidity of Dignity’ (2008). The US President’s Council on Bioethics produced a collection of essays entitled Human Ethics and Bioethics in 2008. This document was produced in response to requests for clarification of the meaning of human dignity, and includes sections on; human dignity and modern science, human nature and the future of man, dignity and modern culture, sources and meaning of dignity, theories of human dignity and human dignity in modern medicine. Pinker highlights some rather alarming segments in the anthology, including where the founding director of the council (Leon R. Kass) denounces licking ice-cream as undignified ‘cat-like behaviour’ and eating in public as unacceptable ‘enslavement to the stomach’. Pinker questions whether a person with such conservative views is well placed as a moral authority to define and describe the role of dignity in medical ethics. He further notes that eleven of the contributors to the 2008 President’s Council work for Christian institutions, and that four others are outspoken advocates for the centrality of religious morality in the public domain. He highlights the potential for bias present on the council, not only because of the political leanings of those included, but also because of the conspicuous absences. There were, for example, no life scientists, historians, sociologists or psychologists involved in writing the Human Ethics and Bioethics document. While acknowledging that partiality does not automatically equate with bias, there is little doubt that the composition of the President’s Council brings with it the potential for a conservative and religious slant on what was presumably intended to be a definitive document on human dignity.
Pinker’s critique of the collection of essays raises an important point in relation to any writings on dignity: the term remains open to interpretation. One example of this comes from France, where both sides of a case invoked human dignity to argue directly opposite points of view (Davis, 2006). French and US legal systems both criminalized the sport of dwarf tossing in the 1990s arguing that the treatment of little people as projectiles, analogous to inanimate objects or sports equipment, compromised their dignity (Conseil D’Etat, 1995). Manuel Wackenheim, one of the little people who was employed by promoters of the sport as a projectile, argued that the legislation contravened his dignity by denying him the right to work. He maintained that it was his autonomous choice to be employed in this manner, and he rejected the idea that the sport represented an affront to his dignity as, for him, dignity consisted of having employment. (Mr Manuel Wackenheim v France Communication No 854/1999, UN Doc CCPR/C/75/D/8541999 [13 November 1996], UN Doc A/57/40 at 179 [2002] Decision of the Human Rights Committee, 75th Session, delivered.) Ultimately, the UN Human Rights Committee upheld the decision of legislators to criminalise the practice, ruling that the ban on dwarf tossing was not discriminatory and could be justified in order to preserve human dignity as a whole. Both sides in this legal case argued on the basis of dignity, demonstrating the subjectivity and malleability of the concept of dignity.

Any ideological standard risks manipulation and misuse. One must only look at how the Nazi party weaponized the concept of ‘purity’ against victims of the Holocaust (Meinecke, Zapruder & Kaiser, 2007) to recognise the harm that can arise from a seemingly innocuous or even positive moral standard. Dignity, being so open to interpretation, could potentially be abused in a similar manner. Using the façade of dignity-preservation to justify external
judgement and limitations of freedom certainly has the potential for harm. There is no doubt that we must be vigilant against the potential for abuse of the concept of dignity in medical ethics, especially within the field of psychiatry.

However, the fact that the concept of dignity is somewhat vague, and remains open to varying interpretation, brings benefits as well as risks. The ambiguity inherent in the term dignity, and the wide acceptance that dignity is an important concept in philosophy and ethics, gives it political weight (Harvey & Salter, 2012). Dignity can be used to draft aspirational policies and to keep politically opposed stakeholders engaged in policymaking, where a more concrete concept might be too polarising (Caulfield & Brownsword, 2006). While opposite sides of the political spectrum might disagree with what constitutes respect for human dignity, they can typically both agree that human dignity should be respected. It is also argued that respect for dignity confers greater protections than autonomy alone. Respect for human dignity is a rationale for preventing degradation, humiliation, shame or maltreatment— none of which are adequately guarded against by respect for autonomy alone (Hoffman, 2020). Moreover, dignity has protective functions even for those with limitations on their autonomy, such as people who lack capacity or those who are incarcerated.

While it may be the case that dignity is too nebulous a concept to use as an arbiter in complex philosophical debates, as argued by Macklin and Pinker, that is not to say that it is without use. A key component of harnessing the usefulness of dignity seems to be acknowledging its place as a guiding principle, used to inform the more specific regulations required to operationalise the term. Using dignity as a fundamental starting point from which an organisation or institution builds policies or rules allows for it to function as a useful tool
(Morrissey, 2016). The commitment to considering and upholding the dignity of people within an organisation becomes a form of social contract, rather than being rule-of-law. Evaluations and governance can be framed around dignity; assessing actions, policies and procedures in terms of whether they enhance or infringe upon the dignity of those affected by them. Dignity, where it is accepted as an important fundamental principle, functions to encourage a ‘reflective perspective’ and can provide guidance on, but not dictate, norms and practices within an institution or community (Morrissey, 2016). This brings us to explore the duality of dignity.

1.7 Duality of dignity in legal philosophy

As described above, critics of the term ‘dignity’ frequently condemn it as too vague to be useful. Responding to these criticisms, legal philosopher Roberto Adorno (2013) suggested that part of the difficulty may stem from a lack of understanding about the duality of dignity. He argues that there is a distinction to be drawn between principles and rules, as they relate to jurisprudence in general and dignity in particular. Making the distinction between dignity as an overarching principle and dignity as a rule, and embracing rather than criticising the broad application of the term ‘dignity’, may allow us to understand and use it in a more nuanced way.

Legal philosopher Ronald Dworkin laid out a framework for distinguishing rules from principles based on the type of guidance that they give. According to Dworkin (1977, pp 35-37); rules are specific, all-or-nothing standards which are either valid; in which case they must be applied and dictate the outcome of a particular situation, or not valid; in which case they contribute nothing. Rules are absolutist and clearly dictate an outcome, for example determining a speed limit for a certain area. If two rules conflict, one of them must be invalid,
in which case an adjudicator (for example a judge) must have recourse to broader underlying principles to help determine which rule to maintain and which to disregard or rewrite. That is the role of principles.

Principles, in Dworkin’s 1977 legal philosophy, are moral standards which do not dictate specific outcomes but rather guide the general direction of a judicial decision. Unlike a rule or law, a principle does not set out specific stipulations for its application. Additionally, principles have the dimension of ‘weight’, or relative importance, so multiple principles may be considered at once without necessarily invalidating each other. Application of one principle may outweigh other principles or invalidate certain rules, depending on the specifics of the case.

Dworkin defines rules as obligations made with proper authority, which exist either because those subject to the rule have agreed to be bound by it, or because the rule has been made in accordance with an agreed set of practices by those with proper authority to do so. For example, the rules of a game can be laid out by those playing the game who agree to a set of rules prior to playing. Or the rules of a game can be made by the person who invented the game, and listed in the formal instructions. These are examples of primary rules. Rules are black and white, and give specific directions to those bound by them.

There may also be secondary rules stemming from a primary rule, i.e.: stipulations as to how and by whom a rule may be enforced. Secondary rules may outline punishments for breaking primary rules (for example, a player losing a turn if they make a mistake). Primary and secondary rules can be enforced by a second-party (i.e.: the person directly affected by the rule being broken, for example another player) or a third-party (i.e.: an external person whose role
it is to enforce the rules, such as a referee) (Haidt, 2001). However, a rule cannot be binding simply because someone with power wishes it to be so. The validity of a rule lies in its having been made by those with the proper authority, and this sets it apart from an order. For example, a kidnapper making the order, ‘Hand over your wallet or I’ll tie you up’ differs from a judge’s order of imprisonment to a person who has failed to pay a fine. The former is an order made by someone with physical force but no legal authority, the latter is an agreed rule of law being validly enforced within a civilised society (Dworkin, 1977).

A principle, in Dworkin’s theoretical framework, is a broader precept which is seen as having fundamental integrity. While rules can derive from principles, principles are generally broader than one rule or set of rules. A principle is a standard with a virtuous basis, the observance of which is necessary to preserve fairness or justice or other aspect of morality. In adjudicating a ‘hard case’, such as where a law runs contrary to general morality, a judge may refer to higher principles in order to justify a ruling which breaches or negates current laws in a jurisdiction.

A famous example of this situation in action comes from the United States of America Brown Vs Board of Education. In 1954, the parents of a black school girl, Linda Brown, sued the Board of Education of Topeka, Kansas on the grounds that denying their daughter access to the all-white elementary school near her house was discriminatory. School segregation was deemed legal at the time on the basis of the ‘separate but equal’ doctrine brought in by the Supreme Court in 1896 (Plessy V Ferguson). In that case, which related to racial segregation on public transport, it was ruled that laws ‘implying merely a legal distinction’ between white and black people were not necessarily discriminatory. In Brown V Board of Education, however, the
Supreme Court ruled that racial segregation in schools was inherently discriminatory and that the ‘separate but equal’ doctrine could not stand (Brown V Board of Education, 2016).

In other words, the rules legislating for segregation of schools violated the principle of equality, and were therefore invalid. From a legal perspective, the local laws on school segregation ran contrary to the 14th amendment of the US Constitution, an amendment which enshrined ‘equal protection under the law’ as a principle of US governance. The 1954 Supreme Court judgement effectively overturned the ‘separate but equal’ doctrine and eventually led to racial integration of the school system in the USA.

Without a higher moral authority to justify deviation from the rule of law in certain cases, the courts would be bound to follow and enforce antiquated laws until such time as they could be changed by legislation. There is value, therefore, in having a broad and widely agreed upon principle, which can be used to uphold or to invalidate more specific rules.

Principles also have value in that they can be used to guide decision making in an arena where a specific rule or law has not yet been made. In 1989 in New York, Elmer Palmer, the grandson of a wealthy man, was named as a heir in the man’s will. He had been convicted of murdering his grandfather in order to inherit his fortune. There were, of course, criminal rules in place which would dictate his punishment for having committed murder, but there was no legislation stipulating that murder on the part of an heir would invalidate a will. In fact, the judge clearly stated that the existing laws, if literally construed, would have granted Palmer his grandfather’s fortune. However, he went on to say that all laws, including contracts, are governed by fundamental maxims and standards of the common law. He gave examples of cases where the principle, ‘No one shall be permitted to profit from his own fraud’ was applied
to invalidate insurance policies or wills, despite there being no statute precisely governing or enforcing the principle. The judge ruled that allowing the will to be executed would violate the common law principle that no man may gain from his own wrong. The grandson was not granted his ill-gotten inheritance (Riggs V Palmer 115 NY 506).

Principles, according to Dworkin’s classification, have the dimension of ‘weight’. Meaning that it is possible to consider more than one principle at a time, and balance their relative weights. Even where they appear to conflict, different principles do not necessarily invalidate one another. In a case where multiple principles are at play, it is the role of an adjudicator to balance the weights of those principles in order to arrive at the most just conclusion possible. While one rule may have more important consequences than another (for example, the rule that one must not drive through a junction when the traffic light is red, versus the rule that one must not throw chewing gum on the ground), two rules within any system of rules have equal weight. Principles, on the other hand, can be considered simultaneously in relation to each other even where they appear to conflict, as each principle is said to have relative weight.

The concept of weight exists within medical ethics. Beauchamp and Childers’ four pillars of medical ethics; beneficence, non-maleficence, justice and autonomy (Beauchamp & Childers, 2019) frequently all apply to some degree or another in medical ethical dilemmas. No simple formula exists to decipher which ethical principle has greatest weight (Page, 2012) but certainly one does not invalidate another. Each pillar must be considered and weighed against the others in coming to the best possible decision in difficult cases.
In terms of healthcare practice and medical ethics, we should not attempt to dispense with the principle of human dignity in favour of a set of enforceable rules stipulating how dignity should govern practice. Instead, we can recognise that rules laid down in legislation and governance codes which define patient dignity as a standard of care are important, but may at times contradict each other. Where conflict or incongruence exists between rules, adjudicators may refer to the principle of human dignity as a guide in order to come up with a fair and just conclusion. Rules and principles function differently from each other in legal practice, with each having an important role to play (Aalto-Heinilä, 2013). The rules outlining how clinicians must respect patient dignity have specificity and enforceability, but the principle of human dignity has flexibility and can be balanced with the weight of other ethical and moral principles. Both of these facets of dignity have relevance and importance in human bioethics (Adorno, 2013).

Dignity as a foundational principle, used to form a reflective perspective and inform policies and practices, encourages the humanisation of medicine and medical institutions. (Morrissey, 2016). Shifting the focus from the current ‘efficiency-enhancing’ perspective of modern medicine to a perspective which values the whole humanity of the patients in a practice can bring about real enhancement of health (Manchada, 2013). There is an argument to be made that focusing on dignity in inpatient psychiatric settings could improve not only individual patient experience but also therapeutic milieu. To understand this better, we must consider in more detail the social and evolutionary aspects of dignity which I describe in the following section.
1.8 Dignity and the social environment

Human beings are a cooperative species. Modern evolutionary biologists suggest that natural cooperation between kin and non-kin human beings is as important to the theory of evolution as genetic mutation or natural selection (Nowak, 2006). Cooperation is vital for the health of our species and accounts for some of the greatest achievements of humankind on the planet, from the pyramids to electricity grids (although it may also be implicated in the climate emergency and collapsing eco-systems associated with human growth, expansion and resource-utilisation). As cooperation is essential to human survival, reciprocity is essential to cooperation (McClelland, 2011). This reciprocity encompasses not only symbiosis, where both parties benefit simultaneously, but also ‘reciprocal altruism’ (Trivers, 1971), where there can be considerable delays in reciprocity or reward for the person who performs the altruistic act. A person who jumps into a river to save another does not do so in order to be saved themselves at a later date. Their act may never be reciprocated or rewarded. It may not benefit the actor at all, but benefits the community or the species at large.

The inverse to this, so called ‘strong reciprocity’ (Gintis, 2000), involves third party punishments for those who deviate from social norms. This links to the idea of ‘secondary rules’, or enforcement of valid rules by external parties as described by Dworkin (1977) and discussed above. Third party enforcement of rules is a characteristic feature of the human race (Haidt, 2001). McClelland (2011) hypothesises that the pervasive presence of complex (sometimes third-party reinforced) non-kin cooperation in human society points to it being the product of human evolution. His article, ‘A Naturalistic View of Human Dignity’ gives fascinating insights into the neurodevelopment of cooperation and reciprocity. Emotional regulation,
shared attention, emotion perception and reflexive distress (i.e.: being distressed by the
distress of another) develop in predictable and well documented ways in human infants. Where
they are disrupted, infants display not only emotional but also neurological dysfunction (Schore
& Schore, 2008; Watt, 2018). Experiencing empathy, perceiving fairness or unfairness, and
being able to detect cheating are also suggested to have an evolutionary neurobiological basis,
and abnormal development of these capacities is associated with psychopathology such as
autism spectrum disorder and psychopathy (McClelland, 2011). McClelland therefore suggests a
biological matrix underpinning the notion of human dignity, which is based in cooperation and
communication. Reciprocity and equity are fundamental aspects of dignity, and function
alongside punishment to produce real social effects.

In order to better understand these effects, and how they may function in the milieu of
an inpatient psychiatric unit, we must first discuss punishment. Norms are developed in
humans both through internal normative guidance (such as an emotional response like guilt)
and socialisation (verbal and non-verbal training by parents and other figures). External
normative guidance comes in the form of rules, enforced through punishment (Gintis, 2003). As
previously described, this enforcement can be second-party (i.e.: the injured party punishes the
injurer) or third-party (i.e.: another person or people punish the injurer for what they did to the
injured party). From a social evolutionary perspective, foraging and hunter-gatherer societies
demonstrated punishment through criticism, ridicule, shunning or exclusion, all the way up to
assault and even execution (Boehm 2009, pp 64-89; Fehr & Fischbahrer, 2004; Panchanthan &
Boyd, 2004). This convention served egalitarian concerns, by suppressing usurpers who might
dominate or kill cooperating members of society to take the resources for themselves. It gave
the collective the power to regulate the individual for the safety of the group, even where that individual was physically strong and non-cooperative.

Punishment, in this way, is largely understood to have promoted cooperation (McClelland, 2011). However, punishment aimed at pro-socially behaving members within the cooperating group can decrease cooperation as a whole (Hermann, Thoni & Gachter, 2008), possible relating to protest or negative reactions to having been punished. Having a broadly cooperative and functional society depends on the threshold for punishment. Unjust punishment, or too low a threshold for punishment, negatively impacts cooperation. Stable and predictable punishment for defectors encourages cooperation (Boyd, Gintis & Bowles, 2010). Groups that confer dignity on all their members protect each other and are more likely to have an egalitarian culture (McClelland, 2011). It is especially important to note the effect of this ethos on newcomers, who may cooperate or defect depending on the social model they come into.

If we consider the psychiatric inpatient setting the social milieu, and experience of coercive interventions, for example, as the ‘punishment’, it becomes evident that having a fair and predictable implementation of these interventions, and protecting the dignity of all members of the group (even, or especially, those members who have experienced coercive interventions) can positively influence the social dynamic and group ethos as a whole. Of course, I am not suggesting that coercive interventions are used intentionally as punishments in psychiatric settings. Many legal and ethical regulations exist to ensure that they are used only when necessary to protect the individual, or individuals on the ward (Mental Health Commission, 2009a; Mental Health Commission, 2009b). I merely intend to highlight that, from
a social perspective, coercive interventions such as seclusion can function similarly to ‘punishments’ as understood by sociologists (e.g. exclusion) and can therefore usefully be considered within the broader concept of ‘punishment’ from an anthropological point of view.

Given the known importance of the therapeutic milieu in psychiatric inpatient settings, consideration of the social and relational aspects of dignity and its preservation through cooperation, reciprocity and fairness is a valuable avenue in improving inpatient care.

1.9 Dignity and Coercion

Dignity is a particularly important concept in the case of people whose autonomy is restricted, such as those who are incarcerated and those who are in hospital involuntarily.

Penal Reform International and the Association for the Prevention of Torture provide a framework for balancing security and dignity in prisons (Huber, Bernath, Allen & Delaplace, 2015) They recommend that monitoring bodies regularly review prisons and other coercive establishments, and interview those who are deprived of their liberty, in order to establish interventions which are negatively impacting on detainees’ dignity. They state that regularly assessing if the coercive practices used are necessary, proportionate and applied in a non-discriminatory way is essential to ensure that the dignity of those who are incarcerated is protected.

Involuntary admission and treatment are a feature of mental health care services around the world (Sheridan Rains et al., 2019). Coercive measures, such as forced medication, restraint and seclusion are not uncommon among involuntary inpatients, occurring in between 21% and 59% of involuntarily admitted inpatients in a large international study (Raboch et al.,
In psychiatric inpatient settings, the experience of coercion is not limited to involuntary inpatients, with up to 22% of voluntary patients reporting levels of perceived coercion similar to those reported by their involuntary counterparts (O’Donoghue et al., 2017).

There is wide variation as to the legislative basis for involuntary treatment internationally, but here we focus on the legislation governing involuntary psychiatric treatment in Ireland, the Mental Health Act (2001).

1.9.1 Involuntary admission under the Mental Health Act

Ireland’s Mental Health Act defines ‘mental disorder’ as ‘mental illness, severe dementia or significant intellectual disability where (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, and/or (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent’ (Section 3(1)). Patients can be involuntary admitted under the ‘risk’ criteria (Section 3(1a)), the ‘insight’ criteria (Section 3(1b)) or both.

The 2001 act states that ‘a person may be involuntarily admitted to an approved centre [inpatient psychiatry unit] and detained there on the grounds that he or she is suffering from a mental disorder’ (Section 8(1)) but cannot be so admitted ‘by reason only of the fact that the
person (a) is suffering from a personality disorder, (b) is socially deviant, or (c) is addicted to drugs or intoxicants’ (Section 8(2)).

There is a three-step procedure to involuntary admission under the mental health act. An initial ‘application’ is made by a concerned member of the public, such as a family member (Section 9(1)). There are people who are precluded from completing an application, for example a spouse currently in the process of separation proceedings, or a person who works in the approved centre named in the application (Section 9(2)).

Once a valid application has been received by a registered medical practitioner, they must review the subject of the application within 24 hours to assess whether they fulfil criteria for a mental disorder as defined by the act (Section 10(2)). The registered medical practitioner is disqualified from completing this assessment if they work or have a financial interest in the approved centre in question, or if they are related to the subject of the application (Section 10(3)). If they are satisfied that the subject of the application does fulfil criteria for involuntary admission, the registered medical practitioner completes a ‘recommendation’ form, and sends a copy of this to staff at the approved centre. The applicant, or the clinical director of the approved centre on their behalf, then arranges for the subject of the application and recommendation to be transported to the approved centre (Section 13).

There is a separate pathway for application by members of An Garda Síochána (Section 12), which involves taking the person into custody for assessment by a registered medical practitioner.

As soon as possible, and within 24 hours of admission to the approved centre, the subject must be assessed by a consultant psychiatrist to determine whether they are suffering
from a mental disorder (Section 14). If so, a 21-day ‘admission order’ is completed by the consultant psychiatrist, authorising involuntary admission to the approved centre. On completion of an admission order, the consultant psychiatrist must notify the Mental Health Commission, and provide the patient with written information about their rights (Section 16). The admission order is subject to independent review by a ‘mental health tribunal’ (Section 18) and the tribunal’s can be appealed by the patient to the Circuit Court (Section 19). The initial 21-day admission order can be followed by a ‘renewal order’ of up to three and then six months’ duration (Section 15), assuming the preceding order is affirmed by a mental health tribunal (Section 18). If and when the consultant psychiatrist is of the opinion that the person no longer fulfils criteria for a mental disorder, they must revoke the involuntary admission order (Section 28). The patient may then be discharged, or choose to remain in hospital on a voluntary basis (Section 29).

1.9.2 Change of inpatient’s legal status under the Mental Health Act

A voluntary adult patient being treated in an approved centre can have their status changed to involuntary under the MHA 2001. Where a voluntary patient requests to leave the approved centre but, in the opinion of a registered nurse or registered medical practitioner, fulfils the criteria for a mental disorder they may be detained temporarily under the mental health act (Section 23). This temporary detention can last for up 24 hours, within which time the patient must be reviewed by their treating consultant psychiatrist and an independent consultant psychiatrist (Section 24). If both the patient’s own consultant and the independent consultant psychiatrist determine that the patient is suffering from a mental disorder as
defined by the act, the patient’s treating consultant psychiatrist completes an admission order (Section 24(3)). Thereafter, the same legal framework and review process apply to these patients as to those admitted under Section 15 above.

1.9.3 Correlates of involuntary psychiatric admission

Internationally, involuntary admission is known to be associated with male gender (Myklebust, Sørgaard & Wynn 2014; Hustoft et al., 2013), psychotic illness (Daly & Craig 2019; Zhou et al., 2015), symptom severity (Kalisova, Raboch, Nawka et al., 2014; Hustoft et al., 2013; Salize & Dressing, 2004), reduced insight (Gou et al., 2014), perceived dangerousness (Mulder et al., 2008; Gou et al., 2014) and unemployment (Chang, Ferreira, Ferreira & Hirata, 2013).

There are increased rates of involuntary admission among minority ethnic groups in many countries, including Switzerland (Lay, Nordt & Rössler, 2011) and New Zealand (Wheeler, Robinson & Robinson, 2005).

Involuntary admission in Ireland, as in other countries, is associated with specific diagnoses, including schizophrenia and related disorders (44%), mania (16%) and depression (10%) (Curley et al., 2016) (Daly & Walsh, 2015).

While patient experience of coercion and restrictive practices in psychiatric care has been widely studied (Chieze, Hurst, Kaiser & Sentissi, 2019; Hotzy & Jaeger, 2016) there is a paucity of research examining patient experience of dignity in involuntary psychiatric settings.
1.10 Dignity in involuntary psychiatric settings

Dignity is relational, existing in the dynamic between individuals. A person has intrinsic dignity by virtue of their humanity, and upholds their own dignity through their actions, attributes and attitudes. Extrinsically, a person’s dignity is upheld by the way in which they are treated by others and by society or its institutions. Conversely, a person’s dignity can be violated by the actions or attitudes of others, or by the actions of the individual themselves. In respecting the dignity of another person, we uphold all human dignity, and thereby our own. At times, societal structures limit the autonomy of individuals and restrict or even criminalise certain actions, attitudes or attributes on the basis that they contravene human dignity, such as in the example of dwarf-tossing described previously in section 1.6. While respect for dignity certainly encompasses regard for autonomy, dignity is nonetheless an external value which extends beyond the individual person (Kelly, 2014).

It could be argued that, in some instances, involuntary admission is undertaken in order to protect a patient’s dignity: for example, in the case of a person with manic and psychotic symptoms such as disinhibition or hypersexuality, where reputational damage is a significant risk. In this case, involuntary admission, if required, may protect or enhance the individual’s dignity through management and treatment of illness in a suitable environment. It is conceivable, therefore, that involuntary psychiatric inpatients may experience equal or enhanced dignity compared with voluntary patients, as a result of symptom type and severity.

Modern psychiatric inpatient care, while significantly advanced and improved since the days of the asylum, continues to present challenges to patients and clinicians alike. Although there are age-old ethical frameworks and more modern legal frameworks in place to protect
the rights of involuntary patients, the dignity of a person whose liberty and autonomy are restricted may be inherently at risk. In addition, as a symptom of illness, some patients may experience disinhibition and behavioural change. This may potentially lead to or add to a person acting in an undignified manner. Despite the difficulties with defining dignity outlined above, it remains a valuable construct to examine for two main reasons. Firstly, the distinction between autonomy and dignity allows it to be used as a comparator between involuntary and voluntary patients, where autonomy would be automatically confounded by legal constraints on patients’ freedom. Secondly, dignity has significant face validity and is defended by clinicians as a useful ethical construct (Hofmann, 2020), especially given that medical and nursing ethical guidelines explicitly stipulate that patients’ human dignity must be respected (IMC, 2016; WMA, 2006).

Given that involuntary admission and coercive treatment are unique to mental health care, assessing the impact (if any) of involuntary treatment on patient dignity is particularly salient. It behoves those working in psychiatry to strive for continued improvement of inpatient care. Understanding how to safeguard the dignity of a person in psychiatric inpatient care is part of that, and requires that we first consider the current evidence on the experience of dignity in inpatient psychiatric care, and then investigate factors associated with lower experience of dignity.

1.11 Study aims and objectives

This research aims to elucidate the factors that people admitted to psychiatry units consider important in relation to their experience of dignity, and to identify the demographic
and clinical features associated with poorer self-rated dignity among psychiatric inpatients. We wish to directly compare voluntary and involuntary patient groups’ subjective experience of dignity, firstly through analysing the existing literature via systematic review and secondly through cross-sectional analysis of current voluntary and involuntary inpatients.

In this exploratory analysis, we aim to gather data on demographic and clinical variables from current psychiatric inpatients, both voluntary and involuntary, under the Mental Health Act, 2001. We hypothesise that certain factors will be associated with patient experience of dignity (such as legal admission status, ethnicity, working alliance, cognition and others) and aim to analyse trends in dignity scores by statistical means.

This study is part of a larger investigation into dignity and coercion among voluntary and involuntary patients in two inpatient psychiatric units in Dublin.

1.12 Research question

We were interested in evaluating the experience of all psychiatric inpatients’ in relation to dignity, and in assessing whether significant differences exist between voluntary and involuntary inpatients. Through discussion, we developed our specific research questions: ‘Do patients in involuntary psychiatric inpatient settings experience their care as dignified, compared to voluntary patients?’ and ‘What factors are associated with poorer experience of dignity in inpatient psychiatric care?’

These questions were developed in line with our objectives as stated above; to specifically interrogate subjective patient experience of dignity; to examine the differences, if
any, between voluntary and involuntary patient groups; and to identify factors associated with poorer experience of dignity among psychiatry inpatients.

1.13 Summary of chapter 1

Dignity is an ancient and multifaceted concept with legal, philosophical and ethical implications in the modern day. In this chapter, I have outlined the background to this thesis and explained why I believe dignity is a relevant construct to study in relation to voluntary and involuntary psychiatric care. Following on from this general introduction, in chapter 2, I will detail the systematic literature review that I performed, arising from my research aims and objectives.
Chapter 2: Systematic Literature Review

2.1 Overview of chapter 2

Following on from the introduction, this chapter details the systematic review and thematic analysis of literature pertaining to dignity that I undertook as part of this thesis. In this chapter, I outline the research question, search protocol, quality assessment and thematic analysis. I then discuss the strengths and limitations of the review, and conclusions arising from it.

2.2 Outline of systematic review

In conducting the literature review, I began by generating a research question, followed by devising a search protocol and inclusion and exclusion criteria, through an iterative process. I registered the review with the International Prospective Register of Systematic Reviews (PROSPERO). I performed a systematic search of PubMed, PsycInfo and the Cochrane Library, and hand-searched references and bibliographies for additional relevant articles.

The systematic search yielded a total of 202 references. The titles and abstracts of these 202 journal articles were reviewed for compliance with inclusion criteria. Eighteen articles were eligible for further review and ultimately nine papers met the criteria for inclusion in the final analysis. I carried out critical appraisal of the individual articles, using the quality analysis templates from the Critical Appraisal Skills Programme (CASP) as a guidance tool. I used a phenomenological approach to analyse the content of the articles and develop a thematic framework, with input and co-assessment from my supervisor (BDK).
This review demonstrated the paucity of literature, especially quantitative literature, examining patient experience of dignity in inpatient psychiatric care.

2.3 Prospective registration

I followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance when performing this systematic review (Page et al., 2021). These guidelines were developed from the earlier QUOROM statement (Moher et al., 1999) which focused primarily on the conduct of meta analyses and randomised controlled trials. The PRISMA guidelines were developed in order to expand the focus to include systematic reviews as well as meta-analyses. They were updated in 2020 to reflect the advances in search technology and methodology. PRISMA aim to improve the quality of systematic reviews and meta analyses by providing explicit guidance on the performance and reporting of these reviews (Page et al., 2021). I registered this review with a prospective database of systematic reviews (PROSPERO ID CRD42020154633).

2.4 Research question

Prior to commencing the systematic search, I discussed the specific aims and hypotheses of this research with my supervisor for this thesis. As outlined in the introduction, we were primarily interested in the construct of dignity and how it is experienced by inpatients in psychiatric settings. In particular, we were curious about the impact of legal admission status on patient experience of dignity in care. Through discussion, we devised the primary research question: ‘Do involuntary psychiatric inpatients experience their care as dignified, compared
with voluntary patients?’ and the secondary question: ‘What factors are associated with experience of dignity in inpatient psychiatric care?’

From the primary research questions, we developed a Population, Intervention, Comparison, Outcome (PICO) grid (Table 1). To generate the PICO grid, we used an iterative process based on clinical and research experience and knowledge of the academic literature to focus on the population of interest to our research programme and this systematic review (psychiatry inpatients), using terms commonly used in the literature on this topic. We identified key terms commonly used to describe the intervention we wished to consider (involuntary psychiatric admission); and to describe the comparison group (voluntary psychiatry inpatients) using medical subject heading (MeSH) terms specific to each database. We described the outcome of interest (dignity) using the closely related terms, ‘dignify’ and ‘dignified’. We deliberately did not broaden the outcome of interest to include thematically related terms, such as ‘respect’, as we were specifically interested in the construct of dignity.

Table 1: Population, Intervention, Comparison, Outcome (PICO) grid

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Inpatients</td>
<td>Involuntary</td>
<td><em>Voluntary admission(s)</em> (in psychiatry)</td>
<td>Dignity</td>
</tr>
<tr>
<td>Inpatient service users</td>
<td>Mental Disorder</td>
<td>Voluntary psychiatric patients</td>
<td>Human dignity</td>
</tr>
<tr>
<td>Inpatient OR</td>
<td>Involuntary admission</td>
<td>Voluntary service users</td>
<td>Patient dignity</td>
</tr>
<tr>
<td>Admitted patients AND</td>
<td>Detained</td>
<td>Voluntary psychiatric inpatients</td>
<td></td>
</tr>
<tr>
<td><em>Psychiatric Department, Hospital</em> OR</td>
<td>Coerced treatment</td>
<td>Voluntary psychiatric admissions</td>
<td></td>
</tr>
</tbody>
</table>
2.5 Eligibility

Phenomenography, deriving from the Greek phainomenon (becoming visible or luminous) and graphia (describing something) (Kaapu, Saarenpaa, Tiainen & Paakki, 2006) is the study of the way people perceive, experience or interpret a phenomenon (Marten, 1981). It is a method of qualitative analysis used to describe the essence of something from the perspective of those who have experienced it. Given our specific research interest, i.e. the subjective experience of dignity among psychiatry inpatients, we determined that this was an appropriate method of analysis for our review. We therefore constructed inclusion and exclusion criteria that supported this method.

To be eligible for inclusion in our analysis, articles we identified in our searches had to (1) comprise novel research; (2) include psychiatric inpatients; (3) examine patients’ subjective experience of psychiatric care, and (4) include involuntary patients. Papers were excluded if they (1) studied relatives or carers only; (2) did not mention patient legal status (3) did not include involuntary inpatients; (4) comprised a single case-study or case-report, or (5) were not available in English.
2.6 Information sources

We carried out the systematic search in PubMed (United States National Library of Medicine), PsycInfo (American Psychological Association) and the Cochrane Library. Relevant search-words were identified from the list of pre-defined vocabulary terms used to index articles, known as Medical Subject Heading or MeSH terms, on PubMed. Where relevant, search terms were adapted to fit pre-defined keywords for the different databases. The initial search was performed in January 2020. Monthly alerts were set up for the search terms after the initial search and monitored for new articles matching inclusion criteria. For non-indexed presentations, researchers hand-searched relevant conference proceedings and websites (e.g. Royal College of Psychiatrists, American Psychiatric Association, College of Psychiatrists of Ireland). In addition, bibliographies of articles included in the review were hand-searched for relevant articles.

2.7 Search protocol

Database-specific search protocols were developed, using both freetext and controlled vocabulary or Medical Subject Heading (MeSH) terms. Searches were completed by using the advanced search function to build a matrix of search terms from the PICO map. The full search protocol for PubMed is shown in Table 2 below.
Table 2: Full search protocol used in Medline (PubMed)

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Search Protocol MEDLINE (PubMed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&quot;psychiatry&quot;[MeSH Terms] OR &quot;psychiatry&quot;[All Fields] OR &quot;psychiatric&quot;[All Fields] AND (&quot;inpatients&quot;[MeSH Terms] OR &quot;inpatients&quot;[All Fields])</td>
</tr>
<tr>
<td>2</td>
<td>&quot;inpatients&quot;[MeSH Terms] OR &quot;inpatients&quot;[All Fields] OR &quot;inpatient&quot;[All Fields] AND service[All Fields] AND users[All Fields]</td>
</tr>
<tr>
<td>3</td>
<td>admitted[All Fields] AND (&quot;patients&quot;[MeSH Terms] OR &quot;patients&quot;[All Fields] OR &quot;patient&quot;[All Fields] AND (&quot;psychiatric department, hospital&quot;[MeSH Terms] OR (&quot;psychiatric&quot;[All Fields] AND &quot;department&quot;[All Fields] AND &quot;hospital&quot;[All Fields]) OR &quot;hospital psychiatric department&quot;[All Fields] OR (&quot;psychiatric&quot;[All Fields] AND &quot;department&quot;[All Fields] AND &quot;hospital&quot;[All Fields]) OR &quot;psychiatric department, hospital&quot;[All Fields])</td>
</tr>
<tr>
<td>4</td>
<td>&quot;inpatients&quot;[MeSH Terms] OR &quot;inpatients&quot;[All Fields] OR &quot;inpatient&quot;[All Fields]</td>
</tr>
<tr>
<td>5</td>
<td>&quot;mental health services&quot;[MeSH Terms] OR (&quot;mental&quot;[All Fields] AND &quot;health&quot;[All Fields] AND &quot;services&quot;[All Fields]) OR &quot;mental health services&quot;[All Fields] OR (&quot;mental&quot;[All Fields] AND &quot;health&quot;[All Fields] AND &quot;service&quot;[All Fields]) OR &quot;mental health service&quot;[All Fields] AND users[All Fields]</td>
</tr>
<tr>
<td>6</td>
<td>4 AND 5</td>
</tr>
<tr>
<td>7</td>
<td>(&quot;inpatients&quot;[MeSH Terms] OR &quot;inpatients&quot;[All Fields] OR &quot;inpatient&quot;[All Fields]) AND (&quot;psychiatry&quot;[MeSH Terms] OR &quot;psychiatry&quot;[All Fields] OR &quot;psychiatric&quot;[All Fields])</td>
</tr>
<tr>
<td>8</td>
<td>&quot;hospitals, psychiatric&quot;[MeSH Terms] OR (&quot;hospitals&quot;[All Fields] AND &quot;psychiatric&quot;[All Fields]) OR &quot;psychiatric hospitals&quot;[All Fields] OR (&quot;mental&quot;[All Fields] AND &quot;institution&quot;[All Fields]) OR &quot;mental institution&quot;[All Fields]</td>
</tr>
<tr>
<td>9</td>
<td>&quot;mentally ill persons&quot;[MeSH Terms] OR (&quot;mentally&quot;[All Fields] AND &quot;ill&quot;[All Fields] AND &quot;persons&quot;[All Fields]) OR &quot;mentally ill persons&quot;[All Fields] OR (&quot;mental&quot;[All Fields] AND &quot;patients&quot;[All Fields]) OR &quot;mental patients&quot;[All Fields]</td>
</tr>
<tr>
<td>10</td>
<td>1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9</td>
</tr>
<tr>
<td>11</td>
<td>“involuntary”[All Fields] OR (&quot;involuntary&quot;[All Fields] AND “admission”[All Fields])</td>
</tr>
<tr>
<td>12</td>
<td>&quot;mental disorders&quot;[MeSH Terms] OR (&quot;mental&quot;[All Fields] AND &quot;disorders&quot;[All Fields]) OR &quot;mental disorders&quot;[All Fields] OR (&quot;mental&quot;[All Fields] AND &quot;disorder&quot;[All Fields]) OR &quot;mental disorder&quot;[All Fields]</td>
</tr>
<tr>
<td>13</td>
<td>“detained”[All Fields]</td>
</tr>
</tbody>
</table>

38
<table>
<thead>
<tr>
<th></th>
<th>Search Protocol MEDLINE (PubMed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>coercive[All Fields] AND (&quot;therapy&quot;[Subheading] OR &quot;therapy&quot;[All Fields] OR &quot;treatment&quot;[All Fields] OR &quot;therapeutics&quot;[MeSH Terms] OR &quot;therapeutics&quot;[All Fields])</td>
</tr>
<tr>
<td>15</td>
<td>&quot;involuntary treatment&quot;[MeSH Terms] OR (&quot;involuntary&quot;[All Fields] AND &quot;treatment&quot;[All Fields]) OR &quot;involuntary treatment&quot;[All Fields] OR (&quot;coerced&quot;[All Fields] AND &quot;treatment&quot;[All Fields]) OR &quot;coerced treatment&quot;[All Fields]</td>
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<tr>
<td>17</td>
<td>&quot;commitment of mentally ill&quot;[MeSH Terms] OR (&quot;commitment&quot;[All Fields] AND &quot;mentally&quot;[All Fields] AND &quot;ill&quot;[All Fields]) OR &quot;commitment of mentally ill&quot;[All Fields] OR (&quot;involuntary&quot;[All Fields] AND &quot;commitment&quot;[All Fields]) OR &quot;involuntary commitment&quot;[All Fields]</td>
</tr>
<tr>
<td>18</td>
<td>involuntary[All Fields] AND (&quot;psychiatry&quot;[MeSH Terms] OR &quot;psychiatry&quot;[All Fields] OR &quot;psychiatric&quot;[All Fields]) AND (&quot;patients&quot;[MeSH Terms] OR &quot;patients&quot;[All Fields])</td>
</tr>
<tr>
<td>19</td>
<td>&quot;coercion&quot;[MeSH Terms] OR &quot;coercion&quot;[All Fields]</td>
</tr>
<tr>
<td>20</td>
<td>&quot;mental health&quot;[MeSH Terms] OR (&quot;mental&quot;[All Fields] AND &quot;health&quot;[All Fields]) OR &quot;mental health&quot;[All Fields]) AND act[All Fields]</td>
</tr>
<tr>
<td>21</td>
<td>&quot;involuntary treatment&quot;[MeSH Terms] OR (&quot;involuntary&quot;[All Fields] AND &quot;treatment&quot;[All Fields]) OR &quot;involuntary treatment&quot;[All Fields] OR (&quot;compulsory&quot;[All Fields] AND &quot;treatment&quot;[All Fields]) OR &quot;compulsory treatment&quot;[All Fields]</td>
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<td>22</td>
<td>11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21</td>
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<td>23</td>
<td>&quot;patient admission&quot;[MeSH Terms] OR (&quot;patient&quot;[All Fields] AND &quot;admission&quot;[All Fields]) OR &quot;patient admission&quot;[All Fields] OR (&quot;voluntary&quot;[All Fields] AND &quot;admissions&quot;[All Fields]) OR &quot;voluntary admissions&quot;[All Fields]</td>
</tr>
<tr>
<td>24</td>
<td>23 AND (&quot;psychiatry&quot;[MeSH Terms] OR &quot;psychiatry&quot;[All Fields] OR &quot;psychiatric&quot;[All Fields])</td>
</tr>
<tr>
<td>25</td>
<td>voluntary[All Fields] AND (&quot;psychiatry&quot;[MeSH Terms] OR &quot;psychiatry&quot;[All Fields] OR &quot;psychiatric&quot;[All Fields]) AND (&quot;patients&quot;[MeSH Terms] OR &quot;patients&quot;[All Fields])</td>
</tr>
<tr>
<td>26</td>
<td>voluntary[All Fields] AND service[All Fields] AND users[All Fields]</td>
</tr>
</tbody>
</table>
### Search Protocol MEDLINE (PubMed)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>27</td>
<td>voluntary[All Fields] AND (&quot;psychiatry&quot;[MeSH Terms] OR &quot;psychiatry&quot;[All Fields] OR &quot;psychiatric&quot;[All Fields]) AND (&quot;inpatients&quot;[MeSH Terms] OR &quot;inpatients&quot;[All Fields])</td>
</tr>
<tr>
<td>29</td>
<td>23 OR 24 OR 25 OR 26 OR 27 OR 28</td>
</tr>
<tr>
<td>30</td>
<td>&quot;respect&quot;[MeSH Terms] OR &quot;respect&quot;[All Fields] OR &quot;dignity&quot;[All Fields]</td>
</tr>
<tr>
<td>31</td>
<td>&quot;personhood&quot;[MeSH Terms] OR &quot;personhood&quot;[All Fields] OR (&quot;human&quot;[All Fields] AND &quot;dignity&quot;[All Fields]) OR &quot;human dignity&quot;[All Fields]</td>
</tr>
<tr>
<td>32</td>
<td>[Patient dignity] (&quot;patients&quot;[MeSH Terms] OR &quot;patients&quot;[All Fields] OR &quot;patient&quot;[All Fields]) AND (&quot;respect&quot;[MeSH Terms] OR &quot;respect&quot;[All Fields] OR &quot;dignity&quot;[All Fields])</td>
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<td>33</td>
<td>30 OR 31 OR 32</td>
</tr>
<tr>
<td>34</td>
<td>10 AND 22 AND 29 AND 33</td>
</tr>
</tbody>
</table>

### 2.8 Data collection and analysis

Articles which met criteria for inclusion were read multiple times during the initial process of familiarisation. Papers were analysed for quality using the relevant checklist from the Critical Appraisal Skills Program (CASP). They were then coded line-by-line and quotes relevant to the study question - both direct quotations from patients and secondary statements by researchers - were extracted into a Microsoft Excel spreadsheet. As previously mentioned, a phenomenographic approach to analysis was adopted. Statements from the papers were categorized into themes and subthemes by an inductive process of repeated review and revision. The thematic framework was continually revised as the process of coding and data extraction progressed. Accuracy and distinctness of the themes and subthemes within the
The thematic framework was assessed using inter-coder reliability. Once the framework was established, papers were re-read to confirm a good fit with the overall thematic framework. The process is described in more detail in the results (sections 2.10 and 2.11) below.

2.9 Results

2.9.1 Study selection

A total of 202 articles were identified across all databases (Fig. 1). Titles and abstracts were screened for relevance and compliance with inclusion criteria by RP and BDK. Articles identified as possibly relevant were read in full and screened for compliance with inclusion criteria.

Eighteen articles were selected for further review. Two articles were not available in English and seven did not include an identifiable involuntarily detained patient group (either the status of patients was not reported or only voluntary patients were studied). Nine articles were suitable for inclusion in the final analysis. The study selection is outlined in the flow diagram below (Figure 1).
Figure 1: Flow diagram

Records obtained from systematic search of databases
201

Additional records from hand-searching references
1

Titles and abstracts screened
202

Articles excluded
184

Full text articles reviewed
18

Articles excluded
9

Articles included in analysis
9
2.9.2 Characteristics and results of individual studies

Six of the nine included studies were qualitative in nature. The other three were quantitative or had mixed methodology. The studies were conducted in six different countries across two continents. Sample sizes varied from five to 84 participants. Brief summaries of the methodology, results and quality analyses of individual studies are summarized in Table 3.

More detailed description of the content of the individual articles follows below.
Table 3: Synthesis of results, quality analysis and risk of bias of primary studies

<table>
<thead>
<tr>
<th>Reference</th>
<th>Methodology</th>
<th>n</th>
<th>Results</th>
<th>Explicit mention of dignity</th>
<th>Overall quality *</th>
<th>Limitations and risk of bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Larsen &amp; Terkelsen (2014)</td>
<td>Qualitative. Ethnographic fieldwork through observation, conversation and formal interviews with inpatients and employees of an inpatient psychiatric unit in Norway over four months. Field notes and quotations examined using phenomenological approach and condensed into themes.</td>
<td>34</td>
<td>Four themes identified: (1) corrections and house rules; (2) coercion is perceived as necessary; (3) significance of material surroundings; and (4) being treated as a human being.</td>
<td>Yes</td>
<td>High</td>
<td>Difficult to assess rigour of data analysis based on process described in paper. Potential for researcher bias given the format of interviews. Translation from Norwegian to English risks choosing words which participants would not have chosen.</td>
</tr>
<tr>
<td>Sibitz et al. (2011)</td>
<td>Qualitative. Modified grounded theory approach, using pragmatism and interactionism. Semi-structured interviews by independent researcher. Patients had experienced involuntary admission in Austria. Transcripts analysed inductively into a coding frame. Final coding frame applied to all transcripts using QSR International’s NVivo software to extract a typology of patient perspectives.</td>
<td>15</td>
<td>Three perspectives on involuntary admission identified: (1) a necessary emergency brake; (2) an unnecessary overreaction; and (3) a practice in need of improvement</td>
<td>No</td>
<td>High</td>
<td>Potential for selection bias given theoretical sampling. Potential for researcher influence due to semi-structured interview. Small size and recruitment process may risk sampling bias.</td>
</tr>
<tr>
<td>Johansson &amp; Lundman (2002)</td>
<td>Qualitative. Narrative interviews of patients who had experienced involuntary psychiatric inpatient care in Sweden. Transcripts analysed using a phenomenological hermeneutic method, with coding.</td>
<td>5</td>
<td>Five themes identified, encompassing 18 condensed meaning units: (1) being restricted in autonomy; (2) being violated by intrusion on</td>
<td>Yes</td>
<td>High</td>
<td>Potential selection bias in view of small sample size. Response rate not clear.</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Data Collection</td>
<td>Data Analysis</td>
<td>Findings</td>
<td>Strengths</td>
<td>Weaknesses</td>
</tr>
<tr>
<td>-------</td>
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<td>--------------</td>
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</tr>
<tr>
<td>Schröder, Ahlstrom &amp; Larsson (2006)</td>
<td>Qualitative. Semi-structured interviews, based on an interview schedule, of patients who had attended an adult mental health service in Sweden, at the point of their discharge. Interviews were carried out in informants’ homes or neutral location within two weeks of discharge. Transcripts analysed using a four-stage phenomenographic method. Results of the analysis compared with the results of a previous study from the same project (looking at staff and carers).</td>
<td>20 Five descriptive categories identified, encompassing 19 conceptions: (1) the patient’s dignity is respected; (2) the patient’s sense of security with regard to care; (3) the patient’s participation in the care; (4) the patient’s recovery; and (5) the patient’s care environment.</td>
<td>Yes</td>
<td>Five descriptive categories identified, encompassing 19 conceptions: (1) the patient’s dignity is respected; (2) the patient’s sense of security with regard to care; (3) the patient’s participation in the care; (4) the patient’s recovery; and (5) the patient’s care environment.</td>
<td>Yes</td>
<td>High</td>
</tr>
<tr>
<td>Chambers et al. (2014)</td>
<td>Qualitative. Semi-structured interviews with involuntarily detained patients, purposively recruited from three hospitals in the south-east of England. Interviews conducted in the inpatient unit, based on an interview schedule. Conducted by three service-user researchers and a clinical psychologist over a six-month period.</td>
<td>19 Five themes identified, encompassing 14 subthemes: (1) ‘heard’ by staff members; (2) involvement in decision-making regarding their care; (3) information about their treatment plans (particularly medication); (4) access to more talking therapies and therapeutic activities; (5) the patient’s care environment.</td>
<td>Yes</td>
<td>Five themes identified, encompassing 14 subthemes: (1) ‘heard’ by staff members; (2) involvement in decision-making regarding their care; (3) information about their treatment plans (particularly medication); (4) access to more talking therapies and therapeutic activities; (5) the patient’s care environment.</td>
<td>Yes</td>
<td>High</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Purpose</td>
<td>Participants</td>
<td>Data Collection</td>
<td>Analysis</td>
<td>Strengths</td>
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<tr>
<td>Husum, Legeres &amp; Pederesen (2019)</td>
<td>Qualitative. Part of a large multi-center study from Oslo, Norway. Semi-structured interviews specific to experience of humiliation conducted with patients who had experienced inpatient and/or outpatient voluntary or involuntary psychiatric care. Specifically recruited patients with experience of humiliation. Transcripts were analysed using a four-stage phenomenological approach.</td>
<td>13</td>
<td>Three themes identified: (1) different perspectives between staff and users; (2) themes related to violation of service-user autonomy; and (3) experiences related to staff attitudes.</td>
<td>No</td>
<td>Medium</td>
<td>Purposive sampling risks high level of selection bias; also possible gender bias, with predominantly female respondents. Retrospective interviews risk recall bias.</td>
</tr>
<tr>
<td>Mielau et al. (2017)</td>
<td>Mixed methodology. Semi-structured interviews conducted with patients with a diagnosis of schizophrenia, bipolar or schizo-affective disorder. Inpatients and/or outpatients. Positive and negative symptoms (PANSS), global function (GAF), manic symptoms (YMRS), insight (SAI, BCIS), admission experience (AES) and experience of coercion (CES) assessed. Additional interview conducted, comprising 54 questions about experienced coercion. Correlation analyses and regression analyses performed using SPSS software.</td>
<td>79</td>
<td>The majority of patients had experienced some coercive intervention (e.g. seclusion, restraint). More patients rated psychiatric clinics as allies (79.7%) than adversaries (20.2%). Perceived fairness and effectiveness of treatment (AES) and patient self-reflectiveness (BCIS-SR) were significant predictors of positive attitude to psychiatry.</td>
<td>Yes</td>
<td>Medium</td>
<td>Limited sample by diagnosis which limits transferability. Possible selection bias evident given that majority rated mental health services as allies. Risk of recall bias, misattribution and selective memory with retrospective self-report design. Use of cross-sectional design precludes proof of causality of coercive interventions on formation of attitudes. Small numbers in regression analysis limit generalisability.</td>
</tr>
<tr>
<td>Study</td>
<td>Design/Methodology</td>
<td>Sample</td>
<td>Sample Size</td>
<td>Findings</td>
<td>Study Type</td>
<td>Study Population</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Kjellin et al. (1997)</td>
<td>Cohort study. Compared consecutively admitted involuntary patients and randomly sampled voluntary inpatients in Sweden. Two time points: admission and at discharge or three weeks into inpatient care. Semi-structured interviews by psychiatrists and psychologists measured DSM-IIIR diagnosis, GAF score and change in GAF score. Self-reported change in mental health, patient satisfaction with care and patient perception of respect for autonomy were obtained at discharge or three weeks after admission. Improvements (change in GAF, self-reported change and satisfaction with care) were termed ‘ethical benefits’ and perceived disrespect or violation of autonomy were grouped as ‘ethical costs.’</td>
<td>168</td>
<td></td>
<td>There was no statistically significant difference between groups at follow up in terms of improvement or satisfaction with care. Involuntary patients who rated themselves not improved were significantly more likely to report disrespect and/or violation of autonomy (ethical costs). 30% of involuntary patients reported ethical benefits without ethical costs. 23% of involuntary and 13% of voluntary patients reported only ethical costs, but very few were not improved on GAF.</td>
<td>No</td>
<td>High</td>
</tr>
<tr>
<td>Aftab et al. (2019)</td>
<td>Pilot study conducted in an inpatient and six outpatient psychiatry clinic sites in the United States of America. A voluntary, anonymous self-reported survey was given to patients currently or recently admitted to hospital. Demographic information, overall view of hospitalisation experience (using themes from Sibitz et al., 2011) and 62 Overall WAS scores were high (mean 4.32, SD 1.04). 68% saw their admission as having been necessary. 15% reported a loss of trust in outpatient psychiatric care providers, but 36% reported an improved ability to trust them. Between 21% and 36% reported they were less</td>
<td>62</td>
<td></td>
<td>No</td>
<td>Medium</td>
<td>Possibility of recall bias as questionnaires were anonymous self-report. Total response rate was not calculated, but inpatient response rate was just 6% and only 62 valid surveys were collected in total. High working alliance scores likely indicate possible selection bias and other</td>
</tr>
<tr>
<td>working alliance score (modified WAS) were obtained. Exploratory analysis and correlation analyses were performed to assess association between demographic and clinical features with working alliance and trust or disclosure.</td>
<td>likely to disclose symptoms or problems to care-providers following admission. There were significant associations between demographic and clinical features and trust, disclosure and working alliance.</td>
<td>results must be interpreted within that context.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Notes:*
* Quality measured by level of compliance with relevant Critical Appraisal Skills Program checklist (CASP).

2.10 Textual summaries of individual studies


This paper presents an qualitative investigation into how patients and staff experience coercion in a secure psychiatric setting. The study was carried out in a locked, 9-bedded adult inpatient psychiatric ward in a medium-sized town in Norway. The fieldwork was undertaken by the second author, Terkelsen, who visited the ward 48 times over the course of four months. She visited at different times of day, approximately three days a week, for between two and seven hours and invited inpatients to speak with her if they wished. Eighteen formal interviews were also carried out, mainly with staff. In total, 22 employees and 12 patients agreed to participate. The authors report that both involuntary and voluntary patients participated, but do not give further detail or state the numbers of each group.

Data was recorded in field notes, consisting of 200 pages of text. Analysis was carried out using a phenomenological approach, posing questions to the text about how patients described their experience of coerced or forced treatment, and how staff experienced this phenomenon. Following familiarisation, the researched aimed to identify repetition, themes, patterns and paradoxes. Through condensation of the material, they detected four themes: (1) corrections and house rules, (2) coercion is perceived as necessary, (3) significance of material surroundings, and (4) being treated as a human being.

Primary quotes and secondary researcher insights were presented under each of the above four headings. There was one mention of dignity in the abstract and one in the text,
where the author noted that one staff member viewed patients’ dignity as being violated by corrections and house rules.


This article presents a classification of the perspectives of patients who experienced involuntary psychiatric admission in Austria, and of the integration of the experience into their life stories. The study was carried out among psychiatric outpatients in Vienna, who had previous experience of involuntary treatment. The interviews lasted between 30 minutes and two hours.

Seven women and eight men participated in this study. Outline demographic and diagnostic information on the group as a whole is provided in the paper, but quotes are presented anonymously.

Interviews were carried out by the second author, and were transcribed verbatim from recordings. Transcripts were coded and analysed by three researchers into a coding framework. Interviews and coding occurred in parallel, and the framework was refined as new themes emerged from subsequent interviews. The authors report that theoretical saturation was reached after 18 interviews. The coding frame was then applied to all transcripts using QSR NVivo version 7, and a typology of perspectives was extracted.

Three main perspectives on involuntary admission were identified in this investigation. Involuntary admission was seen as ‘a necessary brake’, ‘an unnecessary overreaction’ and ‘a
practice in need of improvement’. In relation to integration of the experience into the patients’ life story, three themes emerged; ‘over, not to be recalled’, ‘a life-changing experience’ and ‘motivation for political engagement’.

The authors in this study concluded that patient’s perspectives on involuntary admission were diverse. There was no explicit use of the term ‘dignity’ in this paper, however the authors did mention respect and patients’ sense of self. Antonyms for dignity (shame, stigma and humiliation) also featured in the researcher’s interpretations of patients’ viewpoints.


This paper presents a qualitative study of patients who experienced involuntary psychiatric care in Sweden. All had been admitted involuntarily to non-forensic psychiatric wards within the preceding two years. Three women and two men participated in the study.

Interviews were carried out by the first author, either in participants’ homes or in the local mental health centre. The interviews lasted between 10 and 60 minutes. They were recorded and transcribed verbatim before being analysed using a phenomenological hermeneutic method. This consisted of a naïve reading of the text, followed by a structural analysis to condense the text into themes. The transcripts were then re-read, and both the naïve reading and structural analysis were reflected upon. Previous research and the author’s pre-understanding based on clinical experience were used to inform the interpretation of the text as a whole.
The structural analysis yielded five major themes, extrapolated from the condensed meaning units derived from the text. These were: (1) being restricted in autonomy, (2) being violated by intrusion on physical integrity and human value, (3) being outside and not seen or heard, (4) being respected as an individual, and (5) being protected and cared for.

The authors of this study reflected on the paradoxical views expressed by participants, and interpreted that the experience of involuntary care is characterised by movement between polar opposites: for example a feeling of loss of control and a feeling of safety. The authors conclude that patients can experience a sense of loss of dignity through a lack of respect from others.


This article presented qualitative research into patients’ understanding of quality of care in psychiatry. Participants were recruited at the point of discharge from inpatient care or on completion of outpatient care in Sweden. Seventeen of the 20 participants had previous experience of inpatient treatment, seven had experienced compulsory treatment. Although some demographic details such as age and education status were described, gender makeup was not reported in the article.

The interviews were performed by the first author either in the patient’s home or near the interviewer’s office. They lasted between 45 and 80 minutes. The interview consisted of asking how patients perceive the concept of quality of care in the psychiatric setting, with
follow up questions if needed. They were taped and transcribed verbatim for phenomenographic analysis. The analysis consisted of familiarisation with transcripts, labelling of statements, grouping of statements into descriptive categories and mapping of categories into conceptual framework.

The five distinct descriptive categories identified were (1) the patient’s dignity is respected, (2) the patient’s sense of security with regard to care, (3) the patient’s participation in the care, (4) the patient’s recovery, and (5) the patient’s care environment. Each of these descriptive categories encompassed a number of conceptions, or overarching themes, which grouped similar individual statements together.

Dignity was the focus of the first descriptive category, ‘the patient’s dignity is respected’. This category comprised five distinct conceptions: meeting competent and committed staff, being validated, being seen as just like anyone else, being helped to reduce stigma, and being understood. These conceptions linked 204 individual statements together, from 19 of the 20 participants, however the term dignity originates from the coding framework, rather than patients’ use of the term.


This qualitative study into the dignity experience of involuntary inpatients was conducted in three psychiatric hospitals in England, with participants recruited purposively over the course of six months. Twelve men and seven women participated in this study. All were
involuntary at the time of interview, and all participants had experienced at least one form of coercive intervention such as restraint or seclusion.

Interviews were performed according to an interview schedule agreed in advance. They were performed by a clinical psychologist and three service-user researchers who had received specific training in qualitative methods. The authors state that the interviews took place in a quiet room on the ward where participants were detained, and were between 45 and 60 minutes in duration. They were audio-recorded and transcribed verbatim for thematic analysis. The authors adopted an inductive relational analysis between themes within the data. They identified an overarching principle theme of dignity and respect. Within that, they described five broad themes impacting their sense of being respected; (1) being ‘heard’ by the staff, (2) being involved in decision-making, (3) having information about their treatment, (4) having access to talk-therapy, (5) the physical environment and ward activities. They elucidated a further 14 subthemes.

It is not fully clear whether the principle theme of dignity and respect arose from frequent mention of dignity by participants or was superimposed on the content by the authors. There is inclusion of one direct participant quote specifically discussing dignity, and multiple researcher reflections referencing the term.

This paper presented an exploratory qualitative study into service users experience of humiliation in mental health services in Norway. The thirteen informants were recruited using social media platforms via service user organisations. Ten of the informants had experience of voluntary and involuntary inpatient care, the remaining three were outpatients. Twelve women and one man participated in the study, there was no further demographic or clinical information provided in the paper.

Interviews were carried out in the primary researcher’s office in Oslo by the first author and two masters’ students. The interviews followed a broad interview schedule, they were between 60 and 90 minutes in duration and were audio-recorded for transcription purposes. The authors report using a phenomenological approach to analysis. A coding scheme was created and modified in an iterative process carried out by all three authors.

The researchers identified three distinct themes: (1) different perspectives of staff and patients (2) violation of autonomy (3) experience of staff attitudes. They present a number of primary quotes from participants to illustrate each thematic category in the paper. Dignity is explicitly mentioned by the authors when they conclude that the humiliation experienced by patients stems from a sense of rejection and of having been treated with less dignity than they feel they deserve. There are no patient quotes including the word dignity in the paper.

This article presents the findings of a quantitative study examining the impact of coercive practices on patients’ perception of psychiatric services as either allies or adversaries. Patients with a history of schizophrenia, schizoaffective disorder and bipolar affective disorder were recruited to the study from both inpatient and outpatient services of a clinic in Berlin. The questions regarding coercive practices related predominantly to inpatient interventions such as restraint, seclusion or forced medication. The cohort consisted of 55 men and 24 women.

Patients were assessed using established questionnaires; the Admission Experience Survey (AES) (Gardner et al., 1993), the Coercion Experience Scale (CES) (Bergk, Flammer, & Steinert, 2010), the Positive and Negative Symptom Scale (PANSS) (Kay, Fiszbein, & Opler, 1987), Global Assessment of Function (GAF) (American Psychiatric Association, 2000) and the Young Mania Rating Scale (YMRS) (Young, Biggs, Ziegler, & Meyer, 2000). Insight was measured using the Beck Cognitive Insight Scale (BCIS) (Beck, Baruch, Balter, Steer, & Warman, 2004) and the Schedule of Unawareness of Illness (SAI) (David, Buchanan, Reed, & Almeida, 1992). Patients’ stance regarding psychiatric services was measured on a likert scale from 0 (adversary) to 4 (ally).

The majority (n=64, 79.7%) viewed services as their allies. Correlation analyses and binary logistic regression analyses were performed to identify factors significantly and independently associated with patient stance regarding psychiatric services. Significant negative correlation was reported between patient stance and CES factors ‘separation’ and ‘humiliation’ as well as perceived fairness and effectiveness of treatment rated on the AES. This study included both voluntary and involuntary patients, but no data was presented on differences between these two groups.
The authors conclude that indignity and degradation caused by coercive interventions – in particular, experience of humiliation or separation – is associated with patients viewing psychiatric services as adversaries, rather than frequency or number of coercive interventions. They further demonstrated that those who rated their treatment as fair and effective had a more positive stance towards psychiatric services.


This quantitative study evaluated patients’ impressions of psychiatric care and patient- and clinician-rated functional improvement in two inpatient units in Sweden. Eighty-four involuntary and 84 voluntary patients were recruited, 93 women and 75 men.

Patients were assessed both on admission and at discharge or after three weeks of treatment (whichever came first). They were asked whether they had improved, whether they were satisfied with the care they had received, whether they had been respected as an individual during their inpatient stay, whether they had felt violated, and whether they had experienced interventions against their will apart from involuntary admission. GAF scores were performed by the interviewers at both time points. Ethical benefits were defined by the authors as improvement (beneficience) and patients feeling they had been respected as individuals (autonomy). Ethical costs were defined as patients reporting feeling not respected as a person, feeling violated or being exposed to measures against their will, other than involuntary admission.
The majority of patients in both the voluntary and involuntary groups reported improvement and satisfaction with the care they had received. Among the involuntary group, 33% reported no further violation of their autonomy. The authors found a correlation between GAF score change and self-reported improvement which was significant in the voluntary patient group. Patients who rated themselves as not improved were more likely to have reported feeling violated as a person.

The authors concluded that it was possible for patients to experience improvement without any further violation of their autonomy, following involuntary admission. While they highlighted the correlation between a lack of improvement and feeling violated, they noted that it was not possible to demonstrate a causal link.

While the term dignity was not included in the questions posed to patients in this study, the questions about feeling respected or violated as an individual are closely linked to the concept of inherent dignity.


This quantitative pilot survey examined the effect of current or recent psychiatric inpatient treatment on patients’ attitudes and relationships to outpatient psychiatric care providers. It was conducted in the psychiatry inpatient unit of an academic hospital in Cleveland, and the surrounding outpatient clinics in a practice-based research network. The cohort consisted of 34 women and 27 men.
The survey consisted of questions about demographic and clinical particulars, followed by a modified version of the Working Alliance Interview Scale (Tracey & Kokotovik, 1989) questions about ability to trust psychiatrists, and questions about likelihood of disclosing symptoms and problems in the future. The researchers performed an exploratory analysis, looking at correlations between the variables of interest. From this, they constructed a conceptual framework linking the different impacts found in their analysis. Both voluntary and involuntary patients were included in the sample but results were not analysed according to status.

The majority of respondents (n=42, 68%) felt their admission had been necessary. The majority stated that their admission would have no impact (n=29, 49%) or a benefit (n=21, 36%) in terms of trust in their outpatient psychiatrist, with only 15% (n=9) of respondents indicating it would negatively impact trust. Working alliance scores were positively associated with trust in psychiatry care providers. However, 36% of the sample reported they would be less likely to disclose suicidal ideation in the future.

Dignity, per se, was not investigated in this study however the concepts of trust in and relationship with care providers is linked thematically to the construct.

2.11 Quality analysis

Quality analysis was undertaken for each paper. The Critical Appraisal Skills Program (CASP) checklists for qualitative studies provide a structure for interrogating the validity of papers in relation to aims, methodology, appropriateness of design, recruitment, data collection, relationship between researcher and participants, ethical considerations, data
analysis and communication of findings. They provide for both categorical and descriptive analysis of papers.

Three of the nine included studies were cohort studies (Aftab et al., 2019; Kjellin, Andersson, Candefjord, Palmstierna, & Wallsten, 1997; Mielau et al., 2017), so the 12-point CASP checklist for cohort studies was applied for quality analysis in these cases.

Critical appraisal of individual studies was undertaken using this framework and each paper was rated as having high, medium or low quality, depending on the level of compliance with the relevant CASP checklist. High compliance with the checklist indicates both higher validity and lower risk of bias. The majority of the individual studies demonstrated high compliance with the quality analysis tool used, however there were still some limitations and potential sources of bias identified. Summary results of this analysis is presented in Table 3.

2.12 Data extraction

Following familiarisation and quality analysis of the papers, manual data collection and analysis was carried out. Data collection and thematic analysis began with coding the papers line by line. Statements, including both primary quotes from participants and secondary researcher observations, were highlighted and annotated with a single word or phrase summarising the content of each statement. The statements and their summary word or phrase were then extracted into an excel spreadsheet for thematic mapping. Similar statements were grouped together and the coding framework was developed through an inductive process. This involved grouping similar statements together under subthemes, then reviewing and revising the coding framework to ensure that the subthemes were accurate and suitably distinct.
Subthemes were then grouped into overarching themes. The whole text of the articles was then re-read to confirm good fit with the thematic framework.

Following this, the coding framework was reviewed by a co-assessor (BDK) to establish the extent to which the categories were precise and distinct. This co-assessor reviewed a random sampling of 20 extracted statements and the list of themes and subthemes in random order, and assigned each statement to a theme and subtheme. The inter-coder reliability (ICR) of this co-assessment was 95%. While there is no universally agreed upon figure to indicate satisfactory ICR, a standard of 80-95% agreement has been suggested as a threshold (Miles & Huberman 1994).

Software commonly used in qualitative studies, such as NVivo, was not used because our study examined a relatively small number of papers and it was not required. NVivo and other Computer Assisted Qualitative Data Analysis Software packages (CAQDAS), unlike statistical software packages, chiefly aid in data management (Zamawe, 2015). The size of our sample was such that data management was easily achieved using a simpler spreadsheet system, and manually coding and analysing data allowed for full immersion in the dataset. Closeness to the data can best be achieved by manual data coding and analysis when the dataset is of a manageable size. Over-reliance on CAQDAS can lead to researchers falling into the ‘coding trap’, becoming overly concerned with coding data at the expense of fully understanding it in a meaningful way (Gilbert, 2002). To avoid this, we used a simpler spreadsheet system for analysis to facilitate full immersion in the data, and to allow for flexible iterative synthesis of the data.
2.13 Synthesis of results

As described in detail above, the studies included in this analysis were coded individually and the theoretical framework was continually revised to incorporate themes and findings from individual studies into a cohesive thematic analysis. Thematic saturation occurred after analysis of five of the papers.

In qualitative inquiry, the aim is not to acquire a fixed number of participants or source articles, but rather to gather enough information to satisfactorily describe the phenomenon being studied (Fossey, Harvey, McDermott, & Davidson, 2002). Thematic saturation essentially means the point in data analysis after which nothing new is generated (Green & Thorogood, 2004) or there are no more surprises or newly emergent patterns in the data (Gaskell, 2000). The point at which this happens varies, depending on the issue being studied and the heterogeneity of source material, so there is no accepted standard against which to compare. Qualitative researchers advise against having too prescriptive an approach to analysis, arguing that a ‘checklist approach’ can undermine the contribution that systematic qualitative research can make to health services research (Barbour, 2001).

In our systematic review, quantitative studies were initially analysed separately and then within the coding framework. Examples of quotes and how they were categorized are available as appendix 10 of this thesis. While there were individual statements regarding dignity in five of the papers, these were all secondary statements or interpretations by the authors. There were no direct quotes from patients which mentioned the term ‘dignity’ in any of the papers analysed.
### 2.14 Core themes and sub-themes

Six core themes emerged from the analysis, as presented in Table 4 below.

<table>
<thead>
<tr>
<th>Core theme</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coercion</td>
<td>Coercion can be an aversive experience</td>
</tr>
<tr>
<td></td>
<td>Coercion can be seen as necessary by staff and patients</td>
</tr>
<tr>
<td></td>
<td>Management of coercion influences perception of care</td>
</tr>
<tr>
<td></td>
<td>● Gaining/regaining freedom of movement</td>
</tr>
<tr>
<td></td>
<td>● Timing and proportionality of coercive measures</td>
</tr>
<tr>
<td></td>
<td>● Understanding use of coercive measures</td>
</tr>
<tr>
<td>Powerlessness</td>
<td>‘House rules’ can be frustrating, condescending, limiting</td>
</tr>
<tr>
<td></td>
<td>Staff views of rules can vary from therapeutic to humiliating</td>
</tr>
<tr>
<td></td>
<td>Patients perceive a lack of autonomy over care decisions</td>
</tr>
<tr>
<td>Care environment</td>
<td>Care environment influences patient experience</td>
</tr>
<tr>
<td>Relationship to staff</td>
<td>Personal relationship with staff is seen as positive</td>
</tr>
<tr>
<td></td>
<td>Perceived negative staff attitudes can contribute to negative experience</td>
</tr>
<tr>
<td></td>
<td>Patients desire contact and conversation</td>
</tr>
<tr>
<td></td>
<td>Patient wish to be treated as an ordinary human being</td>
</tr>
<tr>
<td></td>
<td>Patients may disagree with medical/psychiatric view of illness</td>
</tr>
<tr>
<td>Involuntary treatment can have a lasting impact</td>
<td>Impact on trust in mental health services</td>
</tr>
<tr>
<td></td>
<td>Impact on social and family life</td>
</tr>
<tr>
<td>Paradoxes</td>
<td>Patients often express nuanced or seemingly contradictory views on care</td>
</tr>
</tbody>
</table>

Of the six themes identified, five were factors that influenced patients’ experience of care: coercion, powerlessness, the care environment, relationships to staff and the lasting impact of involuntary treatment. The sixth theme, paradoxes, reflected how patients often expressed varying and even contradictory views about their treatment.

Patients frequently described experience of coercive practices as aversive, but many also perceived that some level of coercion was necessary. Their sense of the proportionality and the timing of the coercive interventions, along with their understanding of why these
interventions were being used, were highlighted as important factors influencing the impact of coercion.

Patients greatly valued freedoms such as leave from the ward. A sense of powerlessness, both in terms of day-to-day ‘house rules’ and in relation to influence over treatment decisions, was expressed by many patients in primary studies. Staff perspectives on rules varied, with some believing them to be therapeutic and others seeing them as humiliating to patients.

The relationship between staff and patients significantly influenced experience of inpatient care, with patients desiring a personal relationship and to be treated as ‘an ordinary human being’. Perceived negative attitudes of staff were often cited by patients as a source of a negative experience of care.

The lasting impact of involuntary care, both on patients’ trust in mental health services and on their social circumstances (e.g. visa applications or employment prospects) was highlighted by patients across multiple studies.

Paradoxical views (e.g. house rules being both calming and provoking, or locked doors giving rise to both protest and feelings of being cared for) were present in many statements from patients and staff, as well as secondary observations by researchers.

2.15 Discussion

2.15.1 Main findings

This systematic review and thematic synthesis found a dearth of literature specifically examining or describing patient experience of dignity in voluntary and involuntary psychiatric
care. The references to dignity that did exist were predominantly secondary statements by researchers and authors. In synthesizing results across a wide variety of study types and geographical populations, we found six core themes regarding patient experience of inpatient psychiatric care. Patients identify coercion, powerlessness, the care environment, relationship to staff and the lasting impact of involuntary treatment as important factors. The sixth theme, paradoxes, is found in both patient statements and secondary statements from researchers and encompasses a wide range of seemingly contradictory statements, experiences and views.

Within involuntary treatment settings, coercion and a certain amount of powerlessness might be inevitable. Even so, it is reported that many patients later view involuntary admission as necessary (O’Donoghue et al., 2010), a fact that is reflected in the findings of this review also (‘coercion can be seen as necessary by staff and patients’). Perhaps unsurprisingly, patients frequently mention that the management of coercion significantly influences their experience of it (Husum, Legernes, & Pedersen, 2019). In our study, subthemes of ‘gaining or regaining freedom of movement’, ‘timing and proportionality of coercive measures’ and ‘understanding use of coercive measures’ emerge as impacting on patient experience of coercion.

In the broader literature, dignity is described as having both ‘self-regarding’ and ‘other-regarding’ components (Gallagher, 2004), also known as ‘intrinsic’ and ‘extrinsic’ dignity (Spiegelberg, 1971). That is to say that both how one views oneself and how others treat one impact on one’s overall experience of dignity. Consistent with this, the timing, duration, proportionality and understandability of coercive measures are noted by patients as important in shaping their overall experience (Johansson & Lundman, 2002; Sibitz et al., 2011).
We propose that a careful approach to the timing, duration, proportionality and the patient’s understanding of coercive measures can allow staff to promote the dignity of patients undergoing coercive care. The sense of powerlessness experienced by patients can be seen as a threat to their subjective dignity, as dignity violations are more likely when the subject is in a position of vulnerability (Jacobson, 2009). In our review, it was notable that staff, as well as patients, described ambivalence regarding ‘house rules’ in psychiatric inpatient settings. Some regarded them as humiliating or condescending, acknowledging the unequal power relationship between staff and patients (Husum et al., 2019).

Staff members also acknowledged that restrictive ‘house rules’ reinforced the relative powerlessness of patients; some staff saw this as positive, in that it delineated boundaries, while others saw it as humiliating to patients (Larsen & Terkelsen, 2014). In her taxonomy of dignity, Jacobson (2009) writes that asymmetry of relationship and harshness of circumstances increase the risk of violation of dignity, and that humane environments promote dignity. Our finding that care environments influence patient experiences concurs with this.

‘Relationship to staff’ unsurprisingly emerged as an important overall theme, with a number of related subthemes. Patients described a desire to be treated as ordinary human beings and also desired contact and conversation. Haddock (1996) describes dignity as the ability to feel important and valuable in relation to others, to communicate this to others, and to be treated as such by others, in contexts which are perceived as threatening. She explains that dignity is a dynamic subjective belief with shared meaning among humanity. Dignity is expressed in relationship with other people, and our review emphasises that psychiatric in-
patients’ experience is heavily influenced by interactions with the staff around them (Schroder, Ahlstrom, & Larsson, 2006).

The lasting impact of admission, both on patients’ trust in the health services and on their social and family life, also emerges as a theme (Chambers et al., 2014). Recognising that patients may be subject to stigma or discrimination, or internalised self-stigma following an admission is not new. Acknowledging and further investigating the impact this has on their intrinsic and extrinsic dignity, however, remains relatively unexplored.

2.15.2 Strengths and limitations

This review has a number of strengths including a systematic search strategy and adherence to PRISMA guidelines in order to provide the first systematic review of the topic of dignity in inpatient psychiatric care. The quality analysis of individual studies demonstrated a generally high level of quality among the included studies, allowing robust conclusions to be drawn. The findings of the quantitative studies were in line with those of the qualitative studies and fit closely within the coding framework despite the differing methodology. The inductive approach to thematic synthesis led to development of an in-depth understanding of the existing literature and comprehensive presentation of a large quantity of individual data points. Overall, there was a great deal of agreement between papers on the components of care that impact on patient experience. A further strength of our study was our inter-coder reliability of the categorization of statements into the identified themes, with an agreement of 95% between coders.
Our study is not without limitations. The heterogeneity and predominantly qualitative nature of the source material meant that it was not possible to do mathematical or statistical comparison between individual studies or pooled quantitative analysis of results. Secondary analysis and synthesis were therefore done in a qualitative fashion, with risk of observer bias. Qualitative literature can be inherently subjective and interpretive. As a result, the primary studies included in this thematic synthesis, as well as this paper itself, are necessarily influenced by the perspectives of researchers who performed the original studies, and results must be interpreted in this context.

The fact that the word ‘dignity’ did not appear in a number of the papers (e.g. Husum et al., 2019) reflects the fact that indexing and search terms are not always included within the body of a paper’s text, even if the paper is thematically related to dignity. Papers which were identified in our systematic search and met the inclusion criteria (namely that they comprised novel research; included involuntary psychiatric inpatients; examined patients’ subjective experience of psychiatric care and were not just single case studies) were eligible for inclusion in the analysis, regardless of whether or not they mentioned the word dignity in the text of the paper. We note that the majority of the studies were carried out in settings where English is not the first language. It is possible that ‘dignity’ is absent from patient accounts or statements as a result of translation into English from the original languages. This is a known challenge in qualitative research (van Ness, Abma, Jonsson & Deeg, 2010; Temple & Young, 2004) and our results should be interpreted within the confines of this limitation.

One of the aims of this review was to investigate differences, if any, between involuntary and voluntary psychiatric inpatients’ experience of dignity. We specifically designed
our search strategy to target this question. Our search strategy included ‘dignity’, ‘human
dignity’ and ‘patient dignity’ only, as outcomes of interest. At an early stage in
conceptualisation of this study, we had considered a broader remit, examining other concepts
related to dignity such as respect and coercion. However, given that we were specifically
interested in the construct of dignity, we decided prior to the search to limit ourselves to this
term only in order to enhance specificity of the review.

Unfortunately, we found that there was a paucity of literature on dignity, and what
literature did exist failed to directly investigate any comparison or contrast between voluntary
and involuntary patient groups. Even where the paper focused on comparing voluntary and
involuntary patients (e.g. Kjellin et al., 1997), there was no specific comparison of patients’
experience in relation to dignity. In some cases, even the patients themselves did not
distinguish their experiences based on legal status (e.g. Schroder, Ahlstrom & Larsson 2005).

As a result, it was not possible, through either synthesis of results from primary papers
or thematic analysis of the overall body of literature, for us to draw robust conclusions about
the experiences of voluntary versus involuntary patients in relation to dignity.

It is interesting that, despite this review focusing specifically on the experience of dignity
in inpatient psychiatric care, we found that patient statements about dignity were
conspicuously absent. It is not possible to be definitive about whether this is an artefact of the
studies or whether patients themselves did not consider the concept of dignity as important or
relevant. However, given that most of the qualitative papers considered here used semi-
structured interviews with broad questions aimed to elicit patients’ views without unduly
influencing them, it is likely that the patients themselves said little if anything about dignity in care.

As it was not possible for us to specifically analyse patient experiences of dignity in this review, we draw limited inferences from papers’ other statements regarding experiences of admission and treatment. In our opinion, this is a distinct gap in the current literature which has been highlighted by this review.

The cross-sectional study which is the basis of this thesis is designed to target that gap, and provide information about whether there are appreciable differences in experience of dignity between voluntary and involuntary patient groups.

2.16 Conclusions

Across a broad range of studies, of varying methodologies, covering a wide geographical area, there is a consistent pattern in patient-reported factors influencing the experience of voluntary and involuntary inpatient psychiatric care. Six main themes emerge from the literature: coercion, powerlessness, care environment, relationships to staff, long term impact of involuntary treatment and paradoxes. These six themes and the multiple subthemes identified in this systematic review represent a comprehensive framework of dignity-related factors that influence the patient experience of inpatient psychiatric care. There is a noticeable lack of focus on dignity itself in the existing literature, and it was therefore not possible to conclude whether there are differences between voluntary and involuntary patient groups, or to identify particular factors associated with dignity experience. Dignified treatment is emphasized in palliative care (Kennedy, 2016) and care of the elderly (Kinnear, Williams, &
Victor, 2014; Williams, Kinnear, & Victor, 2016), but often remains an unmentioned ‘elephant in the room’ in inpatient psychiatric care. This represents an important area for study, and forms the basis of the research undertaken for this thesis.

2.17 Summary of chapter 2

This chapter delineates the systematic review and thematic synthesis of the existing literature on dignity in inpatient psychiatric care that I carried out as part of this research project. As described, this systematic review identified a gap in the current literature, and informed the research question and methodology of the novel data research which I will set out in chapter 3.
Chapter 3: Methodology

3.1 Overview of chapter 3

Following the systematic literature review from the last chapter, it was clear that the issue of dignity in inpatient psychiatric care has been under-emphasised to date, and represents an important area of research. This chapter elucidates the methodology used to investigate the correlates of patient-rated dignity in inpatient psychiatric care.

3.2 Introduction

This study was a cross-sectional quantitative investigation using validated tools to examine patient-rated dignity scores, insight, working alliance, perceived coercion on admission, global functioning, cognition and other variables of interest. Demographic and clinical data were obtained from patient charts and statutory logbooks on the wards.

This study was carried out in two adult psychiatric inpatient units in Dublin. I commenced data collection in Connolly Hospital Blanchardstown in September 2017, and Dr Aoife O’Callaghan began collecting data in Tallaght Hospital in August 2018. The dataset for this analysis was finalised in June 2019. Dr O’Callaghan’s research, using the same dataset, focuses on patient experience of coercion. She is recognised in the acknowledgements section of this thesis.

I wrote two papers pertaining to this research, the first relating the findings of my literature review and the second relating the analysis of the cross-sectional study. The published systematic review paper is included in the appendix of this thesis. I also co-authored
two articles with Dr O’Callaghan relating to her research using our combined data set (O’Callaghan, Plunkett & Kelly, 2021a; O’Callaghan, Plunkett & Kelly 2021b [in press]).

3.3 Setting and sampling

Our study sample comprised voluntary and involuntary psychiatry inpatients, of or over 18 years of age, who were admitted to the acute psychiatric units in Tallaght University Hospital and Connolly Hospital, Blanchardstown, Dublin, Ireland over a 21-month period between September 2017 and June 2019.

Both hospitals are based in mixed urban and suburban areas of Dublin, Ireland. Tallaght University Hospital has a 52-bed psychiatry admission unit, with a catchment population of 288,284 people in South-West Dublin. Connolly Hospital, Blanchardstown has a 47-bed psychiatry admission unit, covering a catchment population of 194,243 of in North-West Dublin (Mental Health Commission, 2020).

These units provide acute inpatient psychiatric treatment to adults, including both voluntary and involuntary patients, under Ireland’s Mental Health Act (2001). Their acute psychiatric admission units are both located within general medical hospitals and accept admissions via the hospital wards and emergency departments as well as admissions directly to the psychiatry units. The public mental health service in Ireland is arranged based on catchment areas, meaning that all psychiatry admissions of people living within the geographical catchment area of these hospitals are to their admission units, with the exception of those admitted to private psychiatric hospitals.
We sought to include both voluntary and involuntary patients in our sample to compare these two groups in terms of level of perceived dignity. Involuntary admissions account for only 13% of psychiatric admissions in Ireland (Daly & Craig, 2019) so we preferentially selected involuntary patients for inclusion in our study sample, aiming to obtain double the proportion of involuntary patients that we would expect from national data. Recruiting approximately 26% involuntarily detained patients allowed us to provide sharper focus on involuntary patients and the comparison between voluntary and involuntary groups, while maintaining as large a sample size as possible.

To be eligible for inclusion in this study, participants had to be current inpatients during the study period; be aged 18 years or over; have the capacity to provide valid, written, informed consent, and have sufficient English language fluency to complete the assessment. Participants were recruited with the assistance of nursing staff at both research sites, who identified patients who met inclusion criteria. Participants were provided with written information about the study and assessment. After providing written informed consent, they completed a semi-structured interview, and additional relevant information was obtained from participants’ clinical files, electronic patient records and statutory records on the inpatient units. The interviews took an average of approximately 45 minutes to complete.

### 3.4 Data collection

Data were collected from a number of sources including paper-based clinical charts, electronic patient records, Mental Health Commission statutory logbooks and administrative records kept by the Mental Health Act officer (Connolly Hospital). Where information was
missing from the clinical records (eg. regarding marital or employment status), this was obtained directly from the participant.

We recorded participants’ gender (‘male’, ‘female’ or ‘other’), date of birth, place of birth (‘Ireland’ or ‘non-Ireland’), date of admission and date of assessment. Participants were recorded as having involuntary legal status if they had been involuntary for any part of their admission. For involuntary patients, we recorded the MHA 2001 criteria under which they had been detained ((a) ‘risk’ criteria, (b) ‘insight’ criteria or (c) both). We recorded whether patients had experienced coercive interventions, namely seclusion and restraint, as well as whether they had been admitted to high-observation or high-dependency psychiatric beds.

Marital status was recorded as ‘never married’, ‘married’, or ‘divorced, widowed or separated’. Employment status was initially recorded using the Standard Occupational Classification (SOC, 2000) but later recoded to ‘employed’ or ‘unemployed’ for statistical analysis. We initially recorded ethnicity based on the Central Statistics Office standard classification of ethnicities (CSO, 2016) but later recoded it to ‘Caucasian’ or ‘non-Caucasian’ for the purpose of analysis.

Clinical diagnoses were taken from clinical files and were categorised based on the World Health Organization’s International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organisation, 2010). Following data collection, these were categorised into ‘mental and behavioural disorders due to psychoactive substance use’ (F10-F19), ‘schizophrenia, schizotypal, delusional and other non-mood psychotic disorders’ (F20-29), ‘mood (affective) disorders’ (F30-39), ‘anxiety, dissociative, stress-related, somatoform and
other nonpsychotic mental disorders’ (F40-48), and ‘disorders of adult personality and behaviour’ (F60-69), as there were no participants with diagnoses outside these categories.

Other data was collected using validated clinical rating scales and assessment tools on interview, as detailed below.

### 3.5 Clinical assessment tools

For this study, we assessed participants using the Patient Dignity Inventory (PDI) (Chochinov et al., 2008), the Birchwood Insight Scale (IS) (Birchwood et al., 1994), the Working Alliance Inventory Scale (WAIS-SR) (Tracey & Kokotovic, 1989), the MacArthur Admission Experience Survey (AES) (Short Form) (Gardner et al., 1993), the Global Assessment of Functioning (GAF) (American Psychiatric Association, 1995), the Mini Mental State Examination (MMSE) (Folstein, Folstein & McHugh, 1975), Scale for the Assessment of Positive Symptoms (SAPS) (Andreasen, 1984) and Scale for the Assessment of Negative Symptoms (SANS) (Andreasen, 1989). Summaries of the content, scoring and interpretation of each of these scales is outlined in the following paragraphs. Copies of the assessment tools are included at the end of this thesis as appendices.

#### 3.6 Patient Dignity Inventory

The Patient Dignity Inventory (PDI) (Chochinov et al., 2008) is used to measure participants’ subjectively rated dignity score. The PDI is a 25-item instrument, rating patient distress in a variety of domains relevant to dignity on a Likert scale from 1 to 5, where 1 is ‘not a problem’ and 5 is ‘an overwhelming problem’. The instrument examines patients’ levels of
symptom distress, existential distress, dependency, peace of mind and social support. It is based on the model of dignity (Chochinov, 2002) previously described in the introduction of this thesis. Although the PDI was originally developed for use with patients in palliative care, it has since been translated into multiple languages and validated in other patient populations (Albers et al., 2011; Ripamonti et al., 2012; Sautier, Vehling & Mehnert, 2014; Rullán et al., 2015, Abbaszadeh, Borhani & Rabori, 2015).

We used the wording from the slightly modified version of the PDI adapted by DiLorenzo et al. (2017) as it has been validated for use in psychiatric inpatient settings (DiLorenzo et al. 2017; DiLorenzo et al., 2018). This version contains modifications in item 3, where the original ‘physically distressing symptoms’ is expanded to ‘experiencing physically distressing symptoms such as pain, shortness of breath, nausea or adverse drug effects’, in recognition of the fact that physical symptoms are not typically the main cause of distress in most psychiatric conditions. Item 17 is also modified from ‘concerns regarding spiritual life’ to ‘concerns that my spiritual life is not meaningful’ to avoid the end-of-life connotations of the original wording (DiLorenzo et al., 2017). The remainder of the items, such as item 12 ‘not feeling worthwhile or valued’, item 7 ‘feeling uncertain or worried about my future or treatment’, and item 25 ‘not being treated with respect or understanding by others’ are unchanged from the original.

Scores on the PDI range from 25 to 125, with a higher score indicating a lower level of perceived dignity.
3.7 Birchwood Insight Scale

The Birchwood Insight Scale (IS) (Birchwood et al., 1994) is a widely-used, eight-item, self-report scale which assesses insight across three domains: awareness of symptoms (two items), awareness of illness (two items) and awareness of need for treatment (four items). Each question is answered as ‘agree’, ‘disagree’ or ‘unsure’ and scores on individual items range from 0 to 2. Four of the items are reverse-scored. The ‘awareness of need for treatment’ subscale is totalled and divided by two, such that each of the three subscales has a possible score of 0 to 4. Overall, the scale has a minimum score of 0 and maximum score of 12. Higher scores indicate better insight.

3.8 Working Alliance Inventory Scale

The Working Alliance Inventory Scale Short Form Revised (WAIS-SR) (Tracey & Kokotovic, 1989) rates respondents’ working alliance with their treating psychiatrist. This instrument, adapted from Horvath’s working alliance inventory (Horvath & Greenberg, 1989) comprises 12 questions about the client’s perception of the therapist’s attitude and skills. It is scored on a Likert scale from 1 to 7 where 1 is ‘never’ and 7 is ‘always’. Items 4 and 10 are rated inversely, with 7 representing poorer working alliance. On the remaining 10 items, a higher score represents a stronger working alliance. In calculation of a total score, items 4 and 10 are reverse-scored. The scale ranges from 7 to 84, with a higher score indicating stronger working alliance.
### 3.9 MacArthur Admission Experience Survey

The MacArthur Admission Experience Survey (AES) (Short Form) (Gardner et al., 1993) measures participants’ perceived coercion on admission. This is a validated, observer-rated scale comprising 16 items which are rated as ‘true’, ‘false’ or ‘don’t know’. It contains four subscales; perceived coercion, negative pressures, procedural justice and affective reactions to hospitalization. Its four subscales can be rated individually or added together for an overall score.

On the perceived coercion on admission subscale, each response of ‘true’ is scored as 1 and ‘false’ scored as 0. The scale ranges from 0 to 5, where higher scores indicate higher levels of perceived coercion on admission. The perceived negative pressures subscale comprises six items, one of which is reverse scored. Again, higher scores indicate higher levels of perceived negative pressure. The procedural justice subscale comprises three items, one of which is reverse scored. The subscale gives a range from 0 to 3, with higher scores indicating greater perceived injustice. The negative affective reactions subscale lists six emotional responses (angry, sad, pleased, relieved, confused and frightened) and each is individually rated ‘true’ or ‘false’. In this study, a response of ‘true’ for a positive emotion (pleased and relieved) scored 0, and ‘false’ scored 1. A response of ‘true’ for a negative emotion (angry, sad, confused and frightened) scored 1 and ‘false’ scored 0. This subscale was therefore rated from 0 to 6, where a higher score indicated increased negative affective reaction.

In this study, each subscale of the AES was scored such that a higher score indicated higher levels of perceived coercion, negative pressures, procedural injustice and negative affective reaction. The overall score was calculated by adding the individual subscales, giving a
range from 0 to 20 where higher scores indicated a more negative admission experience overall.

### 3.10 Global Assessment of Function

The Global Assessment of Functioning (GAF) (American Psychiatric Association, 1995) measures symptom severity and level of function across a number of domains. It condenses the observer’s impressions of the subject’s psychological, social and occupational function into a single global score (Aas, Sonesson & Torp, 2014). Despite its imperfections (Goldmann, 2005; Aas, 2010) the GAF is widely used in research and clinical practice and has demonstrated good interrater reliability and correlation with other measures of symptoms and social behaviour (Startup, Jackson & Bendix, 2002).

The GAF scale ranges from 1 to 100, where 1 represents persistent danger of death or inability to care for oneself and 100 indicates superior functioning.

### 3.11 Mini Mental State Examination

The Mini Mental State Examination (MMSE) (Folstein, Folstein & McHugh, 1975) is a screening test used to assess cognition. This assessor-rated tool comprises 11 questions across five domains of cognitive function (orientation, memory, attention/concentration, language and visuospatial). It has good inter-observer reliability, test-retest reliability, sensitivity and specificity to detect mild to moderate cognitive impairment (Lezak, Howieson & Loring, 2004; Tombaugh & McIntyre, 1992).
The MMSE has a range from 0 to 30, with higher scores indicating better cognitive performance. A score of 23 or lower is considered to indicate possible cognitive impairment (Tombaugh & McIntyre, 1992).

3.12 Scales for the Assessment of Positive and Negative Symptoms

The Scale for the Assessment of Positive Symptoms (SAPS) (Andreasen, 1984) and Scale for the Assessment of Negative Symptoms (SANS) (Andreasen, 1983) are used to measure symptoms of schizophrenia. The SAPS is a 30-item, observer-rated scale with four domains: hallucinations (six items), delusions (12 items), bizarre behaviour (four items) and positive formal thought disorder (eight items). Each item is rated from 0 to 5, where 0 is none and 5 is severe. The SAPS score can range from 0 to 150, with higher scores indicating more severe symptomatology. The SANS comprises 20 items across five domains: affective blunting (seven items), alogia (four items), avolition/apathy (three items) anhedonia/asociality (four items) and attention (two items). This is also an observer-rated scale, with each item measured on a six-point scale, ranging from 0 to 5. Total SANS score can range from 0 to 100, with higher scores indicating greater symptom severity.

We note that the SAPS and SANS were designed to specifically assess negative symptoms in patients with a diagnosis of schizophrenia (Andreasen, 1983; Lincoln, Dollfus & Lyne, 2016). However, these widely used rating scales are frequently used to measure symptomatology in research studies of participants with various diagnoses. Our results using the SAPS and SANS must nonetheless be interpreted within this limitation, which will be discussed in more detail in chapter 5.
3.13 Ethics

This study was performed in accordance with General Data Protection Regulations (EU-GDPR) and the Declaration of Helsinki (World Medical Association, 2013). Ethical approval was obtained from the Research Ethics Committees governing Tallaght University Hospital (Ref: SJH/AMNCH REC 2017-08 List31(2)) and Connolly Hospital Blanchardstown (Ref: RCSI REC1448). Written informed consent was obtained from each study participant prior to interview.

3.14 Statistical methods

Data was stored, described and analysed using IBM SPSS Statistics version 26. For bivariate analysis, we used the Student t test, Chi Square test, Mann-Whitney test, Kruskall-Wallis test and Spearman’s rho, as appropriate. We generated a multi-variable linear regression model with patient dignity, measured using the PDI, as the dependent variable. Independent variables were those variables that had statistically significant associations with dignity on bivariate testing; i.e. admission status, (voluntary or involuntary), age, diagnosis, place of birth (Ireland or elsewhere), insight, negative symptoms and perceived coercion on admission.

We tested for multicollinearity, which is when two or more variables are so closely related to each other that the model cannot reliably distinguish the independent effects of each. For this, we calculated a ‘tolerance value’ for each independent variable; tolerance values below 0.25 indicate possible multicollinearity, and tolerance values below 0.10 indicate significant problems with multicollinearity (Katz, 2012). There was no missing data.
3.15 Summary of chapter 3

This chapter has described the tools and methods used in our novel cross-sectional study investigating correlates of subjectively rated dignity among psychiatric inpatients. In the next chapter, I will present the results of this cross-sectional study, before going on to discuss the research findings in the following chapter.
Chapter 4: Results

4.1 Outline of chapter 4

Having outlined the methodology in the preceding chapter, I will now provide the results of the cross-sectional study on dignity which forms the body of this thesis. The demographic and clinical details of the 107 participants, the results of the clinical assessment tools, and outcomes of bivariate and multivariate statistical analyses for the full dataset are detailed in the paragraphs and tables below.

4.2 Description of the data set

Of the 107 participants included in our sample, 78 (72.9%) had voluntary legal status for their entire admission and 28 (27.1%) had involuntary legal status for all or part of their admission. Of those involuntarily admitted, 48.3% (n=14) were detained under the ‘treatment’ criteria (Section 3(1b)) of the Mental Health Act, 2001; 10.3% (n=3) were detained on the basis of the ‘risk’ criteria (Section 3(1a)); and 41.4% (n=12) were detained on the grounds of both ‘treatment’ and ‘risk’. A majority (n=97; 90.7%) were treated on general acute psychiatric wards and 10 (9.3%) were nursed in ‘high dependency units’ or psychiatric intensive care.

Fifty-nine participants (55.1%) were male; 48 (44.9%) were female. No participants answered ‘other’ in response to the gender question. Seventy-nine participants (73.8%) were unemployed. The majority were born in Ireland (n=89; 83.2%) and of Caucasian ethnicity. Only nine participants (8.4%) were non-Caucasian. Mean age was 43.3 years (standard deviation
Almost two-thirds of participants had never been married (n=69; 64.5%); 15 (14.0%) were married at the time of assessment, and 23 (21.5%) were widowed, divorced or separated.

76 participants (71%) were assessed in Connolly Hospital Blanchardstown, with the remaining 31 (29%) coming from Tallaght University Hospital. There were no significant differences in demographic variables between the two hospital sites (p>0.05 in all cases).

Length of stay in hospital at time of assessment was non-normally distributed (skewed to the right), with a median of 11 days (inter-quartile range [IQR]: 5-23). Almost half of the participants had a diagnosis of an affective (mood) disorder (n=50; 46.7%) and just over a quarter had schizophrenia or a related condition (n=29; 27.1%). Personality and behavioural disorders were next most common diagnoses (n=12; 11.2%), followed by substance use disorders (n=9; 8.4%) and neuroses (n=7; 6.5%).

Table 5: Descriptive statistics for full dataset

<table>
<thead>
<tr>
<th>Variable</th>
<th>Participants (n=107) n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td></td>
</tr>
<tr>
<td>Voluntary</td>
<td>78 (72.9)</td>
</tr>
<tr>
<td>Involuntary</td>
<td>28 (27.1)</td>
</tr>
<tr>
<td>Hospital site</td>
<td></td>
</tr>
<tr>
<td>Connolly Hospital, Blanchardstown</td>
<td>76 (71.0)</td>
</tr>
<tr>
<td>Tallaght University Hospital</td>
<td>31 (29.0)</td>
</tr>
<tr>
<td>Ward setting</td>
<td></td>
</tr>
<tr>
<td>General admissions ward</td>
<td>97 (90.7)</td>
</tr>
<tr>
<td>High dependency unit</td>
<td>10 (9.3)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>59 (55.1)</td>
</tr>
<tr>
<td>Female</td>
<td>48 (44.9)</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>79 (73.8)</td>
</tr>
<tr>
<td>Marital status</td>
<td>Employed</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Never married</td>
<td></td>
</tr>
<tr>
<td>Currently married</td>
<td></td>
</tr>
<tr>
<td>Widowed, divorced or separated</td>
<td></td>
</tr>
<tr>
<td>Place of birth</td>
<td>Ireland</td>
</tr>
<tr>
<td></td>
<td>Elsewhere</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Caucasian</td>
</tr>
<tr>
<td></td>
<td>Non-Caucasian</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Mood (affective) disorders</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia and related disorders</td>
</tr>
<tr>
<td></td>
<td>Disorders of personality and behaviour</td>
</tr>
<tr>
<td></td>
<td>Substance use disorders</td>
</tr>
<tr>
<td></td>
<td>Neuroses</td>
</tr>
</tbody>
</table>

### 4.3 Overview of results of assessment tools

The results of the structured assessment tools were analysed in terms of distribution (parametric or non-parametric), mean or median (respectively), and interquartile range (where relevant). The results of these analyses are presented in Tables 6 and 7 below.

Patient Dignity Inventory (PDI) total score was non-normally distributed (skewed to the right), with a median score of 63.0 out of 125.0 (IQR: 40.0-80.0). Total score on the Birchwood Insight Scale (IS) was non-normally distributed (skewed to the left), with a median score of 9.5 out of 12.0 (IQR: 6.0-12.0). Scores on the Working Alliance Inventory Scale (WAIS) were also non-normally distributed (skewed to the left), with a median score of 66.0 out of 84.0 (IQR: 51.0-74.0).
Total score on the MacArthur Admission Experience Survey (AES) on admission was non-normally distributed (skewed to the right), with a median score of 6.0 out of 20.0 (IQR: 3.0-13.0). Mean score on the perceived coercion subscale was 2.04 out of 5.0 (SD: 1.89); mean score on the negative pressures subscale was 1.56 out of 6.0 (SD: 1.98); mean score on the procedural injustice subscale was 1.10 out of 3.0 (SD: 1.19); and mean score on the affective reactions to hospitalization subscale was 2.98 out of 6.0 (SD: 1.80). 16.66% (n=13) of voluntary patients in our sample scored \( \geq 4 \) on the perceived coercion subscale, compared to 68.96% of involuntary patients.

Mean score on the Global Assessment of Function (GAF) was 46.68 out of 100.0 (SD: 14.47). MMSE score was non-normally distributed (skewed to the left), with a median score of 28.0 out of 30.0 (IQR: 27-30). Eight patients (7.5%) scored 23 or under on the MMSE, indicating cognitive impairment.

The Scale for the Assessment of Positive Symptoms (SAPS) total score was non-normally distributed (skewed to the right), with a median score of 8.0 out of 150.0 (IQR: 1.0-17.0). Nineteen patients (17.8%) scored 0 on the SAPS (indicating a lack of any positive symptoms of schizophrenia) and 88 patients (82.2%) scored at least 1. The Scale for the Assessment of Negative Symptoms (SANS) total score was non-normally distributed (skewed to the right), with a median of 7.0 out of 100.0 (IQR: 1.0-15.0). Twenty-three patients (21.5%) scored 0 on the SANS (indicating a lack of any negative symptoms of schizophrenia) and 84 patients (78.5%) scored at least 1.
### Table 6: Results of rating scales with non-parametric distribution: Dignity, Insight, Working alliance, Perceived coercion on admission (total), Cognition, Positive and Negative symptoms

<table>
<thead>
<tr>
<th>Variable</th>
<th>Rating scale used</th>
<th>Median</th>
<th>Inter-quartile range</th>
<th>Rating scale maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity</td>
<td>PDI</td>
<td>63.0</td>
<td>40.0 – 80.0</td>
<td>125.0</td>
</tr>
<tr>
<td>Insight</td>
<td>IS</td>
<td>9.5</td>
<td>6.0 – 12.0</td>
<td>12.0</td>
</tr>
<tr>
<td>Working alliance</td>
<td>WAIS</td>
<td>66.0</td>
<td>51.0 – 74.0</td>
<td>84.0</td>
</tr>
<tr>
<td>Perceived coercion on admission</td>
<td>AES (total score)</td>
<td>6.0</td>
<td>3.0 – 13.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Cognition</td>
<td>MMSE</td>
<td>28.0</td>
<td>27.0 – 30</td>
<td>30.0</td>
</tr>
<tr>
<td>Positive symptoms</td>
<td>SAPS</td>
<td>8.0</td>
<td>1.0 – 17.0</td>
<td>150.0</td>
</tr>
<tr>
<td>Negative symptoms</td>
<td>SANS</td>
<td>7.0</td>
<td>1.0 – 15.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

PDI = Patient Dignity Inventory, IS = Birchwood Insight Scale, WAIS = Working Alliance Inventory Scale (short form), AES = McArthur Admission Experience Scale, MMSE = Mini Mental State Examination, SAPS = Scale for the Assessment of Positive Symptoms, SANS = Scale for the Assessment of Negative Symptoms

### Table 7: Results of rating scales with parametric distribution: Global functioning, and subscales of AES (Perceived coercion on admission, Negative pressures and Procedural injustice)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Rating scale used</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>Rating scale maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global functioning</td>
<td>GAF</td>
<td>46.68</td>
<td>14.47</td>
<td>100</td>
</tr>
<tr>
<td>Perceived coercion</td>
<td>AES subscale</td>
<td>2.04</td>
<td>1.89</td>
<td>5.0</td>
</tr>
<tr>
<td>Negative pressures</td>
<td>AES subscale</td>
<td>1.56</td>
<td>1.98</td>
<td>6.0</td>
</tr>
<tr>
<td>Procedural injustice</td>
<td>AES subscale</td>
<td>2.98</td>
<td>1.80</td>
<td>6.0</td>
</tr>
</tbody>
</table>

GAF = Global Assessment of Functioning, AES = McArthur Admission Experience Survey
4.4 Dignity: Bivariate analysis

Voluntary patients had higher PDI scores compared to involuntary patients (i.e. voluntary patients reported less dignity than involuntary patients; mean ranks 58.35 versus 42.31 respectively; Mann-Whitney U: 792.00, p=0.017). Patients who were born in Ireland had higher PDI scores (i.e. less self-rated dignity) than those born elsewhere (mean ranks 57.31 versus 37.64 respectively; Mann-Whitney U: 506.50, p=0.014), although there was no significant difference between people of Caucasian and non-Caucasian ethnicities (mean ranks 55.13 versus 41.72 respectively; Mann-Whitney U: 330.50, p=0.215). There was a borderline significant negative correlation between age and PDI score (i.e. as age increased, dignity increased; Spearman’s rho: -0.194, p=0.045).

Patient Dignity Inventory (PDI) scores did not differ significantly between males and females (mean ranks 56.15 versus 52.25 respectively; Mann-Whitney U: 1313.00, p=0.519), those who were employed and those who were unemployed (mean ranks 58.27 versus 52.49; Mann-Whitney U: 986.50, p=0.397) or patients with different marital statuses (Kruskal-Wallis statistic: 5.113, p=0.078). PDI score was not related to length of hospital stay at time of assessment (Spearman’s rho: -0.023, p=0.814).

Patients with neuroses had the highest PDI scores (i.e. the least dignity; median: 85.00; IQR: 36.00-87.00), followed by those with personality and behavioural disorders (median: 83.50; IQR: 63.00-101.00), substance use disorders (median: 78.00; IQR: 58.00-98.00), affective disorders (median: 56.50; IQR: 37.00-73.25) and schizophrenia group disorders (median: 55.00; IQR: 38.50-73.00; Kruskal-Wallis statistic: 14.0006, p=0.007).
PDI score was not significantly correlated with WAIS score (Spearman’s rho: -0.097; p=0.323), GAF score (Spearman’s rho: 0.017; p=0.861), MMSE score (Spearman’s rho: -0.144; p=0.139) or SAPS total score (Spearman’s rho: 0.129; p=0.186), but was positively correlated with AES score (i.e. the higher the perceived coercion, the lower the dignity; Spearman’s rho: 0.202; p=0.037) and positively correlated with SANS total score (i.e. the higher the negative symptoms, the lower the dignity; Spearman’s rho: 0.434; p<0001). Patients with better insight scored higher on the PDI (i.e. had less dignity; Spearman’s rho: 0.321, p=0.001).

The demographic and clinical variables which had statistically significant associations with PDI score (ie: admission status, place of birth, age and clinical diagnosis) were incorporated into the multivariable linear regression analysis outlined below.

4.5 Dignity: Multi-variate analysis

We generated a multi-variable linear regression model with patient dignity, measured using the PDI, as the dependent variable. Independent variables were those variables that had statistically significant associations with dignity on bi-variable testing; i.e. admission status, (voluntary or involuntary), age, diagnosis, place of birth (Ireland or elsewhere), insight, negative symptoms and perceived coercion on admission.

We tested for multicollinearity, which is when two or more variables are so closely related to each other that the model cannot reliably distinguish the independent effects of each. For this, we calculated a ‘tolerance value’ for each independent variable; tolerance values below 0.25 indicate possible multicollinearity, and tolerance values below 0.10 indicate significant problems with multicollinearity (Katz, 2012). There was no missing data.
On multi-variable testing, lower self-rated dignity was associated with increased perceived coercion on admission, better insight and more negative symptoms (Table 8). This model accounted for 38.7% of the variation in dignity score between patients. All tolerance values were greater than 0.25, indicating no problems with multicollinearity.

Table 8: Linear regression analysis of demographic and clinical correlates of patient-rated dignity score among voluntary and involuntary psychiatric inpatients in Ireland

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>β</th>
<th>Standard error</th>
<th>p</th>
<th>Tolerance value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission status</td>
<td>-5.507</td>
<td>4.937</td>
<td>0.267</td>
<td>0.697</td>
</tr>
<tr>
<td>(voluntary or involuntary)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.238</td>
<td>0.126</td>
<td>0.061</td>
<td>0.858</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1.688</td>
<td>1.794</td>
<td>0.349</td>
<td>0.948</td>
</tr>
<tr>
<td>Place of birth</td>
<td>-8.795</td>
<td>5.432</td>
<td>0.109</td>
<td>0.813</td>
</tr>
<tr>
<td>(Ireland or elsewhere)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insight ¹</td>
<td>2.578</td>
<td>0.638</td>
<td>p&lt;0.001</td>
<td>0.696</td>
</tr>
<tr>
<td>Negative symptoms ²</td>
<td>0.651</td>
<td>0.188</td>
<td>0.001</td>
<td>0.920</td>
</tr>
<tr>
<td>Perceived coercion on admission ³</td>
<td>1.517</td>
<td>0.406</td>
<td>p&lt;0.001</td>
<td>0.665</td>
</tr>
</tbody>
</table>

Notes:
This table presents a linear regression analysis of patient rated dignity, with Patient Dignity Inventory (PDI) score as the dependent variable ($r^2=38.7\%$; $p<0.001$).

¹ Measured using the Birchwood Insight Scale (IS)

² Measured using the Scale for the Assessment of Negative Symptoms (SANS)

³ Measured using the MacArthur Admission Experience Survey (Short Form) (AES)
4.6 Summary of chapter 4

The results of our investigation and analysis are presented above, and indicate that dignity is associated with perceived coercion on admission, insight and negative symptoms. I will discuss each of these findings, as well as the strengths and limitations of our research in the next chapter.
Chapter 5: Discussion

5.1 Overview of chapter 5

Our cross-sectional study identified a number of interesting findings in relation to patient-rated dignity in inpatient care, as detailed in chapter 4. In this section, I will summarise and discuss the findings of the systematic literature review and cross-sectional study which comprise this thesis, consider the strengths and limitations of this research and contextualise our findings within the broader literature.

5.2 Summary of systematic review

I performed a systematic review of the literature on patient experience of dignity in inpatient psychiatric care. This systematic review was registered with the PRISMA database (PROSPERO ID CRD420154633). The systematic search was performed in Medline (PubMed), ProQuest (PsycInfo) and Cochrane using search protocols adapted to utilize the subject heading search terms relevant to each database. Quality analysis was performed on the individual papers. Thematic synthesis was carried out using a phenomenological approach.

Across the databases, 202 individual papers were identified. Titles and abstracts were screened for relevance and compliance with inclusion/exclusion criteria. Eighteen papers were selected for further review. Of these, nine papers were suitable for inclusion in the analysis, of which six were qualitative and three were quantitative or mixed methodology.

Six key themes emerged during the data synthesis and analysis: coercion, powerlessness, care environment, relationship to staff, impact of involuntary treatment and
paradoxes. These encompassed 15 subthemes as delineated in Chapter 2, Table 4 (reproduced below)

**Table: Core themes and subthemes**

<table>
<thead>
<tr>
<th>Core theme</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coercion</td>
<td>Coercion can be an aversive experience</td>
</tr>
<tr>
<td></td>
<td>Coercion can be seen as necessary by staff and patients</td>
</tr>
<tr>
<td></td>
<td>Management of coercion influences perception of care</td>
</tr>
<tr>
<td></td>
<td>● Gaining/regaining freedom of movement</td>
</tr>
<tr>
<td></td>
<td>● Timing and proportionality of coercive measures</td>
</tr>
<tr>
<td></td>
<td>● Understanding use of coercive measures</td>
</tr>
<tr>
<td>Powerlessness</td>
<td>‘House rules’ can be frustrating, condescending, limiting</td>
</tr>
<tr>
<td></td>
<td>Staff views of rules can vary from therapeutic to humiliating</td>
</tr>
<tr>
<td></td>
<td>Patients perceive a lack of autonomy over care decisions</td>
</tr>
<tr>
<td>Care environment</td>
<td>Care environment influences patient experience</td>
</tr>
<tr>
<td>Relationship to staff</td>
<td>Personal relationship with staff is seen as positive</td>
</tr>
<tr>
<td></td>
<td>Perceived negative staff attitudes can contribute to negative experience</td>
</tr>
<tr>
<td></td>
<td>Patients desire contact and conversation</td>
</tr>
<tr>
<td></td>
<td>Patient wish to be treated as an ordinary human being</td>
</tr>
<tr>
<td></td>
<td>Patients may disagree with medical/psychiatric view of illness</td>
</tr>
<tr>
<td>Involuntary treatment can</td>
<td>Impact on trust in mental health services</td>
</tr>
<tr>
<td>have a lasting impact</td>
<td>Impact on social and family life</td>
</tr>
<tr>
<td>Paradoxes</td>
<td>Patients often express nuanced or seemingly contradictory views on care</td>
</tr>
</tbody>
</table>

There was very little explicit reference to dignity across the identified studies, with only three of the selected papers even including the term. However, the first four of the six themes identified relate aspects of patients’ subjective experience which could be seen as contributing to or detracting from patients’ experience of dignity in care.

Paradoxes were a key finding of this study, and it is clear that the subject is a nuanced one, with plenty of questions and contradictions. Nevertheless, core similarities in patient experience and perspective existed across a wide variety of primary studies from multiple sites.
and countries. The themes of coercion, powerlessness, care environment, relationship to staff, and long-term impact of involuntary treatment indicate factors which are important in patients’ subjective experience of psychiatric inpatient care. Identifying predictors or discriminators of patient-rated dignity among voluntary and involuntary patients was not possible by systematic review, and is the key research question we aimed to address with the data study below.

5.3 Summary of cross-sectional results

This cross-sectional study evaluated the clinical correlates of patient-rated dignity, measured using the PDI score. As described in the previous chapter, we recruited a sample of 107 psychiatric inpatients from two hospitals in Dublin, of whom 27.1% had involuntary status for all or part of their admission. Our sample was roughly evenly split between men and women (55.1% and 44.9%, respectively). Majorities were never married (64.5%), unemployed (73.8%), born in Ireland (83.2%) and Caucasian (91.6%). Affective disorders were the most common diagnoses (46.7%), followed by schizophrenia and related disorders (27.1%), personality and behavioural disorders (11.2%), substance use disorders (8.4%) and neuroses (6.5%). Median length of stay at assessment was 11 days.

Patient Dignity Inventory (PDI) total score was non-normally distributed (skewed to the right), with a median score of 63.0 out of 125 (inter-quartile range: 40.0-80.0). On multi-variable testing, lower self-rated dignity was associated with increased perceived coercion on admission, better insight and more negative symptoms. There was no association between dignity and gender, employment status, marital status, place of birth, ethnicity, age, admission status, length of hospital stay at time of assessment, diagnosis, working alliance, global
functioning, positive symptoms or cognition. The association between lower dignity and voluntary (as opposed to involuntary) status, apparent on bi-variable testing, was not apparent on multi-variable testing. This might be a function of sample size or may represent a true and surprising association. I discuss this finding and the other results of the multivariate analysis in more detail below, after outlining the strengths and limitations of the cross-sectional study.

5.4 Strengths and limitations

The strengths and limitations of the systematic review are covered in more detail in chapter 2. I will briefly summarise them here before going on to discuss the strengths and limitations of the cross-sectional study.

5.4.1 Strengths and limitations of the systematic review

Strengths of the systematic review included the use of a systematic search strategy and the adherence to Preferred Reporting In Systematic Review and Meta Analyses (PRISMA) guidelines. This thematic synthesis is, as far as I can ascertain, the first of its kind and gives new insights into the factors impacting on experience of dignity among voluntary and involuntary psychiatry inpatients. The primary studies were mostly high quality, as measured using the Critical Appraisal Skills Program (CASP) proformas for analysis. The inductive approach to analysis allowed a large quantity of individual data points to be synthesised into a meaningful framework, and inter-coder reliability indicated that the thematic framework accurately reflected the data.
There were some limitations, including the paucity of literature presenting patient experience of dignity in inpatient psychiatric care. It was not possible to robustly analyse differences between voluntary and involuntary patient groups based on the existing literature. Due to the heterogeneity of the studies, and the prevalence of qualitative methodology, it was not possible to perform mathematical or statistical comparison between individual studies, nor to do a pooled quantitative analysis of results. Both the qualitative primary studies and the secondary phenomenological thematic analysis have an inherently subjectivity and are, by definition, influenced by the perspective of the researcher. Results of the systematic review must be interpreted within this context.

Limitations notwithstanding, the systematic review provides a comprehensive analysis of the existing literature examining patient experience of dignity in inpatient psychiatric care and highlights gaps in the current knowledge-base to be addressed through our cross-sectional study.

5.4.2 Strengths and limitations of cross-sectional study

In terms of the cross-sectional study, one major strength is that it is to our knowledge the first quantitative study directly comparing voluntary and involuntary psychiatric inpatients’ experience of dignity. As such, our paper provides a framework for future quantitative investigations into the important issue of patient dignity in psychiatric inpatient settings. Quantitative work in this field is rare and, to date, has focused on validating the PDI in psychiatric settings, rather than exploratory analyses such as ours.
Another strength of our study is the assessment of a broad range of co-variables, including demographic and clinical variables, using documentation from the patients’ charts and statutory records. In particular, we documented patients’ legal status from their contemporaneous medical records which eliminated the risk of recall bias confounding analysis of this variable. Furthermore, we used reliable and validated structured assessment tools in our semi-structured patient interviews, including a tool to measure dignity which has previously been validated in the psychiatric inpatient setting. We performed bi-variable and multi-variable statistical analysis, and tolerance values in our multi-variable model indicated no problems with multicollinearity.

A further strength of this research is the inclusion of two clinical sites, which enhances representativeness. The fact that there were no significant differences in results between sites indicates a level of generalisability, at least within Irish urban and suburban settings.

Limitations of our study include the sampling technique which did not include consecutive admissions, but was purposively enriched with involuntary patients in order to increase focus on variables of interest. Purposive sampling is often used when researchers require participants with certain characteristics who will willingly participate and communicate their experiences (Tongco, 2007). This approach can improve efficiency, but also increases risk of bias and can affect generalisability (Etikan, Abubukan & Sunusi, 2016). We felt the added efficiency was necessary in this instance, in order to include a sufficient number of involuntary patients to explore the likely range of dignity scores.

As mentioned in the methodology chapter, the SANS is a measure which is specific to patients with schizophrenia, and we applied it to patients with varying diagnoses. Our findings
in relation to negative symptoms must be interpreted within the context of this limitation. The 
SANS uses the clinician’s rating of a patient’s affective flattening, alogia, avolition/apathy, 
anhedonia/asociality and inattention to give an overall measure of negative symptoms in 
patients with schizophrenia. Patients with other disorders may display these types of 
symptoms, and therefore generate a score, but the scale was developed (Andreasen, 1982) and 
evaluated (Andreasen, 1986; Andreasen et al., 1995) specifically in patients with schizophrenia. 
We recognise the issues associated with this, and acknowledge that what we were capturing in 
the 78 (72.9%) patients with non-schizophrenia diagnoses who scored above a 0 on the SANS 
were not negative symptoms of schizophrenia, per se, but were signs and symptoms within 
these domains associated with other diagnoses. We present this finding notwithstanding these 
technical issues because we consider it interesting that patients who scored higher on the SANS 
had lower experience of dignity and wish to discuss the potential implications of that finding in 
more detail.

Owing to the novelty of our study, there are no comparable studies in the literature with 
which to compare the PDI results in our study groups. This limits our ability to interpret the 
meaning of the median PDI score in our sample (63.0) and to decide whether this represents an 
acceptable level of patient-rated dignity in a psychiatric inpatient population. Our findings do, 
however, provide an initial benchmark against which future researchers can compare their 
results.

Despite recruiting over 100 patients (n=107), our study is, arguably, still limited in terms 
of sample size, with a risk that Type Two errors might have occurred, incorrectly accepting 
certain null hypotheses. For example, we found no statistically significant relationships between
dignity and ethnicity, admission status or working alliance, on multi-variable testing. These areas merit further study with larger samples, especially as our model leaves 61.3% of the variation in dignity scores between patients unexplained. The lack of association between dignity and ethnicity is of particular interest. Ethnic and racial disparities in healthcare are well documented, and a 2015 systematic review found low to moderate levels of implicit bias among healthcare professionals in 14 out of 15 studies (Hall et al., 2015). It is important to emphasise that while clinicians may consciously reject racist beliefs and oppose prejudice based on nationality, implicit biases operate at an unconscious level and may influence a person’s attitudes and behaviour without their volition or awareness (Greenwald & Banaji, 1995). Evidence and knowledge of the impact and prevalence of implicit bias and systemic racism on dignity are not new (Bracey, 2006), but have been emphasised over the course of 2020 with the Black Lives Matter protests across the globe in the wake of high profile police brutality cases in the United States (CSUSM, 2020). The struggle for racial justice has been described as a struggle to secure dignity in defiance of sustained efforts to degrade individuals on the basis of colour (Bracey, 2005). While our study did not find statistical differences in dignity score between participants of different ethnicities, this was possibly related to the low numbers of non-Caucasian participants or our own unconscious biases in study design or execution.

Future studies with random sampling and larger sample sizes would facilitate further exploration of these and other variables, as well as potentially providing a greater focus on involuntary patients.
Despite some caveats and limitations which must be considered, our study nonetheless revealed a number of interesting correlations with subjective experience of dignity. I discuss these findings with reference to the literature in the following paragraphs.

5.5 Dignity and legal status

The PDI was developed for use in end of life care by Chochinov et al. (2008). It was based on a model which identifies three main domains relevant to patient experience of dignity: illness-related concerns, social dignity inventory and dignity conserving repertoire (Chochinov, Hack, McClement, Kristianson & Harlos, 2002). A person’s illness-related concerns and social dignity burden are filtered through the dignity conserving repertoire, which can moderate the other two factors. The PDI gives clinicians a framework to detect areas of patient distress and provides an accessible way for patients to express difficulties in personal, relational, existential and symptom-related domains. It has been translated into multiple languages (Ripamonti et al, 2012; Sautier, Vehling & Mehnert, 2014; Rullan et al., 2015), and the version used in our study has demonstrated content validity, face validity, concurrent validity, internal consistency and structural validity in the psychiatric inpatient setting (DiLorenzo et al., 2017; DiLorenzo et al., 2018). However, those studies did not present data on differences between voluntary and involuntary patients in terms of PDI score. To the best of our knowledge, our investigation is unique in examining differences between groups of voluntary and involuntary psychiatric patients in terms of quantitatively measured experience of dignity.

One of the hypotheses of this research project was that involuntary legal status would be associated with higher PDI score (ie: lower self-rated dignity) among psychiatry inpatients. This
was based on the systematic literature review and thematic synthesis, described in chapter 2 of this thesis, which identified powerlessness and coercion (among other themes) as factors associated with poorer experience of psychiatric inpatient care. Our assumption was that involuntary legal status, which limits autonomy and is associated with higher rates of coercive interventions (Sampogna et al., 2019), would be associated with higher PDI scores (ie: lower dignity).

Our study, however, found an association between voluntary, rather than involuntary, legal status and PDI score on univariate testing (mean ranks 58.35 versus 42.31 respectively; Mann-Whitney U: 792.00). This finding was statistically significant (p=0.017) although it did not survive multivariate linear regression analysis (β=-5.507, standard error 4.937, p=0.267).

It is interesting to note that perceived coercion on admission retained its significant association with lower dignity on linear regression (β=1.517, standard error 0.406, p<0.001), and that all tolerance values were greater than 0.25, indicating that legal admission status and perceived coercion on admission operated independently of one another in our analysis.

Although the lack of association between involuntary status and lower dignity was initially surprising, it echoed the findings of Schroder, Alstrom and Larsson (2006) who noted that patients did not describe involuntary treatment as a factor impacting quality of psychiatric care. A recent cross-sectional analytic study of complaints among psychiatric inpatients in a South African hospital found that there was no significant association between dignity-related complaints and Mental Health Care Act status, which is also in keeping with our findings (Raphalalani, Becker, Bohmer & Kruger, 2021). These results suggest that patients’ overall care experience, rather than their legal admission status, impacts on their experience of dignity.
As described in the introduction of this thesis, involuntary treatment under the MHA brings with it legal protections and independent oversight by the Mental Health Commission. Involuntary patients are provided with written information about their rights, are assigned an external legal representative and have their admission and treatment independently reviewed by a mental health tribunal (Section 16). Involuntary patients are invited to attend the tribunal and to give evidence, through their legal representative and/or by addressing the tribunal themselves. Even where a patient’s legal status has been or changed to voluntary (ie: the admission order has been ‘revoked’ by the treating consultant psychiatrist), the patient is still entitled to have their detention reviewed by a mental health tribunal if they so request (Section 28). This entitlement only applies to patients who have had an admission order completed. Where a patient is transported to the hospital under the legal powers of the MHA (i.e.: following application and recommendation) but they do not, in the opinion of the assessing consultant psychiatrist, fulfil the criteria for a mental disorder (Section 14(1b)) or they indicate a wish to be admitted as a voluntary patient (Section 16(2g)), an admission order is not completed. Patients who are not subject to an admission order are not afforded legal representation or a mental health tribunal. O’Donoghue et al. (2014) found that patients who were brought to hospital under Mental Health Act legislation but agreed to remain in hospital on a voluntary basis were more likely to report high levels of perceived coercion. The authors in that study noted that ‘coerced voluntary’ inpatients lacked the protections afforded by the MHA, namely access to legal representation and independent review of their admission.

Dignity preservation occurs through social interactions and relationships (the ‘Social Dignity Inventory’), according to Chochinov’s 2002 model. Dignity is impacted by the ways in
which worth and respect are communicated to patients through the demeanour, speech and actions of others (Jacobson, 2009). In addition, dignity violations in healthcare are more common when there is asymmetry in the relationship between patient and practitioner – i.e.: where the practitioner has power or authority over the patient (Jacobson, 2009). Mental health tribunals are a formal process, where legal and professional language is used and where the involuntary patient’s legal rights are the central concern. Both the patient and the consultant psychiatrist are entitled to give evidence to the independent panel of tribunal members. The tribunal has the authority to revoke the involuntary admission order made by the treating consultant (Section 18). The tribunal process, therefore, has the potential to alter the power dynamic between the consultant psychiatrist and involuntary patient.

Therapeutic jurisprudence has been defined as a ‘mental health approach to the law’ (Winick, 1997). Its underlying principle is that if those who are subject to legal proceedings are treated with fairness and dignity, it will benefit their overall wellbeing. It has been suggested that legal proceedings, such as mental health commitment hearings, have the potential for positive psychological impact on the people involved regardless of the outcome of the proceedings if they are conducted in line with the principles of therapeutic jurisprudence (Tyler, 1993; Winick, 2003). Previous empirical research into the concept of therapeutic jurisprudence found that involuntary patients were sensitive to verbal and behavioural indicators of respect and procedural justice in mental health commitment hearings, and that perception of procedural justice was linked with attitudes towards treatment (Cascardi, Poythress & Hall, 2000). In another study, almost half (45.4%) of involuntary patients reported that it was easier to accept their involuntary admission since it had been reviewed by a mental health tribunal,
and over 50% believed the tribunal process was a fair way to review involuntary admissions. (O’Donoghue, Lyne, Hill, Larkin, Feeney & O’Callaghan, 2010). Research in this area has not been universally positive about the impact of mental health tribunals, however. Involuntary patients who had experienced mental health tribunals demonstrated poorer therapeutic alliance than those who had not had a tribunal in one study (Roche, Madigan, Lyne, Feeney & O’Donoghue, 2014). Negative experiences at mental health hearings can damage the therapeutic relationship (Donnelly, Lynch, Mohan & Kennedy, 2011), a concept sometimes named as ‘juridogenic harm’ (Obomanu & Kennedy, 2001). Nevertheless, it is worth considering that the attitudes, behaviours and dialogue experienced by an involuntary patient as part of the mental health tribunal process may contribute to preservation or enhancement of dignity, if the tribunal is conducted in a therapeutic, dignity-conserving manner.

In our multivariate analysis, the association between dignity and legal status was not statistically significant ($\beta=-5.5-7$, $SE=4.937$, $p=0.267$). Despite tolerance values that indicate no problems with multicollinearity, the inclusion of perceived coercion in our model might still have resulted in a degree of ‘over-controlling’ and thus masked a relationship (in either direction) between dignity and admission status. Nevertheless, this study nonetheless raises the possibility that - contrary to expectations - involuntary patients may experience greater preservation of dignity than their voluntary counterparts. Further work is needed to elucidate this apparently paradoxical relationship.
5.6 Dignity and coercion

In our study, higher perceived coercion was associated with lower dignity ($\beta = 1.517$, SE = 0.406, $p<0.001$). Perceived coercion in this cohort was significantly associated with involuntary legal status ($\beta = 5.160$, $p<0.001$) (O’Callaghan, Plunkett & Kelly, 2021a), although involuntary status is not a prerequisite for experiencing coercion. It has previously been demonstrated that some voluntary patients experience levels of coercion similar to their involuntary counterparts, with 22% of voluntary patients in one study rating their perceived coercion as equal to or greater than the level of coercion reported by 80% of involuntary patients (4 out of 5 on the perceived coercion subscale of the AES) (O’Donoghue et al, 2017). 16.66% (n=13) of voluntary patients in our sample scored 4 or 5 on the perceived coercion on admission subscale of the AES, indicating that a significant minority of voluntary patients experienced high levels of perceived coercion in our study.

A 2008 review of the literature on treatment pressures and coercion (Szmukler & Appelbaum) identified a spectrum of pressures associated with psychiatric care ranging from persuasion to leverage, inducements, threats and formal compulsory treatment. Persuasion is an appeal to reason, convincing a person to agree to or accept a course of action. Leverage and inducements involve promising a positive or desired outcome if a person complies, for example, offering a trip to the cinema in exchange for a patient taking their medication. A threat is similarly transactional but implies that the person will be worse off if they do not accept the deal on offer; denying a patient leave home to see their family unless they take their medication, for example. Involuntary treatment is compulsory and backed up by legal and statutory powers, such as in the cases of involuntary admission, change of legal status of an
inpatient or community care orders (where they exist). Szmukler & Appelbaum’s review (2009) also discussed a number of other concepts which are relevant to the idea of non-consensual treatment but conceptually distinct from coercion including deception, exploitation and prediction of negative outcomes of non-compliance.

Informal coercion, where treatment is not legally mandated but is nonetheless not entirely voluntary, is not a new concept. Breggin’s recounting of some of the issues experienced by legally voluntary patients and their treating clinicians in an unlocked psychiatric hospital in New York in 1964 remains relatable today. He describes patients, initially persuaded by family to go to hospital, becoming frightened by the admission procedures but cajoled or induced by staff and family to remain ‘voluntarily’. These very same inducements and threats are described in a Swedish qualitative study from 2019 (Pelto-Piri, Kjellin, Hylen, Valenti & Priebe). Breggin (1964) outlines some of the pressures which may lead clinicians to use informal coercion including the desire to treat, the desire to safeguard patients and their families, and the desire to protect themselves from litigation or reputational damage in the case of a negative outcome. The study by Pelto-Piri, Kjellin, Hylen, Valenti & Priebe (2019) also acknowledges the ethical quandaries faced by clinicians, wishing to protect and treat vulnerable patients in the least coercive manner possible. Finally, Breggin (1964) tells how patients intimidated by the perceived or actual threat of transfer to ‘the state hospital’ (a locked unit with a reputation for long involuntary admissions) would mask or deny symptoms in order to stay in the open ward. Patients ‘playing ball’ by going along with recommendations to avoid or reduce the risk of coercive treatment has been coined ‘coercive shadow’, and is still at play in modern psychiatric care (McGuinness et al., 2018; Szmukler, 2015). The treatment pressures on technically
voluntary patients and the ethical dilemmas faced by staff in relation to informal coercion remain unchanged, despite the passage of five decades since Breggin’s article.

Despite the ethical challenges associated with it, informal coercion is not uncommon in current psychiatric practice. A review from 2016 found that patients reported some form of leverage to be present in their interactions with psychiatric care in 29 – 59% of cases (Hotzy & Jaeger).

Coercion and perceived pressures on admission have been linked to negative outcomes such as poorer working alliance and lower satisfaction with care (Sampogna et al., 2019; Katsakou et al., 2011). Coercion and powerlessness both emerged as important factors in patients’ experience of inpatient psychiatric care in our systematic review. Reducing perception of coercion in psychiatric care has been suggested as an intervention which could improve engagement and outcomes (Katsakou et al., 2011). However, even patients who experience coercion as part of psychiatric admission procedures can come to view their admission as having been necessary or helpful (Sibitz et al., 2011; O’Donoghe et al., 2014), and the effect of coercion on patient satisfaction can be mediated by procedural justice. That is to say that patients who believe they have been treated with respect, concern and fairness tend to view psychiatric care more positively, even if they have experienced formally coercive (ie: involuntary) care (Lidz et al., 1995).

Many psychiatrists, state bodies and regulatory bodies recognise the need to reduce coercion in psychiatry as much as possible (Mental Health Europe, 2019; Sashidharan, Mezzina & Puraz, 2019). Patients and practitioners alike recognise the deleterious impact that excessive coercion can have on patients, their families and their trust in the profession generally
(Sequeira & Halstead, 2002; Strauss et al., 2013; However, most equally acknowledge that some level of coercive care may be necessary for some patients at some times. An individual’s behaviour while they are unwell may in some cases violate the law or risk harm to themselves or others, and there are situations where limiting a person’s autonomy through legal means such as involuntary admission and treatment, despite being formally coercive, conserves and promotes their dignity. Outside psychiatric practice, there is precedent within the legal system to limit individuals’ freedoms, where their actions are ruled to infringe upon human dignity as a whole (Mr Manuel Wackenheim v France Communication No 854/1999, UN Doc CCPR/C/75/D/854/1999 (13 November 1996), UN Doc A/57/40 at 179 (2002) Decision of the Human Rights Committee, 75th Session, delivered 26 September 2002), although this remains a subject of discussion and debate (Davis, 2006).

We found that higher perceived coercion on admission was associated with lower dignity, rather than legal admission status. Patients who appraised their admission as more coercive reported poorer experience of dignity overall, both on bi-variate and multi-variate analysis. While we cannot comment on causality, our findings suggest that it is the perception of coercion at the time of admission which is deleterious to dignity, rather than the process of legal detention, and that patients who feel their care has been more dignified may experience it as less coercive, and vice versa. Beyleverd and Brownsword (2001) conceptualised ‘dignity as empowerment’ and ‘dignity as restraint’, acknowledging that dignity is an inherent human right which imbues individuals with certain freedoms, but can also encompass duty-driven approaches promoting dignity as a virtue. In providing good quality care, clinicians have a duty
to make every effort to conserve patient dignity, especially in the case of formally and informally coercive admissions.

The potential for measures which emphasise dignity-preservation and procedural justice to reduce overall perception of coercion in psychiatric care is yet to be explored fully. It represents a potential avenue for interventional studies in the future.

5.7 Dignity and insight

Insight, as it applies to psychiatric practice, relates to a patient’s appreciation of their mental state and need for treatment. A patient’s level of insight can fluctuate across time and phase of illness, and is thought of as a dynamic, rather than static phenomenon (Gerretsen, Plitman, Rajji & Graff-Guerrero, 2014; Ghaemi & Rosenquist, 2004). Insight is a multidimensional construct, including three main overlapping components; recognition of illness, compliance with treatment and the ability to appreciate mental symptoms as pathological (David, 1990). The Birchwood Insight Scale (Birchwood et al., 1994) evaluates these three dimensions on a scale ranging from 0 to 12. A score of 9 or above has been identified as a cut-off indicating good insight (Birchwood et al., 1994) although insight is widely recognised to be on a spectrum, rather than a binary construct (Amador et al., 1993; Belvederi-Murri & Amore, 2019).

Poor insight is implicated in non-adherence to treatment (Velligan et al., 2009), and is associated with increased risk of violence in some patients, although this is not consistently found (Bjorkley, 2006; Lincoln, Lullmann & Rief, 2007). Improved insight is associated with better functional and clinical outcomes across a range of psychiatric diagnoses (Ghaemi,
Boiman & Goodwin, 2000; Lincoln, Lullmann & Rief, 2007), as well as greater satisfaction and engagement with care (Bainbridge et al., 2018; Bo et al., 2016). Demonstrating high levels of insight is associated with negative, as well as positive outcomes, however. In what has been referred to as ‘the insight paradox’ (Lysaker, Roe & Yanos, 2007) better insight has well demonstrated associations with hopelessness and depressed mood (Amore et al., 2020; Ekinci et al., 2012) and may be implicated in higher risk of suicide in some patient groups (Kim, Jayathilake & Meltzer, 2002).

In our study sample, better insight correlated with worse dignity in that patients with better insight had higher PDI scores (i.e.: lower dignity) (\( \beta = 2.578 \), Standard error = 0.638, \( p < 0.001 \)). One interpretation of this finding is that patients with better insight may be better able to recognise the dignity-limiting consequences of their situation. As described in the introduction, dignity is relational and exists, at least in part, in the interpersonal realm. From a virtue ethics perspective there is virtue in displaying dignity (i.e: in demonstrating actions, attitudes and attributes that are seen as befitting of dignity), and there is virtue in acknowledging the dignity of others (Jones, 2015). Recognising that one’s dignity is being violated requires the ability to appreciate one’s own behaviour and that of others, a capability which is also fundamental to having insight. It may be that patients with better insight are more able to recognise and understand dignity violations in the psychiatric inpatient setting.

As detailed in chapter 2 and summarised above, on systematic review of the literature in this area, we found that patients frequently described wishing for contact and conversation, to have a personal relationship with staff, and to be treated as an ordinary human being. These
interpersonal aspects of care can be seen as aspects of social dignity, or dignity-in-relation, a key component of dignified care (Miller, 2017).

Observantia, a concept first set forth by Thomas Aquinas in Summa Theologia (1991) essentially refers to the way(s) in which a person acknowledges and demonstrates respect for the dignity of another (Jones, 2015). Aquinas was discussing the dignity afforded to those in high positions (analogous to the ‘attributed dignity’ described in Sulmasy’s 2013 taxonomy of dignity). As a result, it was easy to resolve ‘dulia’ (reverence) and ‘obedientia’ (obedience) as respect for and obedience to ones’ superiors (Jones, 2015). This is slightly more complex when we consider observantia in relation to intrinsic dignity, the dignity which every person possesses as an extension of their humanity (Sulmasy, 2013).

In honouring an individual’s intrinsic dignity, we are disposed to actions which demonstrate respect (such as listening attentively when they speak) and we will, at least sometimes, obey their requests by doing what they ask. Even where we cannot or do not obey the person’s request, we may still find ways to demonstrate respect and uphold their dignity, for example by taking the time to explain why we cannot acquiesce, or by offering alternative choices which we could obey. In a healthcare setting, however, this type of conduct is not always the norm. In a busy ward, with multiple demands and requests made of staff by patients, colleagues and the system at large, time pressure (and other pressures) can mean that staff do not always demonstrate a willingness to listen attentively while a patient speaks (Jones, 2015; Jacobson, 2009). Patients with better insight, that is to say patients who have greater self-understanding and reflective capacity, may identify these lapses of observantia and
experience the violation of dignity more readily than their counterparts with less insight at the time.

In addition to noticing the social processes of dignity, psychiatric inpatients with better insight may also perceive dignity violations related to the environment more readily than those with poorer insight. The lack of privacy and control over one’s environment as an inpatient can negatively impact dignity (Baillie, 2009). Well-considered design has an important role in the care experience of inpatients through enabling, maintaining and reinforcing dignity (Clarke, 2009). Clarke, an architect involved with the Irish Hospice Foundation’s ‘design and dignity’ program, wrote about the potential for the physical environment to benefit inpatients in myriad ways. From the reduction of physical discomfort to the protection of privacy, avoidance of exposure to distress and promotion of a dynamic multi-sensory interaction between patient and environment, Clarke (2009) explained that good design can encourage healing, in the broad sense of the word, and enhance patients’ sense of connectedness to nature, arts and culture.

In psychiatric settings, environmental security is an important component of design. Safety considerations such as reducing ligature points, limiting points of egress and securing items of furniture to prevent their use as projectiles all impact upon the environment of the inpatient ward. Nevertheless, the Royal College of Psychiatrists (Burns et al., 1988) have called for the design of units that are pleasant to stay in, with landscaped outdoor spaces, imaginative lighting, good sound-proofing and regular repair and renovation. They assert that the design of such an environment, and the commitment to quality care that it represents, is essential in inpatient psychiatric units – not an optional extra. In our systematic review, the care environment emerged as an important theme influencing patients’ experience of inpatient
care. The material surroundings, including presence of restraint mechanisms, high walls and security alarms can increase patient distress and heighten their sense of themselves as ‘unordinary’ (Larsen & Terkelson, 2013). On the other hand a calm, secure and aesthetically pleasing environment with ample personal space was appreciated by patients and valuable in facilitating therapeutic work (Schroder, Ahlstrom & Larsson, 2005).

Individual patient reactions to environmental safety measures differ: a patient in one study described feeling relieved by the absence of potential instruments of self-harm on the ward (Schroder, Ahlstrom & Larsson, 2005), whilst a patient in another study complained it was like a combination of a creche and a prison (Larsen & Terkelson, 2013). The impact of the physical environment is also mediated by the social environment on the ward.

Improved insight is correlated with improvement in function (Ghaemi, Boiman & Goodwin, 2000) and those with better insight tend to have less severe symptomatology (Kumar et al., 2014). It may be that patients with better insight have lower tolerance for the restrictions imposed by the psychiatric inpatient environment and perceive the dignity-limitations associated with inpatient care more strongly than those who lack insight.

The correlation between better insight and less dignity is a concerning one, as it suggests that those who can more clearly perceive their own mental state and symptoms also perceive infringements of their dignity, which perhaps less insightful patients do not appreciate.

The design of our study precludes us from drawing conclusions about causality, but it would be interesting to look at this relationship in more detail to further investigate the factors which mediate the apparent - and disquieting - relationship between better insight and worse subjective experience of dignity.
5.8 Dignity and negative symptoms

We found that negative symptoms are associated with decreased dignity on multi-variate analysis ($\beta=0.651$, SE=0.188, $p=0.001$). Notwithstanding the limitations discussed above in relation to interpretation of this finding, this finding is important to consider in terms of the wider context.

There is evidence that frailty, physical care needs, cognitive decline, loss of role and loss of independence can all have a deleterious effect on an individual’s experience of dignity (Ounalli et al., 2020; Gallagher et al., 2008; Lothian & Philip, 2001). If we consider the domains assessed by the SANS (affective flattening, alogia, avolition/apathy, anhedonia/asociality and inattention), it is clear that dignity could be impacted by symptoms in this arena.

Intrinsic dignity, as outlined in chapter 1 of this thesis, has both self-regarding and other-regarding aspects. Simply put, dignity is comprised of both the respect one has for oneself, and the respect one is shown by others. Dignity is demonstrated and communicated through social behaviour; summarised by Thomas Aquinas as ‘observantia’ (respect and obedience) or as humanness, humaneness and communication (Johnson, 1998). From an empirical standpoint, according to research done by Chochinov and his research group, dignity can be understood and measured in three domains: illness related concerns, social dignity inventory and dignity conserving repertoire. Illness related concerns include loss of independence and symptom distress. Dignity conservation moderates the former two factors.

In this model, illness related concerns encompass ‘loss of independence’, subdivided into the loss of cognitive acuity and functional capacity; and ‘symptom distress’, which includes physical and psychological suffering. The social dignity inventory is made up of five externally-
linked subthemes: privacy boundaries, social support, tone of care, burden on others and concerns for after death. The dignity conserving repertoire comprises ‘dignity-conserving perspectives’ like role preservation and generativity; and ‘dignity conserving practices’, such as living in the moment. The dignity conserving repertoire, as its name implies, moderates patients’ illness related concerns and the social dignity inventory to preserve dignity (Chochinov, 2002).

What the various classifications outlined above attempt to capture is the essence that being seen and treated as a whole individual with needs and wishes, deserving of acknowledgement and respect, generates a sense of dignity.

This brings us to the symptoms captured by the SANS tool: blunting of emotional responsiveness, limited or absent spontaneity of speech, lack of motivation, lack of interest, loss or absence of pleasure and sociability, limited social attention. A person displaying these characteristics is easily overlooked in a busy, dynamic – possibly even chaotic – inpatient ward environment. In an ideal world they would not be overlooked in this way, but our findings demonstrate that they may be. If they are overlooked, and do not experience affirming interactions from staff and other patients on the ward, one can quickly see how their dignity could suffer. Not only through loss of social support and concerns about being a burden on others, but also through reduced functional capacity and a loss of role.

It is notable that we found an association between lack of dignity and negative symptoms, but not cognition. There is a significant body of literature within gerontology which examines the relationship between dignity and dementia (Tranvag, Peterson & Naden, 2013; van der Geugten & Goossensen, 2019). The processes by which dignity is impacted in dementia are
diverse but include stigmatisation, depersonalisation, loss of identity, estrangement and scarcity or hastiness (van der Geugten & Goossensen, 2019).

Our findings indicate that it is negative symptoms, rather than cognition, which have a significant impact on dignity among psychiatry inpatients. However, some of the processes which negatively impact on patients with negative-type symptoms may be similar to those seen in dementia care. Here, I relate some of the above processes (by which people with dementia are known to lose dignity) to patients with negative-type symptoms, in particular stigmatisation, loss of identity and scarcity.

Stigmatisation is almost synonymous with psychiatric care in the public domain. The issue of stigma among patients, relatives and staff is well described in the literature (Ahmedani, 2011), and remains prevalent despite widespread public health and awareness campaigns to reduce stigma among those with psychiatric needs (Henderson, Robinson, Evans-Lacko & Thornicroft, 2019; Kakuma et al., 2010; Coyle, Lowry & Saunders, 2017). Stigma, derived from the Greek word for scar or mark, is now used to mean a discrediting attribute which reduces the bearer to a tainted individual (Goffman, 1963). Stigmatisation, a form of shunning, alienates individuals who are identifiable through certain traits or markers; patients with alogia, affective blunting and apathy for example.

Personal identity is a cognitive system formed by a complex network of idiosyncratic constructs, i.e.: personally meaningful conceptions generated by a person throughout their life history (Garcia-Mieres et al., 2020). Identities are traits, relationships, roles and groupings which define or delineate who a person is. Personal identity is a complex construct, which I will not attempt a full exposition of within this section. I will instead drastically summarise personal
identity as a stable yet malleable self-concept which is developed over time as a product of social relations. Similarly to dignity, personal identity has both self-regarding and other-regarding aspects. It provides an anchor-point for individuals’ viewpoints and influences one’s judgements, assumptions and choices (Oyserman, Elmore & Smith, 2012). A person who loses the capacity to make or communicate choices, either through physical or neurological incapacity, may lose some aspect of their personal identity. In the context of negative-type symptoms, alogia, avolition/apathy and asociality all have the potential to impact on personal identity. Diminished self-narratives, simple or constricted cognitive structures and reduced interpersonal cognitive richness are all postulated as mechanisms through which negative symptoms manifest (Garcia-Mieres et al., 2020) and represent ways in which self-identity can be eroded. The behaviour of others towards a person with these types of symptoms, for example no longer asking them about their wishes or speaking harshly to them if they have not completed a task, can further compound the dignity-diminishing effects of negative-type symptomatology.

Scarcity, which is identified as an important source of dignity-diminishing care practices within literature on dementia (van der Geugten & Goossensen, 2019) is also highly relevant to psychiatric inpatient environments, and to patients with negative-type symptoms in particular. Lack of time or resources forces professionals to emphasise efficiency and prioritise certain care tasks, lowering the overall quality of care in healthcare environments (Heggestad, Nortvedt & Slettebo, 2015). Scarcity, and the resulting lapses in quality of care can lead to patients feeling neglected, overlooked, forgotten and alone in care-of-the-elderly institutions (Naden, Rehnsfeldt & Raholm, 2013). It is not difficult to see why patients with negative-type symptoms
would suffer most from the effects of scarcity, as their needs risk being de-prioritised over the higher-visibility needs of other patients.

In our study, poorer experience of dignity was seen in participants who scored higher on the SANS but not in those with cognitive impairment. The dignity-violating processes described in dementia research have clear relevance to patients with negative-type symptoms in psychiatric settings.

Further research with larger samples could perhaps identify which symptoms within the SANS are most predictive of lower dignity, and could analyse trends in patients with schizophrenia and those without. Nevertheless, recognising that patients presenting with negative-type symptoms are vulnerable to dignity-violations (whether the symptoms are related to schizophrenia or are occurring due to some other process such as depressed mood) is important in order to target individuals with these symptom clusters for dignity-preserving interventions.

5.9 Summary of chapter 5:

In this chapter I have touched on the strengths and limitations of the research I undertook as the basis for this thesis. I have illustrated how the findings of the systematic review and the cross-sectional study fit within the context of the broader literature on dignity, and indicated some potential avenues for future investigation. In chapter 6, I will describe the conclusions that can be drawn from this research.
Chapter 6: Conclusion

6.1 Overview of chapter 6

In this final chapter, following on from the discussion of my findings, I outline the inferences of the research I have undertaken into dignity in inpatient psychiatric care and suggest directions for future research into this topic.

6.2 Conclusions

Dignity is a complex social and philosophical construct which has relevance in healthcare settings in general, and in psychiatry inpatient settings in particular, due to its distinction from autonomy, the almost universal appreciation for dignity as a fundamental human right and the impact of dignified treatment on the social environment.

There are many and varied interpretations of the word dignity, most of which distil down to the worth, honour and respectability intrinsic to every human being. Dignity can be thought of as an extension of one’s humanity. An empirical model of dignity in healthcare (Chochinov, 2002) comprises illness-related concerns, social dignity inventory and dignity-conserving repertoire.

Among psychiatry inpatients, lower self-rated dignity is associated with higher perceived coercion on admission, better insight and more negative symptoms. There is no association between dignity and ethnicity, admission status, diagnosis, working alliance, positive symptoms, cognition or other factors we assessed.

Contrary to our hypothesis, involuntary patients reported higher levels of dignity compared with voluntary patients (on bi-variable but not multi-variable testing). This may be
accounted for by the dignity-preserving effects the mental health tribunal process can provide, if it is conducted respectfully with a high level of procedural justice. Given the paradoxical nature of this finding, it merits further exploration in future research.

Higher levels of perceived coercion correlate with lower subjective dignity in psychiatry inpatients. This finding is intuitive but nonetheless important, especially in a medical specialty with an historical legacy of human rights violations (Kelly, 2019). It may not be possible for psychiatry to entirely eliminate coercive or involuntary treatment, but it is incumbent upon us to improve on clinical practice and treatment milieux such that patient dignity is centred and conserved as much as possible.

Better insight correlates with lower dignity, a finding which has concerning implications. Frequently, coercive practices within psychiatric care are considered to be justified by the supposed or demonstrated impairment of insight (Marley, 2007; Steinert, 2016). Our study indicates that those who have better appreciation of their mental state and a better understanding of their symptoms as pathological report lower levels of subjective dignity. The insinuation is that those in this patient group are better able to recognise the dignity-limiting effects of their situation, and do not experience sufficient dignity-conservation to counteract this. This is something of an indictment of the current system which has implications for clinical practice as well as future research.

Higher levels of negative symptomatology correlate with lower dignity, which is another somewhat intuitive finding of our research. Loss of role, loss of independence, stigmatisation, loss of personal identity and vulnerability to the effects of under-resourced care environments are all potential mechanisms by which patients with negative-type symptomatology are
vulnerable to dignity-violation. Individuals with these symptom clusters should be identified and dignity-preserving interventions should be emphasised in their care.

Recognising factors associated with poorer experience of dignity, such as perceived coercion on admission, better insight and more negative symptoms, allows for identification of individuals and groups at higher risk of dignity violation, and can highlight those in greatest need of protection of their dignity. This is a worthy aim especially given the restrictions of liberty and autonomy associated with inpatient psychiatric care.

6.3 Future directions of research

As this thesis has highlighted, the dignity of inpatients in psychiatric care is an important area which has received surprisingly little attention in research to date. Based on the findings of this research project, we draw some interesting but tentative conclusions. There is much that remains to be investigated and better understood.

Further studies using the PDI to assess subjective dignity of psychiatric inpatients, especially larger studies and studies with systematic, rather than purposive sampling, would allow more robust analysis of the clinical correlates of dignity in this population. In particular, the relationship between patient legal status and dignity merits further evaluation. In our study, we included patients who had been involuntary for any part of their admission in the involuntary patient group. Research into differences – if any – between patients who were admitted involuntary and those whose legal status was changed to involuntary would be an interesting area of future study. Furthermore, exploration of the dignity-conserving impact of
mental health tribunals and the role of therapeutic jurisprudence or procedural justice in moderating the effects of coercive care is indicated, based on the findings of our analysis.

To our knowledge, personality disorder has not been considered in relation to dignity to date. How patients with personality disorders (or traits thereof) experience dignity on inpatient units would be an interesting avenue of future research. The diagnostic criteria of personality disorders include ‘markedly disharmonious attitudes and behaviour [...] eg. affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others’ (WHO, 1993 pp.157). These characteristics themselves may directly impact upon subjective experience of dignity. Furthermore, relationships to staff or experience of coercion may be different in patients with personality disorder diagnoses compared to those without. There is evidence that clinicians may have negative attitudes towards patients with borderline or emotionally unstable personality disorder (Black et al., 2011) and that patients with personality disorder diagnoses are at increased risk of coercive interventions such as seclusion and restraint (Dumais et al., 2011; Kodal, Kjaer & Larsen, 2018). How certain personality traits or interpersonal styles interfere with patient dignity, either directly or via secondary factors such as coercion and staff relationships warrants investigation in future studies.

The association that we found between better insight and worse dignity is one which certainly requires further study. Replication of this finding in other cohorts and longitudinal analysis of the relationship between insight and dignity are important areas for future research. Further exploration of the correlation between negative-type symptomatology and poorer dignity is also warranted. Larger studies could potentially identify which symptoms within the SANS are most predictive of lower dignity, and could analyse trends in patients with
schizophrenia and those without. A more in-depth analysis of the relationship between dignity and negative symptomatology would be a valuable addition to the literature as well as potentially having clinical implications.

Establishing a cut-off point which represents an acceptable dignity score – something which could reasonably be done in a larger and more generalisable sample – has potential utility for clinical practice. It could allow subjective patient dignity to become a metric by which to assess quality of care in psychiatric inpatient environments and highlight areas in need of improvement.

6.4 Future implications for clinical practice, education and service delivery

Notwithstanding the need for further research into this area, the findings of this thesis have implications for clinical practice, education and service delivery.

The factors associated with patient experience of dignity identified in the systematic review of this thesis, in particular the first four core themes (coercion, powerlessness, care environment and relationship to staff) could be used as a framework through which to analyse current clinical practice and service delivery with an emphasis on patient dignity. While dignified care should be the aim for all patients, recognising those patients who are at increased risk of poor dignity experience within a service (for example those with better insight, higher levels of perceived coercion and negative-type symptomatology) allows for emphasis to be placed on dignity preservation for those patients in particular.

In order for staff to be empowered to provide dignity-emphasising care, increased education around patient dignity in mental health services and in health sciences curricula is
required. Including education on dignity in undergraduate and postgraduate training is important to ensure that this concept is recognised and attended to by clinical staff of all disciplines. This could be achieved through the delivery of lectures and in-service training on dignity, the development of e-learning modules (for example through the postgraduate training bodies such as the College of Psychiatrists of Ireland), and ongoing publication of articles in relation to this topic. The focus of such education might include ensuring a compassionate approach to patients and being mindful of perceived coercion among patients. Education which highlights the importance of dignity, the components of dignified care, and the ways in which dignity-enhancing care can be delivered within mental health services is necessary to ensure that clinicians can recognise and avoid dignity violations in practice and work to promote the dignity of the patients they treat.

Staff burnout is associated with poor quality care and reduced patient satisfaction (Tawfik et al., 2019; Halbesleben & Rathert, 2008). Adequate resourcing of services and appropriate supports for clinicians are important to avoid burnout in front-line mental health workers who are essential for ensuring dignity for patients.

The fundamentals of patient dignity, including ways of preserving and enhancing patient dignity should be highlighted in nursing and medical education. Consideration of patient dignity is also important in the development, delivery and quality analysis of mental health services.
6.5 Summary of chapter 6

In summary, the research undertaken for this thesis reveals a number of factors which are important in terms of patients’ experience of psychiatric inpatient care. It demonstrates associations between poorer dignity and coercion, insight and negative-type symptoms. It also raises a number of questions in relation to associations with patient dignity in inpatient psychiatric care and demonstrates that further appraisal of this subject is indicated. Use of the PDI in both research and clinical practice can facilitate discussion, consideration and protection of patients’ dignity in the psychiatric inpatient setting.

An emphasis on patient dignity in research, clinical practice and staff education could benefit mental health services and improve patient experience.
http://wittgensteinrepository.org/agora-alws/article/view/2753/3230


https://scholarship.law.gwu.edu/cgi/viewcontent.cgi?article=1007&context=faculty_publications


https://doi.org/10.5070/c7261021164


https://www.archives.gov/education/lessons/brown-v-board


Hofmann, B. (2020). The death of dignity is greatly exaggerated: Reflections 15 years after the declaration of dignity as a useless concept. *Bioethics, 34*(6), 602–611.


ISBN:9781937382360


O’Mahony, C. (2012). There is no such thing as a right to dignity. *International Journal of Constitutional Law*, 10(2), 551–574.


https://doi.org/10.21203/rs.2.17476/v2


https://newrepublic.com/article/64674/the-stupidity-dignity


WMA international code of medical ethics. (2006). Retrieved from

https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/


Appendices

Appendix 1: Patient Dignity Inventory
Appendix 2: Birchwood Insight Scale
Appendix 3: Working Alliance Inventory Scale
Appendix 4: MacArthur Admission Experience Survey
Appendix 5: Global Assessment of Function
Appendix 6: Mini Mental State Examination
Appendix 7: Scale for the Assessment of Positive Symptoms
Appendix 8: Scale for the Assessment of Negative Symptoms
Appendix 9: Systematic review article from Irish Journal of Law and Psychiatry
Appendix 10: Examples of phenomenographic analysis from systematic review
Appendix 11: Research and Ethics Committee approval letters
# Appendix 1: Patient Dignity Inventory

## Patient Dignity Inventory

For each item, please indicate how much of a problem or concern these have been for you within the last few days.

<table>
<thead>
<tr>
<th></th>
<th>Not a problem</th>
<th>A slight problem</th>
<th>A problem</th>
<th>A major problem</th>
<th>An overwhelming problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Not being able to carry out tasks associated with daily living (eg. washing myself, getting dressed).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Not being able to attend to my bodily functions independently (eg. needing assistance with toileting-related activities).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>Experiencing physically distressing symptoms (such as pain, shortness of breath, nausea).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>Feeling that how I look to others has changed significantly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>Feeling depressed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>Feeling anxious.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>Feeling uncertain about my health and health care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>Worrying about my future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>Not being able to think clearly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>Not being able to continue with my usual routines.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>Feeling like I am no longer who I was.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>Not feeling worthwhile or valued.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>Not being able to carry out important roles (eg. spouse, parent).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14.</td>
<td>Feeling that life no longer has meaning or purpose.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>Feeling that I have not made a meaningful and/or lasting contribution in my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>Feeling that I have ‘unfinished business’ (eg. things that I have yet to say or do, or that feel incomplete).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>Concern that my spiritual life is not meaningful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>Feeling that I am a burden to others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>Feeling that I don’t have control over my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>Feeling that my health and care needs have reduced my privacy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21.</td>
<td>Not feeling supported by my community of friends and family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>Not feeling supported by my health care providers.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>Feeling like I am no longer able to mentally cope with challenges to my health.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24.</td>
<td>Not being able to accept the way things are.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25.</td>
<td>Not being treated with respect or understanding by others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix 2: Birchwood Insight Scale

**IS – (present)**

Please read the following statements carefully and then tick the box which best applies to you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Some of the symptoms were made by my mind</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I am mentally well</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I do not need medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. My stay in hospital was necessary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The doctor is right in prescribing medication for me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I do not need to be seen by a doctor or psychiatrist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. If someone said I had a nervous or mental illness then they would be right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. None of the unusual things I experienced are due to an illness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Appendix 3: Working Alliance Inventory Scale**

1. ____________, and I agree about the things I will need to do in therapy to help improve my situation.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

2. What I am doing in therapy gives me new ways of looking at my problem.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

3. I believe ____________ likes me.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
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<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

4. ____________ does not understand what I am trying to accomplish in therapy.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

5. I am confident in ____________’s ability to help me.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
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<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

6. ____________ and I are working towards mutually agreed upon goals.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

7. I feel that ____________ appreciates me.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

8. We agree on what is important for me to work on.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

9. ____________ and I trust one another.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

10. ____________ and I have different ideas on what my problems are.

    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    |---|---|---|---|---|---|---|
    | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

11. We have established a good understanding of the kind of changes that would be good for me.

    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    |---|---|---|---|---|---|---|
    | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

12. I believe the way we are working with my problem is correct.

    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    |---|---|---|---|---|---|---|
    | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |
Appendix 4: MacArthur Admission Experience Survey

The MacArthur Coercion Study Admission Experience Survey: Short Form

"I am now going to read you some statements about your coming into the hospital this time. Please answer either "TRUE" or "FALSE" to each statement. Try to answer each question individually, no matter how similar it may sound to another."

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt free to do what I wanted about coming into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2. People tried to force me to come into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>3. I had enough of a chance to say whether I wanted to come into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>4. I chose to come into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>5. I got to say what I wanted about coming into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>6. Someone threatened me to get me to come into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>7. It was my idea to come into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>8. Someone physically tried to make me come into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>9. No one seemed to want to know whether I wanted to come into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>10. I was threatened with commitment.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>11. They said they would make me come into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>12. No one tried to force me to come into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>13. My opinion about coming into the hospital didn't matter.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>14. I had a lot of control over whether I went into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>15. I had more influence than anyone else on whether I came into the hospital.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>16. How did being admitted to the hospital make you feel? Did it make you feel:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Angry.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>b. Sad.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>c. Pleased.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>d. Relieved.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>e. Confused.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>f. Frightened.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
## Appendix 5: Global Assessment of Function

### Global Assessment of Functioning (GAF) Scale

*(From DSM-IV-TR, p. 34.)*

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.</td>
</tr>
<tr>
<td>90</td>
<td>Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities.</td>
</tr>
<tr>
<td>81</td>
<td>Socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).</td>
</tr>
<tr>
<td>80</td>
<td>If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational or school functioning (e.g., temporarily failing behind in schoolwork).</td>
</tr>
<tr>
<td>70</td>
<td>Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.</td>
</tr>
<tr>
<td>60</td>
<td>Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).</td>
</tr>
<tr>
<td>50</td>
<td>Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).</td>
</tr>
<tr>
<td>40</td>
<td>Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).</td>
</tr>
<tr>
<td>30</td>
<td>OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).</td>
</tr>
<tr>
<td>20</td>
<td>Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).</td>
</tr>
<tr>
<td>10</td>
<td>Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.</td>
</tr>
<tr>
<td>1</td>
<td>Inadequate information.</td>
</tr>
</tbody>
</table>
Appendix 6: Mini Mental State Examination

Mini-Mental State Examination (MMSE)

Patient’s Name: ___________________________ Date: ________________

*Instructions: Ask the questions in the order listed. Score one point for each correct response within each question or activity.*

<table>
<thead>
<tr>
<th>Maximum Score</th>
<th>Patient’s Score</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
<td>“What is the year?  Season?  Date?  Day of the week?  Month?”</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>“Where are we now:  State?  County?  Town/city?  Hospital?  Floor?”</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient’s response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: ____________</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>“I would like you to count backward from 100 by sevens.” (93, 86, 79, 72, 65, …) Stop after five answers. Alternative: “Spell WORLD backwards.” (D-L-R-O-W)</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>“Earlier I told you the names of three things. Can you tell me what those were?”</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>“Repeat the phrase: ‘No ifs, ands, or buts.’”</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>“Take the paper in your right hand, fold it in half, and put it on the floor.” (The examiner gives the patient a piece of blank paper.)</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>“Please read this and do what it says.” (Written instruction is “Close your eyes.”)</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>“Make up and write a sentence about anything.” (This sentence must contain a noun and a verb.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Please copy this picture.” (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.)</td>
</tr>
<tr>
<td>30</td>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from Rovner & Folstein, 1987)
SCALE FOR THE ASSESSMENT OF
POSITIVE SYMPTOMS

(SAPS)

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College of Medicine
The University of Iowa
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(SAS Variable Name edition: 2000)
INTRODUCTION

This scale is designed to assess positive symptoms, principally those that occur in schizophrenia. It is intended to serve as a complementary instrument to the Scale for the Assessment of Negative Symptoms (SANS). These positive symptoms include hallucinations, delusions, bizarre behavior, and positive formal thought disorder.

As in the case of the SANS, the investigator using this instrument will need to decide on an appropriate "time set". The instrument was developed with the exception that, in general, the time set will cover the past month as in the case of SANS. This scale can also be used in psychopharmacologic research in order to make weekly ratings and chart the subject's response to treatment.

Investigators using this instrument, particularly in combination with the SANS, will need to use a standard clinical interview in order to evaluate the subject's symptoms. Since positive formal thought disorder is an important positive symptom, it is recommended that, in doing this interview, the investigator begin talking with the subject on a relatively neutral topic for five to ten minutes in order to observe the subject's manner of speaking and responding. Thereafter, he can begin to ask specific questions about the various positive symptoms. Suggested probes are provided in the interview guide.

In addition to using a clinical interview, the investigator should also draw on other sources of information, such as direct observation, reports from the subject's family, reports from nurses, and reports from the subject himself. In general, the subject can usually be considered a relatively reliable informant concerning delusions and hallucinations if he is able to communicate clearly and will comply with a clinical interview. On the other hand, the interviewer will usually have to rely on observation and reports from outside sources in order to evaluate bizarre behavior and positive formal thought disorder.

The last item describing each major type of positive symptom is an overall global rating. This should be a true global rating based on taking into account both the nature and the severity of the various types of symptoms observed. In some cases, a single symptom (e.g., extremely severe persecutory delusions) may lead to a very high global rating, even if other symptoms of this type are not present.
HALLUCINATIONS

Hallucinations represent an abnormality in perception. They are false perceptions occurring in the absence of some identifiable external stimulus. They may be experienced in any of the sensory modalities, including hearing, touch, taste, smell, and vision. True hallucinations should be distinguished from illusions (which involve a misperception of an external stimulus), hypnagogic and hypnopompic experiences (which occur when the subject is falling asleep or waking up), or normal thought processes that are exceptionally vivid. If the hallucinations have a religious quality, then they should be judged within the context of what is normal for the subject’s social and cultural background. Hallucinations occurring under the immediate influence of alcohol, drugs, or serious physical illness should not be rated as present. The subject should always be requested to describe the hallucination in detail.

Auditory Hallucinations
The subject has reported voices, noises, or sounds. The commonest auditory hallucinations involve hearing voices speaking to the subject or calling him names. The voices may be male or female, familiar or unfamiliar, and critical or complimentary. Typically, subjects suffering from schizophrenia experience the voices as unpleasant and negative. Hallucinations involving sounds rather than voices, such as noises or music, should be considered less characteristic and less severe.

Have you ever heard voices or other sounds when no one is around?

What did they say?

Voices Commenting
Voices commenting are a particular type of auditory hallucination which phenomenologists as Kurt Schneider consider to be pathognomonic of schizophrenia, although some recent evidence contradicts this. These hallucinations involve hearing a voice that makes a running commentary on the subject’s behavior or thought as it occurs. If this is the only type of auditory hallucination that the subject hears, it should be scored instead of auditory hallucinations (No. 1 above). Usually, however, voices commenting will occur in addition to other types of auditory hallucinations.

Have you ever heard voices commenting on what you are thinking or doing?

What do they say?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>Questionable</td>
<td>1</td>
</tr>
<tr>
<td>Mild: Subject hears noises or single words; they occur only occasionally</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Clear evidence of voices; they have occurred at least weekly</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Clear evidence of voices which occur almost every day</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Voices occur often every day</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
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<tr>
<td>Mild: Subject hears noises or single words; they occur only occasionally</td>
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<td>3</td>
</tr>
<tr>
<td>Marked: Clear evidence of voices which occur almost every day</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Voices occur often every day</td>
<td>5</td>
</tr>
</tbody>
</table>
**Voices Conversing**  
Like voices commenting, voices conversing are considered a Schneiderian first-rank symptom. They involve hearing two or more voices talking with one another, usually discussing something about the subject. As in the case of voices commenting, they should be scored independently of other auditory hallucinations.

*Have you heard two or more voices talking with each other?*

*What did they say?*

**Somatic or Tactile Hallucinations**  
These hallucinations involve experiencing peculiar physical sensations in the body. They include burning sensations, tingling, and perceptions that the body has changed in shape or size.

*Have you ever had burning sensations or other strange feelings in your body?*

*What were they?*

*Did your body ever appear to change in shape or size?*

**Olfactory Hallucinations**  
The subject experiences unusual smells which are typically quite unpleasant. Sometimes the subject may believe that he himself smells. This belief should be scored here if the subject can actually smell the odor himself, but should be scored among delusions if he only believes that others can smell the odor.

*Have you ever experienced any unusual smells or smells that others do not notice?*

*What were they?*
Visual Hallucinations
The subject sees shapes or people that are not actually present. Sometimes these are shapes or colors, but most typically they are figures of people or human-like objects. They may also be characters of a religious nature, such as the Devil or Christ. As always, visual hallucinations involving religious themes should be judged within the context of the subject's cultural background. Hypnagogic and hypnopompic visual hallucinations (which are relatively common) should be excluded, as should visual hallucinations occurring when the subject has been taking hallucinogenic drugs.

Have you had visions or seen things that other people cannot?

What did you see?

Did this occur when you were falling asleep or waking up?

Global Rating of Severity of Hallucinations
This global rating should be based on the duration and severity of hallucinations, the extent of the subject's preoccupation with the hallucinations, his degree of conviction, and their effect on his actions. Also consider the extent to which the hallucinations might be considered bizarre or unusual. Hallucinations not mentioned above, such as those involving taste, should be included in this rating.

None 0 5541
Questionable 1
Mild: Subject experiences visual hallucinations; they occur only occasionally 2
Moderate: Clear evidence of visual hallucinations; they have occurred at least weekly 3
Marked: Clear evidence of visual hallucinations which occur almost every day 4
Severe: Hallucinations occur often every day 5
DELUSIONS

Delusions represent an abnormality in content of thought. They are false beliefs that cannot be explained on the basis of the subject's cultural background. Although delusions are sometimes defined as "fixed false beliefs," in their mildest form delusions may persist only for weeks to months, and the subject may question his beliefs or doubt them. The subject's behavior may or may not be influenced by his delusions. The rating of severity of individual delusions and of the global severity of delusional thinking should take into account their persistence, their complexity, the extent to which the subject acts on them, the extent to which the subject doubts them, and the extent to which the beliefs deviate from those that normal people might have. For each positive rating, specific examples should be noted in the margin.

Persecutory Delusions
People suffering from persecutory delusions believe that they are being conspired against or persecuted in some way. Common manifestations include the belief that one is being followed, that one's mail is being opened, that one's room or office is bugged, that the telephone is tapped, or that police, government officials, neighbors, or fellow workers are harassing the subject. Persecutory delusions are sometimes relatively isolated or fragmented, but sometimes the subject has a complex set of delusions involving both a wide range of forms of persecution and a belief that there is a well-designed conspiracy behind them. For example, a subject may believe that his house is bugged and that he is being followed because the government wrongly considers him a secret agent for a foreign government; this delusion may be so complex that it explains almost everything that happens to him. The ratings of severity should be based on duration and complexity.

Have people been bothering you in any way?
Have you felt that people are against you?
Has anyone been trying to harm you in any way?
Has anyone been watching or monitoring you?

Delusions of Jealousy
The subject believes that his/her mate is having an affair with someone. Miscellaneous bits of information are construed as "evidence." The person usually goes to great effort to prove the existence of the affair, searching for hair in the bedclothes, the odor of shaving lotion or smoke on clothing, or receipts or checks indicating a gift has been bought for the lover. Elaborate plans are often made in order to trap the two together.

Have you ever worried that your husband (wife) might be unfaithful to you?

What evidence do you have?

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Questionable</th>
<th>Mild: Delusional beliefs are simple and may be of several different types; subject may question them occasionally</th>
<th>Moderate: Clear, consistent delusion that is firmly held</th>
<th>Marked: Consistent, firmly-held delusion that the subject acts on</th>
<th>Severe: Complex well-formed delusion that the subject acts on and that preoccupies him a great deal of the time; some aspects of the delusion or his reaction may seem quite bizarre</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

_ _ 6
Delusions of Sin or Guilt
The subject believes that he has committed some terrible sin or done something unforgivable. Sometimes the subject is excessively or inappropriately preoccupied with things he did wrong as a child, such as masturbating. Sometimes the subject feels responsible for causing some disastrous event, such as a fire or accident, with which he in fact has no connection. Sometimes these delusions may have a religious flavor, involving the belief that the sin is unpardonable and that the subject will suffer eternal punishment from God. Sometimes the subject simply believes that he deserves punishment by society. The subject may spend a good deal of time confessing these sins to whomever will listen.

Have you ever felt that you have done some terrible thing that you deserve to be punished for?

Grandiose Delusions
The subject believes that he has special powers or abilities. He may think he is actually some famous personage, such as a rock star, Napoleon, or Christ. He may believe he is writing some definitive book, composing a great piece of music, or developing some wonderful new invention. The subject is often suspicious that someone is trying to steal his ideas, and he may become quite irritable if his ideas are doubted.

Do you have any special or unusual abilities or talents?

Do you feel you are going to achieve great things?
Religious Delusions
The subject is preoccupied with false beliefs of a religious nature. Sometimes these exist within the context of a conventional religious system, such as beliefs about the Second Coming, the Antichrist, or possession by the Devil. At other times, they may involve an entirely new religious system or a pastiche of beliefs from a variety of religions, particularly Eastern religions, such as ideas about reincarnation or Nirvana. Religious delusions may be combined with grandiose delusions (if the subject considers himself a religious leader), delusions of guilt, or delusions of being controlled. Religious delusions must be outside the range considered normal for the subject’s cultural and religious background.

Are you a religious person?

Have you had any unusual religious experiences?

What was your religious training as a child?

Somatic Delusions
The subject believes that somehow his body is diseased, abnormal, or changed. For example, he may believe that his stomach or brain is rotting, that his hands or penis have become enlarged, or that his facial features are unusual (dysmorphophobia). Sometimes somatic delusions are accompanied by tactile or other hallucinations, and when this occurs, both should be rated. (For example, the subject believes that he has ballbearings rolling around in his head, placed there by a dentist who filled his teeth, and can actually hear them clanking against one another.)

Is there anything wrong with your body?

Have you noticed any change in your appearance?

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<tbody>
<tr>
<td>Questionable</td>
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<tr>
<td>Mild: Delusional beliefs may be simple and may be of several different types; subject may question them occasionally</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Clear, consistent delusion that is firmly held</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Consistent, firmly-held delusion that the subject acts on</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Complex, well-formed delusion that the subject acts on and that preoccupies him a great deal of the time; some aspects of the delusion or his reaction may seem quite bizarre</td>
<td>5</td>
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<td>5</td>
</tr>
</tbody>
</table>
Ideas and Delusions of Reference
The subject believes that insignificant remarks, statements, or events refer to him or have some special meaning for him. For example, the subject walks into a room, sees people laughing, and suspects that they were just talking about him and laughing at him. Sometimes items read in the paper, heard on the radio, or seen on television are considered to be special messages to the subject. In the case of ideas of reference, the subject is suspicious, but recognizes his idea is erroneous. When the subject actually believes that the statements or events refer to him, then this is considered a delusion of reference.

Have you ever walked into a room and thought people were talking about you or laughing at you?

Have you seen things in magazines or on TV that seem to refer to you or contain a special message for you?

Have people communicated with you in any unusual ways?

Delusions of Being Controlled
The subject has a subjective experience that his feelings or actions are controlled by some outside force. The central requirement for this type of delusion is an actual strong subjective experience of being controlled. It does not include simple beliefs or ideas, such as that the subject is acting as an agent of God or that friends or parents are trying to coerce him to do something. Rather, the subject must describe, for example, that his body has been occupied by some alien force that is making it move in peculiar ways, or that messages are being sent to his brain by radio waves and causing him to experience particular feelings that he recognizes are not his own.

Have you ever felt you were being controlled by some outside force?

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<tr>
<td>Questionable</td>
<td>1</td>
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<tr>
<td>Mild: Occasional ideas of reference</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Have occurred at least weekly</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Occurs at least two to four times weekly</td>
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</tr>
<tr>
<td>Severe: Occurs frequently</td>
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<tbody>
<tr>
<td>Questionable</td>
<td>1</td>
</tr>
<tr>
<td>Mild: Subject has experienced being controlled, but doubts it occasionally</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Clear experience of control, which has occurred on two or three occasions in a week</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Clear experience of control, which occurs frequently; behavior may be affected</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Clear experience of control which occurs frequently, pervades the subject's life, and often affects his behavior</td>
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</table>
Delusions of Mind Reading

The subject believes that people can read his mind or know his thoughts. This is different than thought broadcasting (see below) in that it is a belief without a percept. That is, the subject subjectively experiences and recognizes that others know his thoughts, but he does not think that they can be heard out loud.

*Have you ever had the feeling that people could read your mind?*

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<th>None</th>
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<tbody>
<tr>
<td>Questionable</td>
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<tr>
<td>Mild: Subject has experienced mind reading, but doubts it occasionally</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Clear experience of mind reading which has occurred on two or three occasions in a week</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Clear experience of mind reading which occurs frequently; behavior may be affected</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Clear experience of mind reading which occurs frequently, pervades the subject’s life, and often affects his behavior</td>
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</table>
Thought Broadcasting
The subject believes that his thoughts are broadcast so that he or others can hear them. Sometimes the subject experiences his thoughts as a voice outside his head; this is an auditory hallucination as well as a delusion. Sometimes the subject feels his thoughts are being broadcast although he cannot hear them himself. Sometimes he believes that his thoughts are picked up by a microphone and broadcast on the radio or television.

Have you ever heard your own thoughts out loud, as if they were a voice outside your head?

Have you ever felt your thoughts were broadcast so other people could hear them?

Thought Insertion
The subject believes that thoughts that are not his own have been inserted into his mind. For example, the subject may believe that a neighbor is practicing voodoo and planting alien sexual thoughts in his mind. This symptom should not be confused with experiencing unpleasant thoughts that the subject recognizes as his own, such as delusions of persecution or guilt.

Have you ever felt that thoughts were being put into your head by some outside force?

Have you ever experienced thoughts that didn't seem to be your own?
Thought Withdrawal
The subject believes that thoughts have been taken away from his mind. He is able to describe a subjective experience of beginning a thought and then suddenly having it removed by some outside force. This symptom does not include the mere subjective recognition of alogia.

Have you ever felt your thoughts were taken away by some outside force?

Global Rating of Severity of Delusions
The global rating should be based on duration and persistence of delusions, the extent of the subject's preoccupation with the delusions, his degree of conviction, and their effect on his actions. Also consider the extent to which the delusions might be considered bizarre or unusual. Delusions not mentioned above should be included in this rating.

None 0
Questionable 1
Mild: Subject has experienced thought withdrawal, but doubts it occasionally 2
Moderate: Clear experience of thought withdrawal which has occurred on two or three occasions in a week 3
Marked: Clear experience of thought withdrawal which occurs frequently; behavior may be affected 4
Severe: Clear experience of thought withdrawal which occurs frequently, pervades the subject's life and often affects his behavior 5

None 0
Questionable 1
Mild: Delusion definitely present but, at times, the subject questions the belief 2
Moderate: The subject is convinced of the belief, but it may occur infrequently and have little effect on his behavior 3
Marked: The delusion is firmly held; it occurs frequently and affects the subject's behavior 4
Severe: Delusions are complex, well-formed, and pervasive; they are firmly held and have a major effect on the subject's behavior; they may be somewhat bizarre or unusual 5
BIZARRE BEHAVIOR

The subject's behavior is unusual, bizarre, or fantastic. For example, the subject may urinate in a sugar bowl, paint the two halves of his body different colors, or kill a litter of pigs by smashing their heads against a wall. The information for this item will sometimes come from the subject, sometimes from other sources, and sometimes from direct observation. Bizarre behavior due to the immediate effects of alcohol or drugs should be excluded. As always, social and cultural norms must be considered in making the ratings, and detailed examples should be elicited and noted.

Clothing and Appearance
The subject dresses in an unusual manner or does other strange things to alter his appearance. For example, he may shave off all his hair or paint parts of his body different colors. His clothing may be quite unusual; for example, he may choose to wear some outfit that appears generally inappropriate and unacceptable, such as a baseball cap backwards with rubber galoshes and long underwear covered by denim overalls. He may dress in a fantastic costume representing some historical personage or a man from outer space. He may wear clothing completely inappropriate to the climatic conditions, such as heavy wools in the midst of summer.

Has anyone made comments about your appearance?

Social and Sexual Behavior
The subject may do things that are considered inappropriate according to usual social norms. For example, he may masturbate in public, urinate or defecate in inappropriate receptacles, or exhibit his sex organs inappropriately. He may walk along the street muttering to himself, or he may begin talking to people whom he has never met about his personal life (as when riding on a subway or standing in some public place). He may drop to his knees praying and shouting in the midst of a crowd of people, or he may suddenly sit in a yoga position while in the midst of a crowd. He may make inappropriate sexual overtures or remarks to strangers.

Have you ever done anything that others might thing unusual or that has called attention to yourself?

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<thead>
<tr>
<th></th>
<th>None</th>
<th>Questionable</th>
<th>Mild: Occasional oddities of dress or appearance</th>
<th>Moderate: Appearance or apparel are clearly unusual and would attract attention</th>
<th>Marked: Appearance or apparel are markedly odd</th>
<th>Severe: Subject's appearance or apparel are very fantastic or bizarre</th>
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<td>1</td>
<td>2</td>
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<td>4</td>
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Aggressive and Agitated Behavior
The subject may behave in an aggressive, agitated manner, often quite unpredictably. He may start arguments inappropriately with friends or members of his family, or he may accost strangers on the street and begin haranguing them angrily. He may write letters of a threatening or angry nature to government officials or others with whom he has some quarrel. Occasionally, subjects may perform violent acts such as injuring or tormenting animals, or attempting to injure or kill human beings.

Have you ever done anything to try to harm animals or people?

Have you felt angry with anyone?

Repetitive or Stereotyped Behavior
The subject may develop a set of repetitive actions or rituals that he must perform over and over. Frequently, he will attribute some symbolic significance to these actions and believe that they are either influencing others or preventing himself from being influenced. For example, he may eat jelly beans every night for dessert, assuming that different consequences will occur depending on the color of the jelly beans. He may have to eat foods in a particular order, wear particular clothes, or put them on in a certain order. He may have to write messages to himself or to others over and over; sometimes this will be in an unusual or occult language.

Are there any things that you feel you have to do?
Global Rating of Severity of Bizarre Behavior

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<tr>
<th>Severity</th>
<th>Description</th>
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<tr>
<td>None</td>
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<tr>
<td>Questionable</td>
<td>1</td>
</tr>
<tr>
<td>Mild</td>
<td>Occasional instances of unusual or apparently idiosyncratic behavior; subject usually has some insight</td>
</tr>
<tr>
<td>Moderate</td>
<td>Behavior which is clearly deviant from social norms and seems somewhat bizarre; subject may have some insight</td>
</tr>
<tr>
<td>Marked</td>
<td>Behavior which is markedly deviant from social norms and clearly bizarre; subject may have some insight</td>
</tr>
<tr>
<td>Severe</td>
<td>Behavior which is extremely bizarre or fantastic; may include a single extreme act, e.g., attempting murder; subject usually lacks insight</td>
</tr>
</tbody>
</table>
POSITIVE FORMAL THOUGHT DISORDER

Positive formal thought disorder is fluent speech that tends to communicate poorly for a variety of reasons. The subject tends to slip from topic to topic without warning, to be distracted by events in the nearby environment, to join words together because they are semantically or phonologically alike even though they make no sense, or to ignore the question asked and ask another. This type of speech may be rapid, and it frequently seems quite disjointed. It has sometimes been referred to as "loose associations." Unlike alogia (negative formal thought disorder), a wealth of detail is provided, and the flow of speech tends to have an energetic, rather than an apathetic, quality to it.

In order to evaluate thought disorder, the subject should be permitted to talk at length on some topic, particularly a topic unrelated to his psychopathology, for as long as five to ten minutes. The interviewer should observe closely the extent to which his sequencing of ideas is well connected. In addition, the interviewer should insist that he clarify or elaborate further if the ideas seem vague or incomprehensible. He should also pay close attention to how well the subject can reply to a variety of different types of questions, ranging from simple (Where were you born?) to more complicated (How do you think the present government is doing?)

The anchor points for these ratings assume that the subject has been interviewed for a total of approximately forty-five minutes. If the interview is shorter, the ratings should be adjusted accordingly.

Derailment (Loose Associations)
A pattern of spontaneous speech in which the ideas slip off one track onto another which is clearly but obliquely related, or onto one which is completely unrelated. Things may be said in juxtaposition which lack a meaningful relationship, or the subject may shift idiosyncratically from one frame of reference to another. At times there may be a vague connection between the ideas, and at others none will be apparent. This pattern of speech is often characterized as sounding "disjointed." Perhaps the commonest manifestation of this disorder is a slow, steady slippage, with no single derailment being particularly severe, so that the speaker gets farther and farther off the track with each derailment without showing any awareness that his reply no longer has any connection with the question which was asked. This abnormality is often characterized by lack of cohesion between clauses and sentences and by unclear pronoun references.

Example: Interviewer: "Did you enjoy college?"
Subject: "Um-hum. Oh hey well, I oh, I really enjoyed some communities I tried it, and the, and the next day when I'd be going out, you know, um, I took control like uh, I put, um, bleach on my hair in, in California. My roommate was from Chicago, and she was going to the junior college. And we lived in the Y.M.C.A., so she wanted to put it, um, peroxide on my hair, and she did, and I got up and looked at the mirror and tears came to my eyes. Now do you understand it, I was fully aware of what was going on but why couldn't I, I, I, why, why the tears? I can't understand that, can you?"

None 0
Questionable 1
Mild: Occasional instances of derailment, with only slight topic shifts 2
Moderate: Several instances of derailment; subject is sometimes difficult to follow 3
Marked: Frequent instances of derailment; subject is often difficult to follow 4
Severe: Derailment so frequent and/or extreme that the subject's speech is almost incomprehensible 5
Tangentiality
Replying to a question in an oblique, tangential or even irrelevant manner. The reply may be related to the question in some distant way. Or the reply may be unrelated and seem totally irrelevant. In the past tangentiality has sometimes been used as roughly equivalent to loose associations or derailment. The concept of tangentiality has been partially redefined so that it refers only to answers to questions and not to transitions in spontaneous speech.

Example: Interviewer: "What city are you from?" Subject: "That's a hard question to answer because my parents... I was born in Iowa, but I know that I'm white instead of black, so apparently I came from the North somewhere and I don't know where, you know, I really don't know whether I'm Irish or Scandinavian or I don't, I don't believe I'm Polish but I think I'm, I think I might be German or Welsh.

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<td>Questionable</td>
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<tr>
<td>Mild: One or two oblique replies</td>
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<tr>
<td>Moderate: Occasional oblique replies (three to four times)</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Frequent oblique replies (more than four times)</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Tangentiality so severe that interviewing the subject is extremely difficult</td>
<td>5</td>
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Incoherence (Word Salad, Schizophrenia)

A pattern of speech which is essentially incomprehensible at times. Incoherence is often accompanied by derailment. It differs from derailment in that in incoherence the abnormality occurs within the level of the sentence or clause, which contains words or phrases that are joined incoherently. The abnormality in derailment involves unclear or confusing connections between larger units, such as sentences or clauses.

This type of language disorder is relatively rare. When it occurs, it tends to be severe or extreme, and mild forms are quite uncommon. It may sound quite similar to Wernicke's aphasia or jargon aphasia, and in these cases the disorder should only be called incoherence when history and laboratory data exclude the possibility of a past stroke, and formal testing for aphasia is negative.

Exclusions: Mildly ungrammatical constructions or idiomatic usages characteristic of particular regional or ethnic backgrounds, lack of education, or low intelligence.

Example: Interviewer: "What do you think about current political issues like the energy crisis?" Subject: "They're destroying too many cattle and oil just to make soap. If we need soap when you can jump into a pool of water, and then when you go to buy your gasoline, my folks always thought they should, get pop but the best thing to get, is motor oil, and, money. May, may as well go there and, trade in some, pop caps and, uh, tires, and tractors to group, car garages, so they can pull cars away from wrecks, is what I believed in."
Illogicality
A pattern of speech in which conclusions are reached which do not follow logically. This may take the form of non-sequiturs (= it does not follow), in which the subject makes a logical inference between two clauses which is unwarranted or illogical. It may take the form of faulty inductive inferences. It may also take the form of reaching conclusions based on faulty premises without any actual delusional thinking.

Exclusions: Illogicality may either lead to or result from delusional beliefs. When illogical thinking occurs within the context of a delusional system, it should be subsumed under the concept of delusions and not considered a separate phenomenon representing a different type of thinking disorder. Illogical thinking which is clearly due to cultural or religious values or to intellectual deficit should also be excluded.

Example: "Parents are the people that raise you. Any thing that raises you can be a parent. Parents can be anything -- material, vegetable, or mineral -- that has taught you something. Parents would be the world of things that are alive, that are there. Rocks -- a person can look at a rock and learn something from it, so that would be a parent."

Circumstantiality
A pattern of speech which is very indirect and delayed in reaching its goal idea. In the process of explaining something, the speaker brings in many tedious details and sometimes makes parenthetical remarks. Circumstantial replies or statements may last for many minutes if the speaker is not interrupted and urged to get to the point. Interviewers will often recognize circumstantiality on the basis of needing to interrupt the speaker in order to complete the process of history-taking within an allotted time. When not called circumstantial, these people are often referred to as "long-winded."

Exclusions: Although it may coexist with instances of poverty of content of speech or loss of goal, it differs from poverty of content of speech in containing excessive amplifying or illustrative detail and from loss of goal in that the goal is eventually reached if the person is allowed to talk long enough. It differs from derailment in that the details presented are closely related to some particular goal or idea and that the particular goal or idea must be, by definition, eventually reached.
Pressure of Speech
An increase in the amount of spontaneous speech as compared to what is considered ordinary or socially customary. The subject talks rapidly and is difficult to interrupt. Some sentences may be left uncompleted because of eagerness to get on to a new idea. Simple questions which could be answered in only a few words or sentences are answered at great length so that the answer takes minutes rather than seconds and indeed may not stop at all if the speaker is not interrupted. Even when interrupted, the speaker often continues to talk. Speech tends to be loud and emphatic. Sometimes speakers with severe pressure will talk without any social stimulation and talk even though no one is listening. When subjects are receiving phenothiazines or lithium, their speech is often slowed down by medication, and then it can be judged only on the basis of amount, volume, and social appropriateness. If a quantitative measure is applied to the rate of speech, then a rate greater than 150 words per minute is usually considered rapid or pressured. This disorder may be accompanied by derailment, tangentiality, or incoherence, but it is distinct from them.

Distractible Speech
During the course of a discussion or interview, the subject stops talking in the middle of a sentence or idea and changes the subject in response to a nearby stimulus, such as an object on a desk, the interviewer's clothing or appearance, etc.

Example: "Then I left San Francisco and moved to . . . where did you get that tie? It looks like it's left over from the 50's. I like the warm weather in San Diego. Is that a conch shell on your desk? Have you ever done scuba diving?"

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<th>Level</th>
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<tr>
<td>None</td>
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<tr>
<td>Questionable</td>
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<tr>
<td>Mild: Slight pressure of speech; some slight increase in amount, speed, or loudness of speech</td>
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</tr>
<tr>
<td>Moderate: Usually takes several minutes to answer simple questions, may talk when no one is listening, and/or speaks loudly and rapidly</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Frequently talks as much as three minutes to answer simple questions; sometimes begins talking without social stimulation; difficult to interrupt</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Subject talks almost continually, cannot be interrupted at all, and/or may shout to drown out the speech of others</td>
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<td>None</td>
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<tr>
<td>Questionable</td>
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<tr>
<td>Mild: Is distracted once during an interview</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Is distracted from two to four times during an interview</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Is distracted from five to ten times during an interview</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Is distracted more than ten times during an interview</td>
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</table>
Clanging
A pattern of speech in which sounds rather than meaningful relationships appear to govern word choice, so that the intelligibility of the speech is impaired and redundant words are introduced. In addition to rhyming relationships, this pattern of speech may also include punning associations, so that a word similar in sound brings in a new thought.

Example: I’m not trying to make a noise. I’m trying to make sense. If you can make sense out of nonsense, well, have fun. I’m trying to make sense out of sense. I’m not making sense (cents) anymore. I have to make dollars.*

Global Rating of Positive Formal Thought Disorder
In making this rating, the interviewer should consider the type of abnormality, the degree to which it affects the subject’s ability to communicate, the frequency with which abnormal speech occurs, and its degree of severity.

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<th>Rating</th>
<th>Description</th>
<th>Score</th>
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<td>0</td>
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<tr>
<td>Questionable</td>
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<td>1</td>
</tr>
<tr>
<td>Mild: Occurs once during an interview</td>
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<td>2</td>
</tr>
<tr>
<td>Moderate: Occurs from two to four times during an interview</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Marked: Occurs five to ten times during an interview</td>
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<td>4</td>
</tr>
<tr>
<td>Severe: Occurs more than ten times, or so frequently that the interview is incomprehensible.</td>
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*Subject is incomprehensible
SCALE FOR THE ASSESSMENT OF NEGATIVE SYMPTOMS

(SANS)

Nancy C. Andreasen, M.D., Ph.D.
Department of Psychiatry
College of Medicine
The University of Iowa
Iowa City, Iowa 52242

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**AFFECTIVE FLATTENING OR BLUNTING**

Affective flattening or blunting manifests itself as a characteristic impoverishment of emotional expression, reactivity, and feeling. Affective flattening can be evaluated by observation of the subject's behavior and responsiveness during a routine interview. The rating of some items may be affected by drugs, since the Parkisonian side-effect of phenothiazines may lead to mask-like facies and diminished associated movements. Other aspects of affect, such as responsivity or appropriateness, will not be affected, however.

**Unchanging Facial Expression**

The subject's face appears wooden, mechanical, frozen. It does not change expression, or changes less than normally expected, as the emotional content of discourse changes. Since phenothiazines may partially mimic this effect, the interviewer should be careful to note whether or not the subject is on medication, but should not try to "correct" the rating accordingly.

<table>
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<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Not at all: Subject is normal or labile</td>
<td>0</td>
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<tr>
<td>Questionable decrease</td>
<td>1</td>
</tr>
<tr>
<td>Mild: Occasionally the subject's expression is not as full as expected</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Subject's expressions are dulled overall, but not absent</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Subject's face has a flat &quot;set&quot; look, but flickers of affect arise occasionally</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Subject's face looks &quot;wooden&quot; and changes little, if at all throughout the interview</td>
<td>5</td>
</tr>
</tbody>
</table>

**Decreased Spontaneous Movements**

The subject sits quietly throughout the interview and shows few or no spontaneous movements. He does not shift position, move his legs, move his hands, etc., or does so less than normally expected.

<table>
<thead>
<tr>
<th>Description</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all: Subject moves normally or is overactive</td>
<td>0</td>
</tr>
<tr>
<td>Questionable decrease</td>
<td>1</td>
</tr>
<tr>
<td>Mild: Some decrease in spontaneous movements</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Subject moves three or four times during the interview</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Subject moves once or twice during the interview</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Subject sits immobile throughout the interview</td>
<td>5</td>
</tr>
</tbody>
</table>
**Paucity of Expressive Gestures**
The subject does not use his body as an aid in expressing his ideas, through such means as hand gestures, sitting forward in his chair when intent on a subject, leaning back when relaxed, etc. This may occur in addition to decreased spontaneous movements.

<table>
<thead>
<tr>
<th>Degree</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Subject uses expressive gestures normally or excessively</td>
<td>0</td>
</tr>
<tr>
<td>Questionable</td>
<td>decrease</td>
<td>1</td>
</tr>
<tr>
<td>Mild</td>
<td>Some decrease in expressive gestures</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>Subject uses body as an aid in expression at least three or four times</td>
<td>3</td>
</tr>
<tr>
<td>Marked</td>
<td>Subject uses body as an aid in expression only once or twice</td>
<td>4</td>
</tr>
<tr>
<td>Severe</td>
<td>Subject never uses body as an aid in expression</td>
<td>5</td>
</tr>
</tbody>
</table>

**Poor Eye Contact**
The subject avoids looking at others or using his eyes as an aid in expression. He appears to be staring into space even when he is talking.

<table>
<thead>
<tr>
<th>Degree</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Good eye contact and expression</td>
<td>0</td>
</tr>
<tr>
<td>Questionable</td>
<td>decrease</td>
<td>1</td>
</tr>
<tr>
<td>Mild</td>
<td>Some decrease in eye contact and eye expression</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>Subject's eye contact is decreased by at least half of normal</td>
<td>3</td>
</tr>
<tr>
<td>Marked</td>
<td>Subject's eye contact is very infrequent</td>
<td>4</td>
</tr>
<tr>
<td>Severe</td>
<td>Subject almost never looks at interviewer</td>
<td>5</td>
</tr>
</tbody>
</table>

**Affective Nonresponsivity**
Failure to smile or laugh when prompted may be tested by smiling or joking in a way which would usually elicit a smile from a normal individual. The examiner may also ask, "Have you forgotten how to smile?" while smiling himself.

<table>
<thead>
<tr>
<th>Degree</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Questionable</td>
<td>decrease</td>
<td>1</td>
</tr>
<tr>
<td>Mild</td>
<td>Slight but definite lack in responsivity</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>Subject occasionally seems to miss the cues to respond</td>
<td>3</td>
</tr>
<tr>
<td>Marked</td>
<td>Subject seems to miss the cues to respond most of the time</td>
<td>4</td>
</tr>
<tr>
<td>Severe</td>
<td>Subject is essentially unresponsive, even on prompting</td>
<td>5</td>
</tr>
</tbody>
</table>
Lack of Vocal Inflections
While speaking the subject fails to show normal vocal emphasis patterns. Speech has a monotonic quality, and important words are not emphasized through changes in pitch or volume. Subject also may fail to change volume with changes of subject so that he does not drop his voice when discussing private topics nor raise it as he discusses things which are exciting or for which louder speech might be appropriate.

Global Rating of Affective Flattening
The global rating should focus on overall severity of affective flattening or blunting. Special emphasis should be given to such core features as unresponsiveness, inappropriateness, and an overall decrease in emotional intensity.

Inappropriate Affect
Affect expressed is inappropriate or incongruous, not simply flat or blunted. Most typically, this manifestation of affective disturbance takes the form of smiling or assuming a silly facial expression while talking about a serious or sad subject. (Occasionally, subjects may smile or laugh when talking about a serious subject which they find uncomfortable or embarrassing. Although their smiling may seem inappropriate, it is due to anxiety and therefore should not be rated as inappropriate affect.) Do not rate affective flattening or blunting as inappropriate. (This item was in the original SANS. However, subsequent analyses have shown that it loads on a disorganized dimension in factor analyses. Consequently, it should not be used as part of the global rating of affective flattening or in the sum of negative symptoms if three dimensions of psychopathology are being examined.)

Not all: Normal vocal inflections 0 5516
Questionable decrease 1
Mild: Slight decrease in vocal inflections 2
Moderate: Interviewer notices several instances of flattened vocal inflections 3
Marked: Obvious decrease in vocal inflections 4
Severe: Subject's speech is a continuous monotone 5

No flattening: Normal affect 0 5517
Questionable affective flattening 1
Mild affective flattening 2
Moderate affective flattening 3
Marked affective flattening 4
Severe affective flattening 5

Not at all: Affect is not inappropriate 0 5518
Questionable 1
Mild: At least one instance of inappropriate smiling or other inappropriate affect 2
Moderate: Subject exhibits two to four instances of inappropriate affect 3
Marked: Subject exhibits five to ten instances of inappropriate affect 4
Severe: Subject's affect is inappropriate most of the time 5
ALOGIA

Alogia is a general term coined to refer to the impoverished thinking and cognition that often occur in subjects with schizophrenia (Greek α = no, none; logos = mind, thought). Subjects with alogia have thinking processes that seem empty, turgid, or slow. Since thinking cannot be observed directly, it is inferred from the subject's speech. The two major manifestations of alogia are nonfluent empty speech (poverty of speech) and fluent empty speech (poverty of content of speech). Blocking and increased latency or response may also reflect alogia.

Poverty of Speech
Restriction in the amount of spontaneous speech, so that replies to questions tend to be brief, concrete, and unelaborated. Unprompted additional information is rarely provided. Replies may be monosyllabic, and some questions may be left unanswered altogether. When confronted with this speech pattern, the interviewer may find himself frequently prompting the subject in order to encourage elaboration of replies. To elicit this finding, the examiner must allow the subject adequate time to answer and to elaborate his answer.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No poverty of speech: A substantial and appropriate number of replies to questions include additional information</td>
<td>5519</td>
</tr>
<tr>
<td>1</td>
<td>Questionable poverty of speech</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Mild: Occasional replies do not include elaborated information even though this is appropriate</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Moderate: Some replies do not include appropriately elaborated information, and some replies are monosyllabic or very brief—(&quot;Yes.&quot; &quot;No.&quot; &quot;Maybe.&quot; &quot;I don't know.&quot; &quot;Last week.&quot;)</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Marked: Answers are rarely more than a sentence or a few words in length</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Severe: Subject says almost nothing and occasionally fails to answer questions</td>
<td>5</td>
</tr>
</tbody>
</table>
Poverty of Content of Speech

Although replies are long enough so that speech is adequate in amount, it conveys little information. Language tends to be vague, often over-abstract or over-concrete, repetitive, and stereotyped. The interviewer may recognize this finding by observing that the subject has spoken at some length but has not given adequate information to answer the question. Alternatively, the subject may provide enough information, but require many words to do so, so that a lengthy reply can be summarized in a sentence or two. Sometimes the interviewer may characterize the speech as "empty philosophizing."

Exclusions: This finding differs from circumstantiality in that the circumstantial subject tends to provide a wealth of detail.

Example: Interviewer: "Why is it, do you think, that people believe in God?" Subject: "Well, first of all because he uh, he is the person that is their personal savior. He walks with me and talks with me. And uh, the understanding that I have, um, a lot of peoples, they don't really, uh, know they own personal self. Because, uh, they ain't, they all, just don't know they personal self. They don't, know that he uh, seemed like to me, a lot of 'em don't understand that he walks and talks with them."

Blocking

Interruption of a train of speech before a thought or idea has been completed. After a period of silence which may last from a few seconds to minutes, the person indicates that she/he cannot recall what he had been saying or meant to say. Blocking should only be judged to be present if a person voluntarily describes losing his thought or if, upon questioning by the interviewer, the person indicates that that was the reason for pausing.

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No blocking</td>
<td>0</td>
</tr>
<tr>
<td>Questionable</td>
<td>1</td>
</tr>
<tr>
<td>Mild: Occasional replies are too vague to be comprehensible or can be markedly condensed</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Frequent replies which are vague or can be markedly condensed to make up at least a quarter of the interview</td>
<td>3</td>
</tr>
<tr>
<td>Marked: At least half of the subject's speech is composed of vague or incomprehensible replies</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Nearly all the speech is vague, incomprehensible, or can be markedly condensed</td>
<td>5</td>
</tr>
</tbody>
</table>
**Increased Latency of Response**

The subject takes a longer time to reply to questions than is usually considered normal. He may seem "distant" and sometimes the examiner may wonder if he has even heard the question. Prompting usually indicates that the subject is aware of the question, but has been having difficulty in formulating his thoughts in order to make an appropriate reply.

- Not at all 0 SS22
- Questionable 1
- Mild: Occasional brief pauses before replying 2
- Moderate: Often pauses several seconds before replying 3
- Marked: Usually pauses at least ten to fifteen seconds before replying 4
- Severe: Long pauses prior to nearly all replies 5

**Global Rating of Alogia**

Since the core features of alogia are poverty of speech and poverty of content of speech, the global rating should place particular emphasis on them.

- No alogia 0 SS23
- Questionable 1
- Mild: Mild but definite impoverishment in thinking 2
- Moderate: Significant evidence for impoverished thinking 3
- Marked: Subject's thinking seems impoverished much of the time 4
- Severe: Subject's thinking seems impoverished nearly all of the time 5

**AVOLITION-APATHY**

Avolition manifests itself as a characteristic lack of energy, drive, and interest. Subjects are unable to mobilize themselves to initiate or persist in completing many different kinds of tasks. Unlike the diminished energy or interest of depression, the avolitional symptom complex in schizophrenia is usually not accompanied by saddened or depressed affect. The avolitional symptom complex often leads to severe social and economic impairment.

**Grooming and Hygiene**

The subject displays less attention to grooming and hygiene than normal. Clothing may appear sloppy, outdated, or soiled. The subject may bathe infrequently and not care for hair, nails, or teeth—leading to such manifestations as greasy or uncombed hair, dirty hands, body odor, or unclean teeth and bad breath. Overall, the appearance is dilapidated and disheveled. In extreme cases, the subject may even have poor toilet habits.

- No evidence of poor grooming and hygiene 0 SS24
- Questionable 1
- Mild: Some slight but definite indication of inattention to appearance, i.e., messy hair or disheveled clothes 2
- Moderate: Appearance is somewhat disheveled, i.e., greasy hair, dirty clothes 3
- Marked: Subject's attempts to keep up grooming or hygiene are minimal 4
- Severe: Subject's clothes, body and environment are dirty and smelly 5

**Impersistence at Work or School**

The subject has had difficulty in seeking or maintaining

- No evidence of impersistence at work 7
employment (or schoolwork) as appropriate for his or her age and sex. If a student, he/she does not do homework and may even fail to attend class. Grades will tend to reflect this. If a college student, there may be a pattern of registering for courses, but having to drop several or all of them before the semester is completed. If of working age, the subject may have found it difficult to work at a job because of inability to persist in completing tasks and apparent irresponsibility. He may go to work irregularly, wander away early, complete them in a disorganized manner. He may simply sit around the house and not seek any employment or seek it only in an infrequent and desultory manner. If a housewife or retired person, the subject may fail to complete chores, such as shopping or cleaning, or complete them in an apparently careless and half-hearted way.

Have you been having any problems at (work, school)?

Do you ever start some project and just never get around to finishing it?

Physical Anergia
The subject tends to be physically inert. He may sit in a chair for hours at a time and not initiate any spontaneous activity. If encouraged to become involved in an activity, he may participate only briefly and then wander away or disengage himself and return to sitting alone. He may spend large amounts of time in some relatively mindless and physically inactive task such as watching TV or playing solitaire. His family may report that he spends most of his time at home "doing nothing except sitting around". Either at home or in an inpatient setting he may spend much of his time sitting in his room.

Are there times when you lie or sit around most of the day?

(Does this ever last longer than one day?)

Global Rating of Avolition - Apathy
The global rating should reflect the overall severity of the avolition symptoms, given expectational norms for the subject’s age and social status or origin. In making the global rating, strong weight may be given to only one or two prominent symptoms if they are particularly striking.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Evidence of Physical Anergia</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Questionable</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mild Anergia</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Moderate: Subject lies in bed or sits immobile at least a quarter of normal waking hours</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Marked: Subject lies in bed or sits immobile at least half of normal waking hours</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Severe: Subject lies in bed or sits immobile for most of the day</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Avolition</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Questionable</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mild, But Definitely Present</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Moderate Avolition</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Marked Avolition</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Severe Avolition</td>
<td></td>
</tr>
</tbody>
</table>
**ANHEDONIA-ASOCIALITY**

This symptom complex encompasses the schizophrenic subject's difficulties in experiencing interest or pleasure. It may express itself as a loss of interest in pleasurable activities, an inability to experience pleasure when participating in activities normally considered pleasurable, or a lack of involvement in social relationships of various kinds.

### Recreational Interests and Activities

<table>
<thead>
<tr>
<th>Description</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Inability to Enjoy Recreational Interests or Activities</td>
<td>0</td>
</tr>
<tr>
<td>Questionable</td>
<td>1</td>
</tr>
<tr>
<td>Mild Inability to Enjoy Recreational Activities</td>
<td>2</td>
</tr>
<tr>
<td>Marked: Subject often is not &quot;up&quot; for recreational activities</td>
<td>3</td>
</tr>
<tr>
<td>Severe: Subject has little interest in and derives no pleasure from recreational activities</td>
<td>5</td>
</tr>
</tbody>
</table>

*Have you felt interested in the things you usually enjoy?*

**(Have they been as fun as usual?)**

### Sexual Interest and Activity

<table>
<thead>
<tr>
<th>Description</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Inability to Enjoy Sexual Activities</td>
<td>0</td>
</tr>
<tr>
<td>Questionable Decrement in Sexual Interest and Activity</td>
<td>1</td>
</tr>
<tr>
<td>Mild Decrement in Sexual Interest and Activity</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Subject occasionally has noticed decreased interests in and/or enjoyment from sexual activities</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Subject has little interest in and/or derives little pleasure from sexual activities</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Subject has no interest in and/or derives no pleasure from sexual activities</td>
<td>5</td>
</tr>
</tbody>
</table>

*Have you noticed any changes in your sex drive?*
Ability to Feel Intimacy and Closeness
The subject may display an inability to form close and intimate relationships of a type appropriate for his age, sex, and family status. In the case of a younger person, this area should be rated in terms of relationships with the opposite sex and with parents and siblings. In the case of an older person who is married, the relationship with spouse and with children should be evaluated, while older unmarried individuals should be judged in terms of relationships with the opposite sex and any family members who live nearby. Subjects may display few or no feelings of affection to available family members. Or they may have arranged their lives so that they are completely isolated from any intimate relationships, living alone and making no effort to initiate contacts with family or members of the opposite sex.

Have you been having any problems with your (family, spouse)?

How would you feel about visiting with your (family, parents, spouse, etc.)?

Relationships with Friends and Peers
Subjects may also be relatively restricted in their relationships with friends and peers of either sex. They may have few or no friends, make little or no effort to develop such relationships, and choose to spend all or most of their time alone.

Have you been spending much time with friends?

Do you enjoy spending time alone, or would you rather have more friends?

Global Rating of Anhedonia-Asociality
The global rating should reflect the overall severity of the anhedonia-asociality complex, taking into account the norms appropriate for the subject's age, sex, and family status.

No Inability to Feel Intimacy and Closeness 0  SS30
Questionable Inability 1
Mild, But Definite Inability to Feel Intimacy and Closeness 2
Moderate: Subject appears to enjoy family or significant others but does not appear to "look forward" to visits 3
Marked: Subject appears neutral toward visits from family or significant others. Brightens only mildly 4
Severe: Subject prefers no contact with or is hostile toward family or significant others 5

No Inability to Form Close Friendships 0  SS21
Questionable Inability to Form Friendships 1
Mild, But Definite Inability to Form Friendships 2
Moderate: Subject able to interact, but sees friends/acquaintances only two to three times per month 3
Marked: Subject has difficulty forming and/or keeping friendships. Sees friends/acquaintances only one to two times per month 4
Severe: Subject has no friends and no interest in developing any social ties 5

No Evidence of Anhedonia-Asociality 0  SS32
Questionable Evidence of Anhedonia-Asociality 1
Mild, But Definite Evidence of Anhedonia-Asociality 2
Moderate Evidence of Anhedonia-Asociality 3
Marked Evidence of Anhedonia-Asociality 4
Severe Evidence of Anhedonia-Asociality 5
ATTENTION

Attention is often poor in schizophrenics. The subject may have trouble focusing his attention, or he may only be able to focus sporadically and erratically. He may ignore attempts to converse with him, wander away while in the middle of an activity or task, or appear to be inattentive when engaged in formal testing or interviewing. He may or may not be aware of his difficulty in focusing his attention.

In some factor analyses, attentional impairment loads on the disorganized dimension, when three dimensions of psychopathology emerge. Consequently, analyses that examine three dimensions may choose to place this item in the disorganized dimension rather than the negative dimension.

**Social Inattentiveness**

While involved in social situations or activities, the subject appears inattentive. He looks away during conversations, does not pick up the topic during a discussion, or appears uninvolved or unengaged. He may abruptly terminate a discussion or a task without any apparent reason. He may seem “spacy” or “out of it”. He may seem to have poor concentration when playing games, reading, or watching TV.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Indication of Inattentiveness</td>
<td>0</td>
<td>SS33</td>
</tr>
<tr>
<td>Questionable Signs</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mild, But Definite Signs of Inattentiveness</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Moderate: Subject occasionally misses what is happening in the environment</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Marked: Subject often misses what is happening in the environment; has trouble with reading comprehension</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Severe: Subject unable to follow conversation, remember what he's read, or follow TV plot</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**Inattentiveness During Mental Status Testing**

The subject may perform poorly on simple tests of intellectual functioning in spite of adequate education and intellectual ability. This should be assessed by having the subject spell “world” backwards and by serial 7’s (at least a tenth grade education) or serial 3’s (at least a sixth grade education) for a series of five subtractions. A perfect score is 10.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Errors</td>
<td>0</td>
<td>SS34</td>
</tr>
<tr>
<td>Questionable: No errors but subject performs in a halting manner or makes/corrects an error</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mild, But Definite (One Error)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Moderate (Two Errors)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Marked (Three Errors)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Severe (More Than Three Errors)</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**Global Rating of Attention**

This rating should assess the subject's overall ability to attend or concentrate, and include both clinical appearance and performance on tasks.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Indications of Inattentiveness</td>
<td>0</td>
<td>SS35</td>
</tr>
<tr>
<td>Questionable</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mild, But Definite Inattentiveness</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Moderate Inattentiveness</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Marked Inattentiveness</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Severe Inattentiveness</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 9: Systematic review from International Journal of Law and Psychiatry

Dignity: The elephant in the room in psychiatric inpatient care? A systematic review and thematic synthesis
Roisin Plunkett a,b,*, Brendan D. Kelly a

ARTICLE INFO
Keywords:
Dignity
Psychiatry
Coercion
Involuntary

ABSTRACT
Involuntary psychiatric inpatient care presents a unique ethical challenge not least because the dignity of a person whose liberty and autonomy are restricted is inherently at risk. Understanding patients’ experience of voluntary and involuntary care is an important part of ensuring that dignity is upheld as a key value. This study aimed to provide the first thematic synthesis of the existing literature on patient experience of dignity in voluntary and involuntary inpatient psychiatric care. PubMed (United States National Library of Medicine), PsycInfo (American Psychological Association), the Cochrane Library and bibliographies of relevant articles were searched for peer-reviewed, English-language studies from the start date of the databases through May 2020. Systematic searches identified 202 original papers. Consensus criteria were used to determine study inclusion through abstract and manuscript review. Eighteen articles were initially identified as suitable and nine met criteria for the final analysis. This study followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Given the high proportion of qualitative literature, a thematic synthesis approach was adopted. Critical Appraisal Skills Program (CASP) checklists were used to assess quality of papers. Familiarization and line-by-line coding were carried out on qualitative studies and a thematic framework developed using an iterative approach. Six key themes emerged: coercion; powerlessness; care environment; relationship to staff; impact of involuntary treatment, and paradoxes. These encompassed 15 subthemes, comprising 111 individual statements. Despite dignity being at the core of this review, only five of the identified papers explicitly referenced the term. Nevertheless, core similarities in patient experiences and perspectives existed across a wide variety of primary studies from multiple sites. These themes can be taken to represent the components of dignified care and used as a framework for further research and service reform.

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1. Introduction
Dignity, the state or quality of being worthy of honor and respect, is a construct which has been debated in philosophy and bioethics for many centuries (Lanigan, 2009). The Latin dignitas is related to both deus (decent, decorous) and yasas, a Sanskrit root denoting fame, honor or glory (Jones, 2010). There is some disagreement among theorists as to the place and usefulness of ‘dignity’ as a concept in bioethics, with some maintaining that dignity is essentially just respect for people and their autonomy (Macklin, 2003; Pinker, 2008). In contrast, others argue that dignity is a distinct and particularly important concept in the case of people whose autonomy is restricted (Huber, Bernath, Allen, & Delaplace, 2015). It can be thought of as a theoretical ‘highest authority’ to refer to when value judgments or difficult questions arise in psychiatric bioethics (Achatz & Knoepffler, 2014).
Dignity is a nuanced, complicated concept which is not easy to define. Chochinov (2008), after ten years of research on terminally ill and dying individuals, concluded that dignity means different things to different people. Unsurprisingly, many approaches
are used to contextualise dignity (Sulmasy, 2013). Subtleties and differences of approach notwithstanding, however, respecting dignity ultimately comes down to respecting peoples’ status, value or honor and treating others well (Michael, 2014).

In healthcare settings, a person’s dignity is at risk in two main ways (Jones, 2015). First, due to illness itself, a person may have diminished control over their body, emotional life or mental faculties. Second, illness and the requirements of healthcare delivery place numerous restrictions on people’s freedom. This is especially true in the case of an involuntarily admitted psychiatric inpatient. The psychiatric hospital environment can not only restrict the behaviors and freedoms by which people typically express their dignity or self-respect, but can also restrict the ways in which respect can be shown to the person by others (Jones, 2015).

Dignity and humane treatment in psychiatric settings is not only a moral claim but also a human right (Gostin, 2001). Patients, however, commonly report that their dignity is not always protected in mental health services (Kogstad, 2009). Patient experience of coercion and restrictive practices in psychiatric settings have been the subjects of systematic review (Chieze, Hurst, Kaiser, & Sentissi, 2019; Hotzy & Jaeger, 2016), but dignity among psychiatric inpatients remains understudied. Although a ‘Patient Dignity Inventory’ (PDI) was developed for palliative care settings (Chochinov et al., 2008) and has been validated in the psychiatric inpatient setting (Di Lorenzo et al., 2017), there is still a paucity of literature on this topic.

Against this background, we aim to provide the first systematic review and thematic synthesis of the literature on patient experience of dignity in voluntary and involuntary inpatient psychiatric care.

2. Methods
2.1. Research question
We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance when performing this systematic review (Moher et al., 2009) and registered the review with the PRISMA database (PROSPERO ID CRD42020154633).

Through discussion, we developed our specific research question: ‘Do patients in involuntary psychiatric inpatient settings experience their care as dignified, compared to voluntary patients?’ This question was developed in line with our objective to specifically interrogate subjective patient experience of dignity and examine the differences – if any – between voluntary and involuntary patient groups. Our research question was developed in the context of separate research being undertaken by the authors regarding perceptions of dignity among voluntary and involuntary psychiatric inpatients, given the long-standing occurrence of involuntary admission and treatment in mental health care. The design of that study will allow direct comparison between the experiences of voluntary and involuntary patients, looking specifically at their perceived level of dignity (among other matters). This systematic review of the literature aimed to determine the extent of existing data on this topic. Given that our aim was to compare voluntary and involuntary patients, papers were excluded if there was no distinction between these two patient groups.

Our research question informed our search by forming the basis of our Population Intervention Comparison Outcome (PICO) search table: the population being psychiatric inpatients, the intervention being involuntary admission and the comparison group being voluntary patients, with perceived level of dignity as the outcome of interest (Table 1).

Relevant search-words were identified from the list of pre-defined vocabulary terms used to index articles, known as Medical Subject Heading or MeSH terms, on PubMed (Table 2). The MeSH terms were adapted as needed to provide best fit with other databases.

To generate our PICO grid, we used an iterative process based on clinical and research experience and knowledge of the academic literature to (a) focus on the population of interest to our research programme and this systematic review (psychiatry inpatients), using terms commonly used in the literature on this topic; (b) identify key terms commonly used to describe the intervention we wished to consider (involuntary psychiatric admission); (c) identify key terms used to describe the comparison group (voluntary psychiatry inpatients); and (d) describe the outcome of interest (dignity).
The terms in italics in Table 1 feature as Medical Subject Headings (MeSH) terms, which facilitate searches.

### Table 1
Population, intervention, comparison, outcome (PICO) grid.

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric inpatients</td>
<td>Involuntary</td>
<td>Voluntary admissions</td>
<td>Dignity</td>
</tr>
<tr>
<td>Inpatient service users</td>
<td>Mental disorder</td>
<td>Voluntary psychiatric</td>
<td>Human dignity</td>
</tr>
<tr>
<td>Inpatients</td>
<td>Involuntary admission</td>
<td>Voluntary psychiatric</td>
<td>Patient dignity</td>
</tr>
<tr>
<td>Admitted patients</td>
<td>Detained</td>
<td>Voluntary service users</td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric Department, Hospital</strong></td>
<td>Coerced treatment</td>
<td>Voluntary psychiatric inpatients</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health service users</strong></td>
<td>Compulsory admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Service inpatients</strong></td>
<td>Involuntary commitment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient unit</td>
<td>Coercion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental institution</strong></td>
<td>Mental Health Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental patients</td>
<td>Compulsory treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Medical Subject Heading (MeSH) terms are italicised.

### 2.2. Eligibility
To be eligible for inclusion, articles we identified in our searches had to (1) comprise novel research; (2) include psychiatric inpatients; (3) examine patients’ subjective experience of psychiatric care, and (4) refer to involuntary patients. Papers were excluded if they (1) studied relatives or carers only; (2) did not reference involuntary patients; (3) comprised a single case-study or case-report, or (4) were not available in English.

### 2.3. Information sources
A systematic search was performed in PubMed (United States National Library of Medicine), PsycInfo (American Psychological Association) and the Cochrane Library. Where relevant, search terms were adapted to fit MeSH criteria for the different databases. Monthly alerts were set up for the search terms after the initial search and monitored for new articles matching inclusion criteria. For non-indexed presentations, researchers hand-searched relevant conference proceedings and websites (e.g. Royal College of Psychiatrists, American Psychiatric Association, College of Psychiatrists of Ireland). In addition, bibliographies of articles included in the review were hand-searched for relevant articles.

### 2.4. Search
Database-specific search protocols were developed, using both free-text and controlled vocabulary or MeSH terms. Searches were completed by using the advanced search function to build a matrix of search terms from the PICO map. The full search protocol for PubMed is included in Table 2.

### 2.5. Study selection
Titles and abstracts were screened for relevance independently by RP and BDK. Articles identified as possibly relevant were read in full and screened for compliance with inclusion criteria.

### 2.6. Data collection
Articles which met criteria for inclusion were read multiple times during the initial process of familiarization. Papers were analyzed for
AND ("psychiatry"[MeSH Terms] OR "psychiatry"[All Fields] OR "psychiatric"[All Fields] AND admission[All Fields])
17 "commitment of mentally ill"[MeSH Terms] OR ("commitment"[All Fields] AND "mentally"[All Fields] AND "ill"[All Fields]) OR "commitment of mentally ill"[All Fields] OR ("involuntary"[All Fields] AND "commitment"[All Fields]) OR "involuntary commitment"[All Fields]
18 involuntary[All Fields] AND ("psychiatry"[MeSH Terms] OR "psychiatry"[All Fields] OR "psychiatric"[All Fields] AND "patients"[MeSH Terms] OR "patients"[All Fields])
19 "coercion"[MeSH Terms] OR "coercion"[All Fields]
20 "mental health"[MeSH Terms] OR ("mental"[All Fields] AND "health"[All Fields]) OR "mental health"[All Fields] AND act[All Fields]
21 involuntary treatment[MeSH Terms] OR ("involuntary"[All Fields] AND "treatment"[All Fields] OR "involuntary treatment"[All Fields] OR ("compulsory"[All Fields] AND "treatment"[All Fields]) OR compulsory treatment[All Fields]
22 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21
23 "patient admission"[MeSH Terms] OR ("patient"[All Fields] AND "admission"[All Fields]) OR ("patient admission"[All Fields] OR ("voluntary"[All Fields] AND "admissions"[All Fields]) OR ("voluntary admissions"[All Fields])
24 23 AND ("psychiatry"[MeSH Terms] OR "psychiatry"[All Fields] OR "psychiatric"[All Fields])
25 voluntary[All Fields] AND ("psychiatry"[MeSH Terms] OR "psychiatry"[All Fields] OR "psychiatric"[All Fields] AND "patients"[MeSH Terms] OR "patients"[All Fields])
26 voluntary[All Fields] AND service[All Fields] OR users[All Fields]
27 voluntary[All Fields] AND ("psychiatry"[MeSH Terms] OR "psychiatry"[All Fields]) OR ("psychiatric"[All Fields] AND ("patients"[MeSH Terms] OR "patients"[All Fields]))
Table 2 (continued)

Search terms
29 23 OR 24 OR 25 OR 26 OR 27 OR 28
30 "respect"[MeSH Terms] OR "respect"[All Fields] OR "dignity"[All Fields]
31 "personhood"[MeSH Terms] OR "personhood"[All Fields] OR ("human"[All Fields] AND "dignity"[All Fields]) OR ("human dignity"[All Fields])
32 [Patent dignity] OR ("patients"[MeSH Terms] OR "patients"[All Fields] OR "patient"[All Fields]) AND ("respect"[MeSH Terms] OR "respect"[All Fields] OR "dignity"[All Fields])
33 30 OR 31 OR 32
36 10 AND 22 AND 29 AND 33

quality using the relevant checklist from the Critical Appraisal Skills Program (CASP). Articles were then coded line-by-line and quotes relevant to the study question - both direct quotations from patients and secondary statements by researchers - were extracted into a Microsoft Excel spreadsheet. These quotes were categorized into themes and subthemes by an inductive process of repeated review and revision. The thematic framework was continually revised as the process of coding and data extraction progressed. Once the framework was established, papers were re-read to confirm a good fit with the overall thematic framework. A co-assessor estimated to what extent the categories were distinct. This co-assessor (BDK) reviewed a random sample of 20 extracted statements and the list of themes and subthemes in random order. When the co-assessor assigned each statement to a theme and subtheme, the inter-rater reliability was 95%.

3. Results
3.1. Study selection
A total of 202 articles were identified across all databases (Fig. 1). Titles and abstracts were screened for relevance and compliance with inclusion criteria. Eighteen articles were selected for further review. Two articles were not available in English and seven did not include an identifiable involuntarily detained patient group (either the status of patients was not reported or only voluntary patients were studied). Nine articles were suitable for inclusion in the final analysis.

3.2. Study characteristics and results of individual studies
The methodologies, results and quality analyses of individual studies are summarized in Table 3. Six of the nine included studies were qualitative in nature. The other three were quantitative or had mixed methodology. The studies were conducted in six different countries across two continents. Sample sizes varied from five to 84 participants.

3.3. Quality analysis and data extraction
Quality analysis was undertaken for each paper. The Critical Appraisal Skills Program (CASP) checklists for qualitative studies provide a structure for interrogating the validity of papers in relation to aims, methodology, appropriateness of design, recruitment, data collection, relationship between researcher and participants, ethical considerations, data analysis and communication of findings. They provide for both categorical and descriptive analysis of papers. Critical appraisal of individual studies was undertaken using this framework and each paper was rated as having high, medium or low compliance with CASP checklist (Table 3). High compliance with the checklist indicates both higher validity and lower risk of bias. Three studies were cohort studies (Aftab et al., 2019; Kjellin, Andersson, Candefjord, Palmstierna, & Wallsten, 1997; Mielau et al., 2017), so the 12-point CASP checklist for cohort studies was applied for quality analysis in these cases. Results
Flow diagram

Records obtained from systematic search of databases 201

Additional records from hand-searching references 1

Titles and abstracts screened 202

Articles excluded 184

Full text articles reviewed 18

Articles excluded 9

Articles included in analysis 9

Fig. 1. Flow diagram.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Methodology</th>
<th>n</th>
<th>Results</th>
<th>Explicit mention of dignity</th>
<th>Overall quality</th>
<th>Limitations and risk of bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Larsen and Terkelset</td>
<td>Qualitative. Ethnographic fieldwork through observation, conversation and formal interviews with inpatients and employees of an inpatient psychiatric unit in Norway over four months. Field notes and quotations examined using phenomenological approach and condensed into themes.</td>
<td>34</td>
<td>Four themes identified: (1) corrections and house rules; (2) coercion is perceived as necessary; (3) significance of material surroundings; and (4) being treated as a human being.</td>
<td>Yes</td>
<td>High</td>
<td>Difficult to assess rigor of data analysis based on process described in paper. Potential for researcher bias given the format of interviews. Translation from Norwegian to English risks choosing words which participants would not have chosen.</td>
</tr>
<tr>
<td>Sibitz et al. (2011)</td>
<td>Qualitative. Modified grounded theory approach, using pragmatism and interactionism. Semi-structured interviews by independent researcher. Patients had experienced involuntary admission in Austria. Transcripts analyzed inductively into a coding frame. Final coding frame applied to all transcripts using QSR International’s NVivo software to extract a typology of patient perspectives.</td>
<td>15</td>
<td>Three perspectives on involuntary admission identified: (1) a necessary emergency brake; (2) an unnecessary overreaction; and (3) a practice in need of improvement</td>
<td>No</td>
<td>High</td>
<td>Potential for selection bias given theoretical sampling. Potential for researcher influence due to semi-structured interview. Small size and recruitment process may risk sampling bias.</td>
</tr>
<tr>
<td>Johansson and Lundman</td>
<td>Qualitative. Narrative interviews of patients who had experienced involuntary psychiatric inpatient care in Sweden. Transcripts analyzed using a phenomenological hermeneutic method, with coding, structural analysis and condensation of meaning units into themes. Independent control of consistency in structural analysis done by second author. Naïve reading, structural analysis and whole interpretation considered in final reflection.</td>
<td>5</td>
<td>Five themes identified, encompassing 18 condensed meaning units: (1) being restricted in autonomy; (2) being violated by intrusion on physical integrity and human value; (3) being outside and not seen or heard; (4) being respected as an individual, and (5) being protected and cared for.</td>
<td>Yes</td>
<td>High</td>
<td>Potential selection bias in view of small sample size. Response rate not clear.</td>
</tr>
<tr>
<td>Schroder et al. (2006)</td>
<td>Qualitative. Semi-structured interviews, based on an interview schedule, of patients who had attended an adult mental health service in Sweden, at the point of their discharge. Interviews were carried out in informants' homes or neutral location within two weeks of discharge. Transcripts analyzed using a four-stage phenomenographic method. Results of the analysis compared with the results of a previous study from the same project (looking at staff and carers).</td>
<td>20</td>
<td>Five descriptive categories identified, encompassing 19 conceptions: (1) the patient’s dignity is respected; (2) the patient’s sense of security with regard to care; (3) the patient’s participation in the care; (4) the patient’s recovery; and (5) the patient’s care environment.</td>
<td>Yes</td>
<td>High</td>
<td>Purposive sampling with potential gender bias; sampled a relatively homogenous group. Predominantly Swedish, middle-aged, university-educated women with depression. Not clear whether patients recruited from multiple services or just one. Potential researcher bias in view of interview technique.</td>
</tr>
<tr>
<td>Chambers et al. (2014)</td>
<td>Qualitative. Semi-structured interviews with involuntarily detained patients, purposively recruited from three hospitals in the southeast of England. Interviews conducted in the inpatient unit, based on an interview schedule. Conducted by three service-user researchers and a clinical psychologist over a six-month period. Transcripts analyzed using an inductive thematic approach.</td>
<td>19</td>
<td>Five themes identified, encompassing 14 subthemes: (1) ‘heard’ by staff members; (2) involvement in decision-making regarding their care; (3) information about their treatment plans (particularly medication); (4) access to more talking therapies and therapeutic engagement; and (5) physical setting/environment and daily activities to alleviate boredom.</td>
<td>Yes</td>
<td>High</td>
<td>Purposive sampling risks selection bias. Predominantly male sample, but ethnically diverse. Interviews conducted in inpatient unit and by multiple researchers contributes to possible observer bias.</td>
</tr>
<tr>
<td>Husum et al. (2019)</td>
<td>Qualitative. Part of a large multi-center study from Oslo, Norway. Semi-structured interviews specific to experience of humiliation conducted with patients who had experienced inpatient and/or outpatient voluntary or involuntary psychiatric care. Specifically recruited patients with experience of humiliation. Transcripts were analyzed using a four-stage phenomenological approach.</td>
<td>13</td>
<td>Three themes identified: (1) different perspectives between staff and users; (2) themes related to violation of service-user autonomy; and (3) experiences related to staff attitudes.</td>
<td>No</td>
<td>Medium</td>
<td>Purposive sampling risks high level of selection bias; also possible gender bias, with predominantly female respondents. Retrospective interviews risk recall bias.</td>
</tr>
<tr>
<td>Reference</td>
<td>Methodology</td>
<td>n</td>
<td>Explicit mention of dignity</td>
<td>Overall quality</td>
<td>Limitations and risk of bias</td>
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<tr>
<td>Mielau et al.</td>
<td>Mixed methodology. Semi-structured interviews conducted with patients with a diagnosis of schizophrenia, bipolar or schizo-affective disorder. Inpatients and/or outpatients. Positive and negative symptoms (PANSS), global function (GAF), manic symptoms (YMRS), insight (SAL, BCIS), admission experience (AES) and experience of coercion (CES) assessed.</td>
<td>79</td>
<td>Yes</td>
<td>Medium</td>
<td>Limited sample by diagnosis which limits transferability. Possible selection bias evident given that majority rated mental health services as allies. Risk of recall bias, misattribution and selective memory with retrospective self-report design. Use of cross-sectional design precludes generalizability.</td>
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<tr>
<td>Aftab et al.</td>
<td>Pilot study conducted in an inpatient and six outpatient psychiatry clinic sites in the United States of America. A voluntary, anonymous self-reported survey was given to patients currently or recently admitted to hospital. Demographic information, overall view of hospitalization experience (using themes from Sibitz et al., 2011) and working alliance score (modified WAS) were obtained. Exploratory analysis and correlation analyses were performed to assess association between demographic and clinical features with working alliance and trust or disclosure.</td>
<td>62</td>
<td>No</td>
<td>Medium</td>
<td>Possibility of recall bias as questionnaires were anonymous self-report. Total response rate was not calculated, but inpatient response rate was just 6% and only 62 valid surveys were collected in total. High working alliance scores likely indicate possible selection bias and other results must be interpreted within that context.</td>
<td></td>
</tr>
<tr>
<td>Kjellin et al.</td>
<td>Cohort study. Compared consecutively admitted involuntary patients and randomly sampled voluntary inpatients in Sweden. Two time points: admission and at discharge or three weeks into inpatient care. Semi-structured interviews by psychiatrists and psychologists measured DSM-IV-R diagnosis, GAF score and change in GAF score. Self-reported change in mental health, patient satisfaction with care and patient perception of respect for autonomy were obtained at discharge or three weeks after admission. Improvements (change in GAF, self-reported change and satisfaction with care) were termed 'ethical benefits' and perceived disrespect or violation of autonomy were grouped as 'ethical costs.'</td>
<td>168</td>
<td>No</td>
<td>High</td>
<td>Systematically sampled population, validated measure used for objective improvement rating (GAF), with high inter-rater reliability (k = 0.96). Risk of recall bias minimized by timing of patient assessment and combination of clinician- and patient-rated measures. 'Ethical benefits' and 'ethical costs' are terms which not widely established in the literature and introduce possible researcher bias.</td>
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</tbody>
</table>

**Table 3 (continued)**

**Abbreviations:** PICO: Population, intervention, comparison, outcome; CASP: Critical Appraisal Skills Program; PANSS: Positive and Negative Symptom Scale; GAF: Global Assessment of Function; YMRS: Young Mania Rating Scale; SAL: Schedule for the Assessment of Insight; BCIS: Beck Cognitive Insight Scale; BCIS-SR: Beck Cognitive Insight Scale-Self Reflection Score; AES: Admission Experience Survey; CES: Coercive Experience Scale; SPSS: Statistical Package for the Social Sciences; DSMIII-R: Diagnostic and Statistical Manual (3rd Edition, Revised); WAS: Working Alliance Scale; SD: Standard deviation. 4 Quality measured by level of compliance with relevant Critical Appraisal Skills Program checklist (CASP).
of quality analyses and summaries of risk of bias for each study are presented in Table 3. Software commonly used in qualitative studies, such as NVivo, was not used because our study examined a relatively small number of papers and it was not required. NVivo and other Computer Assisted Qualitative Data Analysis Software packages (CAQDAS), unlike statistical software packages, chiefly aid in data management (Zamawe, 2015). The size of our sample was such that data management was easily achieved using a simpler spreadsheet system, and manually coding and analysing data allowed for full immersion in the dataset. Closeness to the data can be best achieved by manual data coding and analysis when the dataset is of a manageable size. Over-reliance on CAQDAS can lead researchers to fall into the ‘coding trap’, becoming overly concerned with coding data at the expense of fully understanding it in a meaningful way (Gilbert, 2002). To avoid this, we used a simpler spreadsheet system for analysis to facilitate full immersion in the data.

3.4. Synthesis of results
All studies included in this analysis were coded individually and the theoretical framework was continually revised to incorporate themes and findings from individual studies into a cohesive thematic analysis. Thematic saturation occurred after analysis of five of the papers. In qualitative inquiry, the aim is not to acquire a fixed number of participants or source articles, but rather to gather enough information to satisfactorily describe the phenomenon being studied (Fossey, Harvey, McDermott, & Davidson, 2002). Thematic saturation essentially means the point in data analysis after which nothing new is generated (Green & Thorogood, 2004) or there are no more surprises or newly emergent patterns in the data (Gaskell, 2000). The point at which this happens varies, depending on the issue being studied and the heterogeneity of source material, so there is no accepted standard against which to compare. Qualitative researchers advise against having too prescriptive an approach to analysis, arguing that a ‘checklist approach’ can undermine the contribution that systematic qualitative research can make to health services research (Barbour, 2001).

In our systematic review, quantitative studies were initially analyzed separately and then within the coding framework. Examples of quotes and how they were categorized are available in the Addendum (available from the authors on request). While there were individual statements regarding dignity in five of the papers, these were all secondary statements or interpretations by the authors. There were no direct quotes from patients which mentioned the term ‘dignity’.

<table>
<thead>
<tr>
<th>Core theme</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coercion</td>
<td>Coercion can be an aversive experience Coercion can be seen as necessary by staff and patients Management of coercion influences perception of care Gaining/regaining freedom of movement Timing and proportionality of coercive measures Understanding use of coercive measures</td>
</tr>
<tr>
<td>Powerlessness</td>
<td>‘House rules’ can be frustrating, condescending, limiting Staff views of rules can vary from therapeutic to humiliating Patients perceive a lack of autonomy over care decisions</td>
</tr>
</tbody>
</table>
3.5. Core themes and sub-themes

Six core themes emerged from the analysis (Table 4). Five of these themes were factors that influenced patients’ experience of care: coercion, powerlessness, the care environment, relationships to staff and the lasting impact of involuntary treatment. The sixth theme, paradoxes, reflected how patients often expressed varying and even contradictory views about their treatment. Patients frequently described experience of coercive practices as aversive, but many also perceived that some level of coercion was necessary. Their sense of the proportionality and the timing of the coercive interventions, along with understanding why they were being used, were highlighted as important factors influencing the impact of coercion. Patients greatly valued freedoms such as leave from the ward. A sense of powerlessness - both in terms of day-to-day ‘house rules’ and in relation to influencing treatment decisions - was expressed by many patients in primary studies. Staff views around rules varied, with some believing them to be therapeutic and others seeing them as humiliating to patients. The relationship between staff and patients significantly influenced experience of inpatient care, with patients desiring a personal relationship and to be treated as an ordinary human being. Perceived negative attitudes of staff were often cited by patients as a source of a negative experience of care. The lasting impact of involuntary care, both on patients’ trust in mental health services and on their social circumstances (e.g. visa applications or employment prospects) was highlighted by patients across multiple studies. Paradoxical views (e.g. house rules being both calming and provoking, or locked doors giving rise to both protest and feelings of being cared for) were present in many statements from patients and staff, as well as secondary observations by researchers.

4. Discussion

4.1. Main findings

Our systematic review and thematic synthesis found a dearth of literature specifically examining patient experience of dignity in voluntary and involuntary psychiatric care. The references to dignity that did exist were secondary statements by researchers and authors. In synthesizing results across a wide variety of study types and geographical populations, we found six core themes regarding patient experience of inpatient psychiatric care. Patients identify coercion, powerlessness, the care environment, relationship to staff and the lasting impact of involuntary treatment as important factors. The sixth theme, paradoxes, is found in both patient statements and secondary statements from researchers and encompasses a wide range of seemingly contradictory statements, experiences and views. Within involuntary treatment settings, coercion and a certain amount of powerlessness might be inevitable. Even so, it is reported that many patients later view involuntary admission as necessary.
(O’Donoghue et al., 2010), a fact that is reflected in the findings of this review also (Table 4: ‘coercion can be seen as necessary by staff and patients’). Perhaps unsurprisingly, patients frequently mention that management of coercion significantly influences their experience of it (Husum, Legernes, & Pedersen, 2019). In our study, subthemes of ‘gaining or regaining freedom of movement’, ‘timimg and proportionality of coercive measures’ and ‘understanding use of coercive measures’ emerge as impacting on patient experience of coercion.

In the broader literature, dignity is described as having both ‘self-regarding’ and ‘other-regarding’ components (Gallagher, 2004), also known as ‘intrinsic’ and ‘extrinsic’ dignity (Spiegelberg, 1971). That is to say that both how one views oneself and how others treat one impact on one’s overall experience of dignity. Consistent with this, the timing, duration, proportionality and understandability of coercive measures are noted by patients as important in shaping their overall experience of coercion (Johansson & Lundman, 2002; Sibitz et al., 2011).

We propose that a careful approach to the timing, duration, proportionality and patient’s understanding of coercive measures can allow staff to promote the dignity of patients undergoing coercive care. The sense of powerlessness experienced by patients can be seen as a threat to their subjective dignity, as dignity violations are more likely when the subject is in a position of vulnerability (Jacobson, 2009). In our review, it was notable that staff, as well as patients, described ambivalence regarding ‘house rules’ in psychiatric inpatient settings. Some regarded them as humiliating or condescending, acknowledging the unequal power relationship between staff and patients (Husum et al., 2019).

Staff members also acknowledged that restrictive ‘house rules’ reinforced the relative powerlessness of patients; some staff saw this as positive, in that it delineated boundaries, while others saw it as humiliating to patients (Larsen & Terkelsen, 2014). In her taxonomy of dignity, Jacobson (2009) writes that asymmetry of relationship and harshness of circumstances increase the risk of violation of dignity, and that humane environments promote dignity. Our finding that care environments influence patient experiences concurs with this.

‘Relationship to staff’ unsurprisingly emerged as an important overall theme, with a number of related subthemes. Patients described a desire to be treated as ordinary human beings and also desired contact and conversation. Haddock (1996) describes dignity as the ability to feel important and valuable in relation to others, communicate this to others, and be treated as such by others, in contexts which are perceived as threatening. She explains that dignity is a dynamic subjective belief with shared meaning among humanity. Dignity is expressed in relationship with other people, and our review emphasises that psychiatric inpatients’ experience is heavily influenced by interactions with the staff around them (Schroder, Ahlström, & Larsson, 2006).

The lasting impact of admission, both on patients’ trust in the health services and on their social and family life, also emerges as a theme (Chambers et al., 2014). Recognising that patients may be subject to stigma or discrimination, or internalised self-stigma following an admission is not new. Acknowledging and further investigating the impact this has on their self-regarding dignity, as well as their other-regarding dignity, however, remains relatively unexplored.

4.2. Strengths and limitations of this study

Our study has a number of strengths including a systematic search strategy and our adherence to PRISMA guidelines in
order to provide the first systematic review of the topic of dignity in inpatient psychiatric care. The quality analysis of individual studies demonstrated a generally high level of quality among the included studies, allowing robust conclusions to be drawn. The findings of the quantitative studies were in line with those of the qualitative studies and fit closely within the coding framework despite the differing methodology. The inductive approach to thematic synthesis led to development of an in-depth understanding of the existing literature and comprehensive presentation of a large quantity of individual data points. Overall, there was a great deal of agreement between papers on the components of care that impact on patient experience. A further strength of our study was our inter-rater verification of the appropriateness of the categorization of statements into the identified themes, with an inter-rater reliability of 95%.

Our study is not without limitations. The heterogeneity and predominantly qualitative nature of the source material meant that it was not possible to do mathematical or statistical comparison between individual studies or pooled quantitative analysis of results. Secondary analysis and synthesis were therefore done in a qualitative fashion, with risk of observer bias. Qualitative literature can be inherently subjective and interpretive. As a result, the primary studies included in this thematic synthesis, as well as this paper itself, are necessarily influenced by the perspectives of researchers who performed the original studies, and results must be interpreted in this context. The fact that the word ‘dignity’ did not appear in a number of the papers (e.g. Husum et al., 2019) reflects the fact that indexing and search terms are not always included within the body of a paper’s text, even if the paper is thematically related to dignity. Papers which were identified in our systematic search and met the inclusion criteria (namely that they comprised novel research; included psychiatric inpatients; examined patients’ subjective experience of psychiatric care, and referred to involuntary patients) were eligible for inclusion in the analysis, regardless of whether or not they mentioned the word dignity in the text of the paper.

Our research aim was to investigate differences, if any, between involuntary and voluntary psychiatric inpatients’ experience of dignity. We specifically designed our search strategy to target this question. Our search strategy included ‘dignity’, ‘human dignity’ and ‘patient dignity’ only, as outcomes of interest. Interestingly, neither the work of Svindseth, Nøttestad, and Dahl (2013) on humiliation nor the MacArthur study (Gardner et al., 1993) were found as a result of the search protocol used. On closer examination, we note that ‘dignity’ is not included in the keywords on either of those papers, explaining their absence in our review. Certainly both are very interesting studies which go some distance towards illuminating experiences of psychiatric care. They were not, however, part of the dataset which this search identified. We appreciate that this is a potential limitation of our study. However, we also consider that the omission of ‘dignity’ as a key concept in so many studies reflects one of the findings of our review – namely, that dignity is often overlooked in the psychiatric literature.

At an early stage in conceptualisation of this study, we had considered a broader remit, examining other concepts related to dignity such as respect and coercion. However, given that we were specifically interested in the construct of dignity, we decided prior to the search to limit ourselves to this term only in order to enhance specificity of the review. Unfortunately, we found that there was a paucity of literature on dignity, and what literature did exist failed to directly
investigate any comparison or contrast between voluntary and involuntary patient groups. Even where the paper focused on comparing voluntary and involuntary patients (e.g. Kjellin et al., 1997), there was no specific comparison of patients’ experience in relation to dignity. In some cases, even the patients themselves did not distinguish their experiences based on legal status (e.g. Schroder & Ahlstrom, 2004). As a result, it was not possible, through either synthesis of results from primary papers or thematic analysis of the overall body of literature, for us to draw robust conclusions about the experiences of voluntary versus involuntary patients in relation to dignity. In our opinion, this is a distinct gap in the current literature which has been highlighted by this review. We hope that our upcoming study of dignity in psychiatric care will provide information about the differences in experience of dignity between voluntary and involuntary patient groups. The paucity of references to ‘dignity’ in the literature to date, however, mean that it was not possible for us to specifically analyze patient experiences of dignity in this systematic review, so we draw limited inferences from papers’ other statements regarding experiences of admission and treatment. It is nonetheless interesting that in systematically reviewing the literature on patients’ experience of involuntary inpatient psychiatric care, we found that patient statements about dignity were conspicuously absent. It is not possible to be definitive about whether this is an artefact of the studies or whether patients themselves did not consider the concept of dignity as significant. However, given that most of the qualitative papers considered here used semi-structured interviews with broad questions aimed to elicit patients’ views without unduly influencing them, it is likely that the patients themselves said little if anything about dignity in care. Dignified treatment is emphasized in palliative care (Kennedy, 2016) and care of the elderly (Kinnear, Williams, & Victor, 2014; Williams, Kinnear, & Victor, 2016), but often remains an unmentioned ‘elephant in the room’ in inpatient psychiatric care. Finally, in our results, we distinguish themes and subthemes based on content rather than source, which means that in some instances there is a mixture of statements from patients, staff and even researchers within a single subtheme. We appreciate that this can be confusing, but we determined that it was not a good fit for the data to be divided into staff views and patient views, as there is considerable overlap between them.

5. Conclusions
Across a broad range of studies, covering a wide geographical area, there is a consistent pattern in patient-reported factors influencing the experience of voluntary and involuntary inpatient psychiatric care. Six main themes emerge from the literature: coercion, powerlessness, care environment, relationships to staff, long term impact of involuntary treatment and paradoxes. These six themes and the multiple subthemes identified in this systematic review represent a comprehensive framework of dignity-related factors that influence the patient experience of inpatient psychiatric care. There is a noticeable lack of focus on ‘dignity’ itself in the existing literature, so this represents an important area for future study.

Funding
None.

Declaration of Competing Interest
None.
Acknowledgements

The authors are most grateful to the editor and reviewers for their comments and suggestions.

References


Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijlp.2021.101672.
Appendix 10: Examples of phenomenographic analysis of statements

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>Quote (quotes from informants in double quotation marks, secondary researcher observations in single quotation marks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Coercion</td>
<td>Coercion can be an aversive experience</td>
<td>'Violation of personal integrity is a terrible experience and can arouse feelings of not being treated as a human being.'</td>
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<td></td>
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<td>&quot;Being restrained was the most horrible experience I had in my life... that is horrible&quot;</td>
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<td>&quot;The scariest time was the first time, I was just petrified&quot;</td>
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<td></td>
<td>Coercion can be seen as necessary by staff and patients</td>
<td>'Some patients found this kind of coercion necessary and almost everyone among the staff was likely to agree about coercion as a necessity for the patients.'</td>
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<td></td>
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<td>&quot;The conclusion is that I needed the coercion I was exposed to... It was necessary, it was. But it wasn’t good&quot; (patient)</td>
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<td></td>
<td>&quot;It was the only possibility to bring me back to normality&quot;</td>
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<td></td>
<td>&quot;And then that you maybe for your own safety and the safety of others have to be locked in on the ward [...] it is done for my own good&quot;</td>
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<tr>
<td>1b Management of coercion influences perception of care</td>
<td>Importance of retaining or gaining freedom to leave</td>
<td>'Permission to visit home offers further freedom... This is experienced as an opportunity and is very highly valued'</td>
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<td></td>
<td>Importance of timing/proportionality of coercive measures</td>
<td>&quot;I could go out on the grounds. I knew that they could trust me and I could trust them&quot;</td>
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<td>&quot;Having to ask permission to go get some air, having to wait for hours because there aren't enough staff [...] I found it to be degrading&quot;</td>
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<td></td>
<td>Importance of understanding use of coercion</td>
<td>&quot;We need rules but flexibility is important&quot;</td>
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<tr>
<td></td>
<td></td>
<td>'Dignity can be promoted or diminished. Alternatives to coercive practices may help service users feel, think and behave in relation to their worth and value'</td>
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<td></td>
<td>'Lack of information about what was to happen next, and [...] rationale for treatment [...] contributed to increased anxiety and sometimes a worsening of psychotic experiences'</td>
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<td></td>
<td>&quot;If it’s possible to understand their use of coercion, it’s acceptable&quot;</td>
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<td>&quot;I got no information about the injection [...] then they could have saved themselves the trouble of the injection because that way it would have been possible to talk to me&quot;</td>
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<td>&quot;You feel ever so small and vulnerable [...] don’t think the staff are aware of what power they’ve got&quot;</td>
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<td></td>
<td>&quot;You felt like a naughty child, you know? It’s sort of in your mind that you’ve got to watch your Ps and Qs&quot;</td>
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<td>&quot;I suddenly felt subjected to the raising of a child&quot;</td>
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<tr>
<td>2. Powerlessness</td>
<td>Patients see rules as frustrating, condescending, limiting</td>
<td>The field notes show that patients and staff were concerned about corrections and house rules. Some found them humiliating and hard to understand.</td>
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<tr>
<td></td>
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<td>&quot;Many rules and regulations. Like for example with permission [to visit home]. That a doctor is needed to approve&quot;</td>
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<tr>
<td></td>
<td></td>
<td>&quot;You feel ever so small and vulnerable [...] don’t think the staff are aware of what power they’ve got&quot;</td>
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<td></td>
<td>&quot;You felt like a naughty child, you know? It’s sort of in your mind that you’ve got to watch your Ps and Qs&quot;</td>
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<td></td>
<td>Staff have divergent views on rules/restrictions</td>
<td>&quot;William (staff) felt that the patient’s dignity was violated&quot; [by house rules]</td>
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<td>&quot;We shouldn’t humiliate people by correcting them all the time...we should ask ourselves how our mothers would like to be treated&quot; (staff)</td>
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<td>&quot;Gary said it was necessary to correct more. To him, house rules were vital and patients ought to learn about them on arrival&quot;</td>
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<td></td>
<td>Perceived lack of autonomy regarding care decisions</td>
<td>Experiences of care without information or participation, receiving a treatment you do not understand, of being ignored and of wishes of consideration and involvement'</td>
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<td></td>
<td></td>
<td>&quot;The consciousness that there is lack of control, that you cannot control anything, that you cannot control yourself, you cannot decide yourself&quot;</td>
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<td>&quot;When you ask for something to change, like medication, nothing changes until they’re ready to change you&quot;</td>
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<td>&quot;I felt like a chemical guinea pig [...] They started on top of the (medication) list and worked down&quot;</td>
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<td></td>
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<td>&quot;If I had refused the would’ve forced me anyway&quot;</td>
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<td></td>
<td>&quot;If there’s going to be a care plan you’ve got to be able to have a say in it&quot;</td>
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<tr>
<td>3. Care environment influences patient experience</td>
<td></td>
<td>'The significance of the material surroundings'</td>
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</tbody>
</table>
4. Perceived attitudes of staff impacts significantly

<table>
<thead>
<tr>
<th>Personal relationship between staff and patient is positive</th>
<th>“If you’re going to get well you need to be somewhere where there's peace and quiet”</th>
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<tr>
<td></td>
<td>“Space I think is really important; everyone requires their own space, even down to their dormitories”</td>
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<td></td>
<td>“There are experiences of being well cared for and having received personal attention and service”</td>
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<td>“It’s important to know something about the person, things that interest them, and then you can use this while talking to them.” (staff)</td>
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<td>“The staff need to have a passionate interest in people, need to be humane and to like people”</td>
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<td></td>
<td>“Building and establishing effective and trusting relationships with services users promotes and supports recovery”</td>
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<tr>
<td>Perceived staff attitudes can contribute to negative experience</td>
<td>“He was so [...] rude, he flared up and ‘Well now you will be admitted to involuntary care’ and that was all”</td>
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<td></td>
<td>“Basically we’re supposed to be mad and they’re supposed to be perfect”</td>
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<td>“The people who come in to psychiatric care are not taken seriously, it’s just that simple. The staff often have a condescending view of people”</td>
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<td>Patients desire contact and conversation</td>
<td>“I felt so extremely bad and I wanted someone to talk to [...] he could at least sit by my side. Or talk to me about anything then... I don’t expect him to work miracles but just being there”</td>
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<td></td>
<td>“If someone would have talked to me, half an hour, all that acute [physical restraint, forced drugs] would not have happened”</td>
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<td>“You want an open dialogue where staff understand your problem, understand how you feel and keep the conversation going forward”</td>
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<td>Patients desire treatment as ‘an ordinary human being’</td>
<td>“No one was explaining to me what was happening [...] it was just given to me, nobody did sit and discuss it with me”</td>
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<td>“They can put us not as a human being but as a series of quirky behaviours which they can sort of diagnose”</td>
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</table>

5. Impact of involuntary treatment

<table>
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<tr>
<th>Impact on trust of/engagement with Mental Health Service</th>
<th>“I often thought this can’t be true, I can’t do anything, I can’t go anywhere, can’t show any kid of personality, the first thing that happens is that I have to go to a psychiatric clinic”</th>
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<td></td>
<td>“For sure I became more cautious related to doctors and nurses”</td>
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<td></td>
<td>“Between 21% and 36% reported they were less likely to disclose symptoms or problems to care providers following admission.”</td>
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6. Paradoxes

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<th>Impact on social/family relationships</th>
<th>“I kept quiet about it because most people can’t deal with it, they actually don’t understand it”</th>
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<tr>
<td>Rules as calming, rules as provoking</td>
<td>“The involuntary care is experienced as something that the patient has no part in, where no one cares or explains what is happening. On the other hand, there are feelings of being respected and cared for by the personnel”</td>
</tr>
</tbody>
</table>
Appendix 11: Research and Ethics Committee approval letters

Royal College of Surgeons in Ireland
The Research Ethics Committee
121 St. Stephens Green, Dublin 2, Ireland.
Tel: +353 1 4022205 Email: recaadmin@rcsi.ie

Dr David Smith, Acting Chair
Dr Sinead Healy, Convener

24th August 2017

Dr. Roisin Plunkett
Department of Psychiatry
RCSI Academic Building
Connolly Hospital
Blanchardstown

<table>
<thead>
<tr>
<th>Ethics Reference No:</th>
<th>REC1448 (Accepted approval from SJH/AMNCH)</th>
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<tbody>
<tr>
<td>Project Title:</td>
<td>Dignity, Coercion and Involuntary Care: A Study of Involuntary and Voluntary Psychiatry Inpatients in Dublin</td>
</tr>
<tr>
<td>Researchers Name (PI):</td>
<td>Professor Brendan Kelly</td>
</tr>
<tr>
<td>Researchers Name (lead applicant):</td>
<td>Roisin Plunkett</td>
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</tbody>
</table>

Dear Dr Plunkett,
Thank you for your Research Ethics Committee (REC) application. The RCSI HREC accepts the ethical approval granted by Tallaght Hospital (SJH/AMNCH) for the research study (details above) submitted by Dr. Plunkett.

This letter provides approval for data collection for the time requested in your application and for an additional 6 months. This is to allow for any unexpected delays in proceeding with data collection. Therefore this research ethics approval will expire on 01/10/2019.

Where data collection is necessary beyond this point, approval for an extension must be sought from the Research Ethics Committee.

This ethical approval is given on the understanding that:

- All personnel listed in the approved application have read, understand and are thoroughly familiar with all aspects of the study.
- Any significant change which occurs in connection with this study and/or which may alter its ethical consideration must be reported immediately to the REC, and an ethical amendment submitted where appropriate.
- A final report will be submitted to the REC upon completion of the project.

We wish you all the best with your research.

Yours sincerely,

Sinead Healy
PP Dr Sinead Healy (Convener)
Dr David Smith (Acting Chair)
Dr. Shane Rooney  
Psychiatry Registrar  
Tallaght Hospital  
Tallaght  
Dublin 24  

16 August 2017  

Re: Dignity, Coercion and Involuntary Care: A Study of Involuntary and Voluntary Psychiatry Inpatients in Dublin  

REC Reference: 2017 – 08 List 31 (2)  
(Please quote reference on all correspondence)  

Dear Dr. Rooney,  

Thank you for your correspondence in which you sent in a response to the Committee’s letter which detailed the Committee’s queries and concerns in relation to the submission of the above referenced research study.  

The Chairman has reviewed your responses on behalf of the Committee, is happy all issues are dealt with satisfactorily and on that basis, gives full ethical approval for the study to proceed.  

Yours sincerely,  

Claire Hartin  
Secretary  
SJH/AMNCH Research Ethics Committee  

The SJH/AMNCH Joint Research and Ethics Committee operates in compliance with and is constituted in accordance with the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004 & ICH GCP guidelines.