International Journal of Law and Psychiatry 62 (2019) 148–153

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage: www.elsevier.com/locate/ijlawpsy

"A plea for recognition" Users' experience of humiliation during mental health care

Tonje Lossius Husum[a,*], Elisa Legernes[b], Reidar Pedersen[a]

[a] Centre for Medical Ethics, University of Oslo, Norway
[b] Department of Psychology, University of Oslo, Norway

ARTICLE INFO

Keywords:
Mental Health
Humiliation
User experience
Qualitative research

ABSTRACT

Background: Studies reveal that users of mental health care services sometimes experience humiliation during care. These experiences may influence the users' recovery process and treatment satisfaction.
Method: Thirteen informants with experience in mental health services were recruited for semi-structured interviews. Informants were recruited through collaboration with users' organisations. Modified text condensation was used for analysis of the qualitative data.
Results: Users' experiences with humiliation in mental health care were sorted into three main themes. These are themes related to different perspectives between staff and users; themes related to violence of user autonomy; and experiences related to staff attitudes.
Discussion: The service users in this study spoke about many different kinds of experiences with humiliation during care. It was a main finding that the feeling of not being recognized for one's own perception of the situation was experienced as a humiliation. This study is a contribution to a better understanding of the humiliation process between staff and users in mental health care services. The findings may be used to improve interaction between staff and users, improve quality of care and to prevent such experiences.

1. Background

User experiences of negative experiences such as humiliation in mental health care (MHC) are ubiquitous in popular media, literature and research (Gilburt, Rose, & Slade, 2008; Van den Hooff & Goossensen, 2014). This paper presents a qualitative study on users' experiences of humiliation in Norwegian MHC services. As a group, people with psychological functional disabilities are vulnerable, and the experience of humiliation has been implicated in pathogenesis of numerous psychosocial difficulties, including depression, anxiety and low self-esteem (Kendler, Hettema, Butera, Gardner, & Prescott, 2003). The experience of humiliation is also set forth as one of the main sources of aggression and violence (Hartling, Lindner, Spalthoff, & Britton, 2013; Haugvaldstad & Husum, 2016). While social scientists such as Linda Hartling (2007) and Evelin G. Lindner (2006) have suggested that humiliation is a pervasive experience in our society, it has remained almost unexamined by empirical research. The experience of humiliation is claimed to be one the most common and dangerous emotional experiences in society and is an element in most incidents containing aggression, from domestic violence to terrorism and war (Hartling, 2007; Lindner, 2017). The emotional experience of feeling humiliated is described as a strong and intensely aversive and negative emotion (Otten & Jonas, 2013). A definition of the construct of humiliation is:

> The internal experience of humiliation is the deep dysphoric feeling associated with being, or perceiving oneself as being, unjustly degraded, ridiculed, or put down- in particular, one's identity has been demeaned or devalued (Hartling & Luchetta, 1999).

The presented definition of the experience of humiliation highlights that the experience is an internal and subjective one. What one person may experience as humiliation is individual and varies between individuals. A person may have felt humiliated even if the other person's intentions were good. Staff and users possess different perspectives, which may lead to different perceptions of situations (Norvoll & Husum, 2011). Despite this, perhaps some common factors are involved.

"Shame" is an adjoining concept, but is considered to refer to a more internal experience, while "humiliation" is more interactional and relational. Experiences of humiliation occur in interactions with other people. Although shame and humiliation have common certain characteristics, shame and humiliation involve quite different dynamics and can be dealt with differently both on an individual and a collective

* Corresponding author.
E-mail address: t.l.husum@medisin.uio.no (T.L. Husum).

https://doi.org/10.1016/j.ijlp.2018.11.004
Received 13 May 2018; Received in revised form 12 November 2018; Accepted 12 November 2018
Available online 26 December 2018

level. A key difference is that "humiliation involves being put into a lowly, debased, and powerless position by someone who has, at that moment, greater power than oneself", whereas "shame involves primarily a reflection upon the self by the self" (Miller, 1988). Shame may be said to be a more private feeling, while humiliation is more public experience. The term "humiliation" is chosen for this study because it investigates users' experiences in relation to staff during mental health care. The experience of humiliation is relational. Typically, humiliation occurs within relationships of unequal power where the humiliator has power over the victim (Klein, 1991). Due to the inherent power incongruence between users and personnel in mental health care treatment settings, experiences of humiliation may occur. Other risk factors for experiences of humiliation may be inadequate inspection and control of the quality of services, weak management, insufficient guidance and supervision, inattention to ethics, under-educated staff, lack of observation of human rights and weak culture of user participation.

There are few studies about users' experiences of humiliation in mental health services specifically. The studies that were found provide, however, disturbing findings. Frueh et al. (2005) examined persons who had been admitted to day hospital programs in the US and their perceptions of traumatic and harmful incidents during treatment in mental institutions. The findings show that a high rate of the respondents perceived potentially traumatic incidents during their admission. Furthermore, many of the respondents described experiences of physical violence and sexual humiliation and violation. The study concludes that humiliating, traumatic and potentially harmful incidents within the psychiatric setting occur, and that research efforts and clinical work need to devote more attention to these issues. A comprehensive Norwegian national survey of 1831 users' experiences showed that around one-third of the users admitted to mental health care had experienced humiliation during hospitalization (Bjerkan, Pedersen, & Lilleeng, 2009). Around 10% of the users had felt personally humiliated, and 130 users stated that they were personally humiliated to an utmost degree during hospitalization. Furthermore, Svindseth, Dahl, and Hatling (2007) found that half of the users in their sample had felt humiliated in connection with negative events during the admission process. The Norwegian Knowledge Centre for the Health Services has performed a national inquiry of user experiences. As much as 30% of the users of MHC services in Norway answered that they had experienced being treated with too little respect or had been humiliated during treatment (Skudal et al., 2017). Nyttingnes, Ruud, and Rugkåsa (2016) also found, in their analysis of users' experiences of use of coercion in MHC, that some users had very strong experiences and perceptions of humiliation in relation to use of coercion in MHC.

In sum, previous studies have shown that the experience of coercion is not a good measure of users' perceptions of humiliation, and researchers have pointed to the need for research on the users' perception of what is perceived to be humiliation in a wide sense, without the perceptions being linked to coercive measures (Eriksson & Westrin, 1995; Frueh et al., 2005; Hoge et al., 1997; Svindseth, 2010; Westrin & Nilstun, 2000). As shown, some users of mental health care have felt humiliated during care. It does not, however, elaborate further on what kind of experiences can be experienced as humiliating, which is the main scope of the present study.

1.1. Aim of the study

The aim of the study was to explore users' experiences of humiliation in mental health care. The knowledge may be used to prevent such experiences and it could also be transferred to other health care settings.

2. Method

2.1. Design & organisation of the study

This study is part of a comprehensive multi-centre study located at the Centre of Medical Ethics at the University of Oslo, which investigated different aspects of ethics, mental health and use of coercion in mental health care services. The part of the study presented consists of qualitative data and individual semi-structured interviews of 13 informants with user experience of mental health care services. Two researchers and two master's students in psychology were involved in performing the study. The intention of the study is to explore a new issue for research, and it has an exploratory design.

2.2. Sample

The population was people with user experiences of MHC who had had explicitly negative experiences from mental health care. The 13 informants were recruited through collaborating with three Norwegian user organisations. The organisations advertised for the study on their home-pages, through Facebook and newsletters to their members. The invitation to participate in the study explicitly asked for users who had experienced various forms of humiliation during treatment in mental health care. The users were encouraged to contact the researcher by phone or e-mail. Altogether, 14 users responded and wanted to participate in interviews. Interviews were performed during 2014. One informant withdrew the informed consent after the interview was performed, and the interview were taken out of the study. The main author and two master's students in psychology conducted the interviews. The sample consisted of 12 women and one man, with the age ranging from 30 to 60 years. All had extensive experience of receiving mental health care. Ten of the users had experience of voluntary and involuntary admissions in MHC institutions, and three had experience of out-patient services. Altogether, the sample of users is considered to have various experience of MHC services. The users were members of or had contact with a user organisation. Information about the users in the sample are kept to a minimum so as not to compromise the users' anonymity. Information about the informants' mental health challenges or what diagnosis they had received was not collected.

2.3. Interviews

The interviews were mostly conducted at the main researchers' workplace at the University of Oslo. One interview was performed by telephone, but this interview was later withdrawn by the informant. The interviews were conducted by the main researcher or the master's students, or by the researcher while the master's students were observing. The interviews took about 1–1.5 h each. As part of the study design, there was a reference group with a user-participant. The reference group gave feedback and was involved in the process of making the interview guide. The interview guide had two main questions:

- Have you experienced humiliation during treatment in mental health care?
- What was it about the experience that you felt to be humiliation?

The interview guide included more questions, but these are the questions which are presented in the present paper. The scope of this study is to explore users' negative perceptions of humiliation during MHC.

2.4. Ethics

The informants received written and verbal information about the study and gave written consent. One informant withdrew consent after the interview was conducted, and the interview was deleted. In order to

not compromise the informants' anonymity, information about them is kept to a minimum. The informants were encouraged to contact the main researcher in case of distress after the interviews. None of the informants made contact because of distress. The only person who made contact was the person who withdrew the consent after the interview was conducted. Since the informants were recruited outside the health services, the Norwegian ethical board for medical research (REK) did not consider this study notifiable to them. The Norwegian National Data directorate approved the study and it got the receipt number: 27.08.2014, Ref.: 39196 / 3 / AMS.

2.5. Analysis

Interviews were recorded and transcribed. The transcribed interviews were analysed according to the principles of Giorgi's method for phenomenology: modified text condensation (Malterud, 2001; Malterud, 2011). The process consists of four phases: 1) read through the whole manuscript; 2) look for main themes; 3) look for sub-themes and meaningful elements; and 4) look for bigger categories and interpret findings. The data analysis was performed by creating categories and subcategories based on informant data in the transcript, and then testing the chosen themes by applying the created coding scheme in a 'top-down' manner, modifying the categories when necessary through an iterative process. Three people (two researchers and a master-student) have been included in the process of analysing the data to improve interpretation of findings and interrater reliability. Some quotations will be presented as examples of statements. Some quotes involve elements from more than one theme, but are chosen to be placed under one of the three headings.

3. Results

After analysis, the informants' descriptions of experiences of humiliation were categorized into three themes and presented under the headings:

1. Different perspectives between staff and users
2. Themes related to violence of user autonomy
3. Experiences related to staff attitudes

The three themes are considered to represent such different branches of experience as to be presented as different themes. The first theme (different perspectives) involves users' experiences of not being understood or recognized and that the staff holds different views about the situation than they do. The second theme (autonomy) includes experiences of being overruled and not respected. The third theme (staff attitudes) involves experiences of the staff behaving in an unprofessional way and showing bad behaviour towards the informant. The chosen themes are what seemed most plausible after thorough consideration.

3.1. Different perspectives between staff & users

The first theme chosen was different aspects of different perspectives between users and staff. This included humiliating experiences which occurred because the professionals and users had different perspectives of and expectations to the situation or disagreed about the content of the treatment. Eight of the informants expressed that their own perspectives on the reasons for their psychological suffering were different from the staff's views. As a consequence of this, there had been disagreement and different expectations between the staff/therapist and the informants about what the content of the therapeutic conversations should be. For instance, the therapist wanted to talk about the present, while the user wanted to talk about the past. This could, for example, be about experiences of trauma and of their childhood. A reoccurring theme amongst the informants was the feeling of suffering from the aftermath of trauma, but they perceived that the staff/therapist did not acknowledge this. As a consequence, they perceived that the staff/therapist dismissed their experiences of sexual abuse or incest. They said they felt suspected and mistrusted when they talked about their own experience of suffering from trauma, attachment-trauma, relational-trauma or early attachment disorders. This was described as a painful and humiliating experience, and some even described it as re-traumatizing. In the following quotation, the user did not feel that her story about being victimized by incest was recognized by the staff.

> The problem was, that what you had been through, was incest. They did not deal with that. This would feel problematic for anyone.

Because of this, several informants mentioned that they wished health care services had more knowledge about, and treatments aimed at, reactions after trauma (PTSD). Disagreement about the content of the treatment was also described by one person who said she had not been helped with what she felt she needed help with. In this case, she needed help with basic, practical needs such as finances, housing and work.

> 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. People may not have an apartment, they have lost their job, they need to get on the right track and be given social assistance. They are blind to the social bit.

Twelve of the thirteen informants had experienced that the staff had the power to define the interpretation of the situation, and they perceived the staff as unwilling to listen and to explore their perspective. Furthermore, they said that they felt pressured to take on the staff's interpretation of the situation, and that they were not allowed to keep their own thoughts and opinions.

Another example of different perspectives between users and the staff is related to the informant's diagnosis. It was a common theme amongst the informants that they felt humiliated because of the diagnosis they were given. It was not necessarily receiving a diagnosis in itself that was perceived as humiliating, but receiving a diagnosis that did not fit into their own understanding of their psychological suffering. As a consequence of perceiving their own diagnosis as incorrect, many felt that they were mistreated and wrongfully medicated. Several of the informants expressed that the way the diagnosis was given was experienced as humiliating. For instance, the diagnosis may have been given haphazardly, in an insensitive and un-empathic way. Several of the informants also mentioned that it felt especially humiliating that they were being informed of their diagnosis through reading their medical records, treatment plans and epicrises.

Several informants said that they first became aware of their diagnosis when they read their medical record. Reading descriptions of themselves and their life circumstances was often described as uncomfortable, and it was often perceived as a description of and perspective on themselves and their situation which they did not recognize. Examples includes descriptions of themselves as being manipulative, hysterical, dramatic, seductive, having shown omnipotent control, shown paranoia, experienced transference, projecting or lacking the ability to function. The professional terminology and the language of diagnosis was often perceived as defining, categorizing and objectifying. About half of the informants described the language used by the staff as humiliating and said that it created distance between them and the staff.

Written descriptions are especially pointed to as alienating. Six informants specifically mentioned reading their own medical record as a painful and humiliating experience, and that they were left feeling grossly misunderstood. It did not seem that it was that the information or medical record was written in and of itself that was perceived as a humiliation. It seemed more that it was by reading their own medical record or epicrisis that the user became aware of the staff's/therapist's views. Their view did often not correspond with their own perception of

the situation, and this was perceived as a humiliation. The informants also mentioned factual mistakes in their medical record or epicrisis that were not corrected and therefore stuck with them. In the next quotation, there is an example of how reading one's own treatment plan has been experienced as a humiliation.

> The treatment plan didn't mention that I suffer from anxiety or depression. The doctor had written a really humiliating treatment plan, which in itself felt like a violation.

3.2. Themes related to violence of user autonomy

The second chosen theme is experiences of humiliation in relation to lack of respect or violation of user autonomy. Most of the informants in the present study expressed that they felt that their autonomy was violated and not respected, and that they wished for more user participation. They felt that they did not have the choice to participate in or influence their own treatment. Another recurrent theme was that the staff decided too much, taking unnecessary amounts of control, like not being allowed to decide when to smoke or when to go for a walk.

> I have the impression that the staff might think that it doesn't matter if the user has to wait until meal time to get a slice of bread or a coffee, or whatever. But they are not in the situation of having others decide the thousand details of their day. When you have others creating the frameworks and premises of your day, it becomes more important to be part of the decision making for some small things.

Seven informants said that they found being forcefully medicated as one of the worst violations of their hospital stay. It felt like an assault and was very traumatizing, and they had suffered from nightmares and difficult memories in the aftermath. One person described it as a "rape of the soul", and another said that she felt emotionally dulled, flat, quieted and indifferent.

> I felt like a chemical guinea pig. They were (…) desperate to stabilize me. Instead of asking for my advice, they just went ahead. They started on top of the (medication) list and worked down.

Loss of freedom when admitted involuntarily was also described as humiliating. Some said that losing their freedom could bring up memories and associations of previous assaults, and therefore became re-traumatizing.

> There was really quite a lot of those (humiliations); the kinds of things like being locked in a closed ward, having staff members hanging over you all day…. It was incredibly degrading. Being locked up, being totally dependent upon others for all kinds of things. Having to ask permission to go get some air, having to wait for hours, because there aren't enough staff… things like that… It was, yes, I found that to be very degrading.

The informant's experiences with the formal use of coercion was the subject that varied the most in this study: from those who felt grateful for being coerced, to those who said it was the most traumatic experience of their life. Most prominent, however, was the informants expressing that the use of coercion had not been the worst humiliation they had experienced through their admission.

Staff breaching confidentiality was also experienced as a humiliation. This could entail speaking to next of kin without permission, or sharing information seen as confidential with other staff members.

> It felt like a huge humiliation! First because he (the therapist) actually said that he wouldn't do it, and then he did, and secondly because he actually gave information in my medical record to others.

Another example of themes related to lack of respect for user autonomy is that one informant found her therapist to be emotionally invading: he had promoted an unhealthy dependence, and the therapist used her for his own needs. She said that she had found the entirety of the therapy to be a reactivation of earlier relational trauma.

3.3. Experiences related to staff attitudes

The last theme chosen in the analysis includes experiences of humiliation related to staffs' attitudes. This includes experiences of not being treated with respect and being degraded, looked down upon and rejected by staff. Under this theme, we have categorized users' descriptions of experiences of humiliation which they attributed to traits concerning the staff. This could, for example, be staff behaving in an unprofessional way or in a rough manner. Some informants experienced the staff as overbearing and condescending and said that they had a top-down attitude towards them. Many wished for more equality in the relationship between staff members and users in institutions. The staff could also be seen upon as rude, unprofessional, inappropriate in their communication and generally displaying bad attitudes towards users.

> The staff members had completely different rights than the users. The value difference was clear, and I found it awful that a staff member should increase the difficulties for someone with bad relational experiences, low self-esteem, and in general a difficult life. The disappointment was tremendous. The powerlessness enormous. Got nowhere.

Some of the informants described that they felt small in their encounter with the mental health care services and staff. They had felt incapacitated and as though the staff treated and talked to them as if they were children, such as being given tasks that were perceived as undignified, or actions that showed that their abilities were underrated. They mentioned that being treated as incapable could be re-traumatizing, since several had had earlier trauma and experiences related to being suppressed and not in control in a relationship.

> I suddenly felt subjected to the raising of a child…. It was shocking that someone being paid to help, suddenly chose the role as child rearer. I felt completely powerless and cut off from help. It was a clear violation of power.

Several informants felt that there is a diagnostic culture in mental health care, and that everything they said or did was interpreted by staff as a symptom of their diagnosis. Several informants described this experience as an example of the staffs' prejudice and said that it felt like a humiliation.

> Being the object of others' prejudice, quite simply, in a mental health care setting, that was the most offensive. (…) That everything I did to try to get out of it just made it worse, because I was just confirming, everything I did was interpreted as a confirmation of my diagnosis.

Another primary finding in this study is the experience of feeling rejected by the staff or therapist, which was perceived as a humiliation. This was seen in many forms, such as feeling that their emotions were rejected, or that they were completely rejected as a person by the treatment system. In some cases, informants wanted more help from the health care services than they received, like a longer hospital stay. They also spoke about feeling rejected by their families, employers, friends and municipality services, but first and foremost, it was about feeling rejected when their needs or desires to feel comfort and someone to talk to were rejected. Several of the informants felt that the staff was afraid of open expression of emotions and therefore did not tolerate it. As a consequence, they felt that it was forbidden to show feelings and that they were not accepted as themselves. An example of this is one informant who told of how she had experienced being put in restraints because she cried and openly showed emotion.

> If there was any sort of emotional reaction, then, then they were

very quickly there, I mean, they were threatening me with the restraints.

The feeling of being rejected when asking for comfort and contact was a reoccurring theme amongst the informants. Many of the informants felt that the staff members lacked empathy, and that the staff were perceived as unauthentic, cold and not comforting. The feeling of explicitly exposing their vulnerabilities to the staff, but not receiving any kind of empathy or care in return, was described as deeply humiliating. Many described how this kind of rejection from the staff could create great anger. Aggression and anger were also especially highlighted as something that was rejected by the staff and prohibited. About half of the informants told us that they felt that their need to release anger and frustration was not tolerated. They explained that they were told by staff to get it together and to be considerate of other users. Several of the informants told us that they were offered medication when they expressed their sadness or their need for comfort. They felt that the health care services are meeting users' emotional and relational needs with medication, when what they really need is someone to talk to.

How is it ok to stand and watch someone breaking, perhaps asking them if they want a pill? I don't think it's ok.

Other experiences described as humiliations include feeling like the staff did not trust them, or that they did not take the informants seriously. Not having felt seen, heard or respected is something many of the informants had in common: a general sense of not feeling recognized.

4. Discussion

The informants in this study told about experiences of humiliations of not being understood, hurt feelings, feeling of rejection and lack of recognition. They did not feel validated and recognized. They described subtle relational experiences of being diagnosed, reading descriptions alienating to themselves and feeling objectified. The experience that their needs for care and comfort were not met is also a prominent finding. The informants spoke about subtle meetings with health professionals, which have felt like great emotional dramas. They spoke about powerful feelings of humiliations, bringing up strong emotions such as aggression and anger. In general, the experience of formal use of coercion was the area with most variation in experiences between the users, from experiencing it as life-saving to describing it as the most traumatic experience in their life. This study gives support to results from earlier research that shows that the experience of humiliation is not limited to the use of coercion.

One of the main findings in this study is that many of the informants experienced having different perspective than the professionals. They had different explanations for their suffering, different expectations about how to be met and to what treatment to expect. This has also been found in other studies (Gudde, Olsø, Whittington, & Vatne, 2015; Norvoll & Husum, 2011). These situations may evolve because there are parallel understandings and explanations in MHC concerning reasons for mental suffering and what treatment should contain. The informants often had the experience that while the MHC service had an understanding of the mental suffering as a disease and wanted to cure it with medication, the users often had other beliefs, explanations and expectations. For example, it was perceived that the mental suffering was in reaction to experiencing traumatic experiences, life crises and other stressful life events, and was not considered by them as a disease. This difference in views seems to give different expectations about the content of the treatment. While the users perceived strong emotions in an existential framework, the professionals viewed strong emotions as symptoms of the illness that ought to be treated with medication. Ilkiv-Lavalle and Grenyer (2003) also found in their study that users and staff had different interpretation of conflict and aggression on the wards. Staff and users framed the situations differently. While staff tended to attribute aggression as a trait of the person and as a symptom of a disease, the users interpreted the aggression in a contextual framework. Staff would suggest more medication to solve the situation, while users proposed more and better communication and more flexible rules on wards. This experience is shared with the informants in this present study. A similar finding was found in another study on users' views of aggressive situations in MHC. Their findings suggested that incidents are triggered when users experience staff behaviour as custodial rather than caring and when they feel ignored (Gudde et al., 2015). Theoretically, self-conscious emotions such as humiliation have been related to aggression, anger and violence (Walker & Knauer, 2011).

By striving to treat all persons and users with respect and being more aware of user feelings, some of these experiences could perhaps be prevented. The user experience of humiliation could be prevented with interventions based on recognition and implementation of more care and comfort in mental health care. By using the philosophers Skjervheim, Vetlesen and Bauman; Malterud and Hollnagel (2007) has identified the role of objectivism, instantiation and indifference in the dynamics in the process which may lead to user experiences of humiliation. She used these concepts in developing a model *(The Awareness Model)* for avoiding humiliation in the clinical encounter between doctor and user, especially those which are unintended and recognized by the doctor. Although this model is developed for the clinical, medical encounter between doctor and patient, the principles may be transferred to the MHC setting.

Considering this study's findings and previous research, we suggest that an effort should be made to implement more comfort and care in mental health care. The Netherlands have introduced “compassionate interference” as a form of intervention in MHC (Verkerk, 1999). Compassionate interference is interpreted as giving comfort and care and addressing existential themes. In general, we have found little writing and research on giving comfort in MHC, with a few exceptions in “Care ethics” (Kolcaba, 2003; Voskes, Kemper, Landeweer, & Widdershoven, 2013). “Care ethics” is a normative ethical theory developed by Carol Gilligan in the eighties that holds that moral action centres on interpersonal relationships and care or benevolence as a virtue (Tronto, 1993). “Care ethics” strive to meet users' existential needs and to be aware of the relationship between user and staff.

The four ethical pillars in the health services are the ethical principles: respect for autonomy, never to do harm, to do good and justice (Beauchamp & Childress, 1979). Users' experiences of humiliation violate all of these principles. First, the users in this sample did not perceive the help as good or helpful (violates the principle of beneficence); and second, feelings of humiliation may re-traumatize users and harm self-worth and respect (violates the principle of not-harm). Furthermore, users do not feel respected as autonomous persons (violates the principle of respect for autonomy), and on the contrary, they feel discriminated against and stigmatized (violates the principle of justice).

Mental health services in Norway, as in the rest of Europe, are going through change towards new content in mental health care. This includes the possibility of improving user involvement and receiving help for psychological suffering without solely using medication (Norwegian Health Directorate, 2018). According to the users in this sample, these needs to include: to be recognized and validated for their own understanding of why they suffer, that their need for comfort are met and that they are included in decision-making about the content of their treatment. Alternative MHC service models could be based on recovery, care ethics, family−/network−/dialogue- models and other therapeutic interventions. The “dialogue-model” have an equal concept of the relation between carer and user, where the carer is not an expert on the user's life, but they find the solution together within the user's network (Seikkula, 2012).

4.1. Limitations and strengths of the study

A main limitation of this study is its procedure for recruiting users. User organisations encouraged users with negative experiences of humiliation during treatment in mental health care to participate in the study. This kind of self-sampling represents a bias because users with mostly negative experiences with mental health care may sign up to participate in the study. On the other hand, the scope of this study was to investigate users' experiences of humiliation during care. Qualitative methods do not claim that results are generalizable, but rather, its aim is to gain an in-depth understanding of the phenomenon. By claiming transparency in analysis and presentation of the data, the knowledge may be useful for MHC in their development of services.

Another limitation of the study is that the experiences were spoked about in retrospect. Mental health services in Norway have experience many changes implemented by the medical authorities to improve the quality of care. MHC services in Norway may have undergone changes, and some of the informants may have experiences belonging to previous services and cultures in care. The gender bias may also be a limitation of the study. We were contacted by and interviewed mainly women (12 women, one man). Previous studies have found gender differences in the amount of anxiety and depressive disorders (Kessler et al., 1994). Kendler et al. (2003) did not, however, find gender differences on a scale to measure life events of loss, humiliation and entrapment (Stressful Life Event Categories (SLE)). The questions of gender differences in experiencing humiliation need to be further explored in future research.

A strength of the study is that users were recruited outside the MHC, which may strengthen the informants' trust and ability to speak freely. The study's strong user focus is also a strength of the study. The study had a user-participant in the reference group, and recruitment of informants was done through collaboration with Norwegian user organisations.

5. Conclusion

The main findings in this study are that the experiences of users in this sample with humiliation in mental health care could be sorted into three main themes: themes related to different perspectives between user and staff; themes related to violence of user autonomy; and experiences related to staff attitudes. This sample of users did not have their expectations regarding the content of care fulfilled. They longed for recognition, care and comfort. This is an important finding for future MHC to reflect upon, that is, how to better be able to meet users' existential need for recognition, care and comfort. Several of the informants' experiences are not coarse examples of malpractice by staff, but are perceived as inadequate care by the user. These informants have experienced different variations and degrees of experiences of not being recognized, of feeling rejected and not being treated with the respect and with less dignity than they feel they deserve. This is the essence of the experience of humiliation. More concern towards these issues could prevent this kind of experience and heighten the quality and ethics of MHC care.

Funding

The project has received funding from Ekstrastiftelsen (NGO founding) Nr: 2014/FOM5645.

References

Beauchamp, T. L., & Childress, J. F. (1979). *Principles of biomedical ethics.* New York: Oxford University Press.

Bjerkan, A.-M., Pedersen, P. B., & Lilleeng, S. (2009). Brukerundersøkelse blant døgnbrukere i psykisk helsevern for voksne. *SINTEF – Rapport 4/09. Trondheim: SINTEF Teknologi og samfunn*.

Eriksson, K. I., & Westrin, C. (1995). Coercive measures in psychiatric care. Reports and reactions of patients and other people involved. *Acta Psychiatrica Scandinavica, 92*, 225–230. https://doi.org/10.1111/j.1600-0447.1995.tb09573.x.

Frueh, B. C., Knapp, R. G., Cusack, K. J., Grobaugh, A. L., Savageot, J. A., Cousins, V. C., ... Hiers, T. G. (2005). Users' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services, 56*, 9.

Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experience of psychiatric hospital admission in the UK. *BMC Health Service Research, 8*, 92. https://doi.org/10.1186/1472-6963-9-92.

Gudde, C. B., Olsø, T. M., Whittington, R., & Vatne, S. (2015). Service users' experiences and views of aggressive situations in mental health care: A systematic review and thematic synthesis of qualitative studies. *Journal of Multidisciplinary Healthcare, 8*, 449–462.

Hartling, L. M. (2007). Humiliation: Real Pain - a Pathway to Violence. *Brazilian Journal of Sociology of Emotion. 6*(17), 466–479.

Hartling, L. M., Lindner, E., Spalthoff, U., & Britton, M. (2013). Humiliation: A nuclear bomb of emotions? *Psicologia Politica, 46*, 55–76.

Hartling, L. M., & Luchetta, T. (1999). Humiliation: Assessing the impact of derision, degrading, and debasement. *The Journal of Primary Prevention, 19*, 4.

Haugvaldstad, M. J., & Husum, T. (2016). Influence of staff's emotional reactions on the escalation of user aggression in mental health care. *International Journal of Law and Psychiatry, 49*, 130–137.

Hoge, S. K., Lidz, C. W., Eisenberg, E., Gardner, W., Monahan, J., Mulvey, E., ... Bennett, N. (1997). Perceptions of coercion in the admission of voluntary and involuntary psychiatric patients. *International Journal of Law and Psychiatry, 20*(2), 167–181.

Ilkiv-Lavalle, O., & Grenyer, B. F. (2003). Differences between user and staff perceptions of aggression in mental health units. *Psychiatry Services, 54*(3), 389–393.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H. U., & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Archives General Psychiatry, 51*(1), 8–19.

Kendler, K. S., Hettema, J. M., Butera, F., Gardner, C. O., & Prescott, C. A. (2003). Life event dimensions of loss, humiliation, entrapment, and danger in the prediction of onsets of major depression and generalized anxiety. *Archives General Psychiatry. 60*(8), 789–796.

Klein, D. C. (1991). The humiliation dynamic: An overview. *Journal of Primary Prevention, 12*, 93–121.

Kolcaba, K. (2003). *Comfort theory and practice: A vision for holistic health care and research.* New York, USA: Springer Publishing Company.

Lindner, E. (2017). *Honor, humiliation, and terror - An explosive mix - And how we can defuse it with dignity.* Lake Oswego, OR: World Dignity University Press.

Lindner, E. G. (2006). Emotion and conflict: Why it is important to understand how emotions affect conflict and how conflict affects emotions. In A. Deutsch, P. T. Coleman, M. Deutsch, & E. C. Marcus (Vol. Eds.), *The handbook of conflict resolution: Theory and practice*(Second edition). *12. The handbook of conflict resolution: Theory and practice* (pp. 268–293). San Francisco, CA: Jossey-Bass.

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *Lancet, 358*(9280), 483–488.

Malterud, K. (2011). *Kvalitative metoder i medisinsk forskning Qualitative research methods in medical research* (3 edition). Oslo: Universitetsforlaget.

Malterud, K., & Hollnagel, H. (2007). Avoiding humiliation in the clinical encounter. *Scandinavian Journal of Primary Health Care, 25*, 69–74.

Miller, S. (1988). Humiliation and shame. *Bulletin of the Menninger Clinic, 52*, 42–51.

Norvoll, R., & Husum, T. L. (2011). Som natt og dag?- Om forskjeller i forståelse mellom misfornøyde brukere og ansatte om bruk av tvang. *Norwegian: As night and day – users and professionals different preceptions of coercion in mental health care.* Norwegian Council for Mental Health & National Centre for User Experiences in Mental Health Care.

Norwegian Health Directorate (2018). https://helsedirektoratet.no/folkehelse/psykisk-helse-og-rus/psykisk-helsevern/legemiddelfri-behandling-i-psykisk-helsevernhttps://helsedirektoratet.no/folkehelse/psykisk-helse-og-rus/psykisk-helsevern/legemiddelfri-behandling-i-psykisk-helsevern.

Nyttingnes, O., Ruud, T., & Rugkåsa, J. (2016). It's unbelievably humiliating: Patients' expressions of negative effects of coercion in mental health care. *International Journal of Law and Psychiatry, 49*, 147–153.

Otten, M., & Jonas, K. (2013). Humiliation as an intense emotional experience: Evidence from the electro-encephalogram. *Social Neuroscience, 9*(1), 23–35. https://doi.org/10.1080/17470919.2013.855660.

Seikkula, J. (2012). *Åpne samtaler (Open Dialogue).* Universitetforlaget.

Skudal, K. E., Holmboe, O., Haugum, M., & Iversen, H. H. (2017). *Pasienters erfaringer med døgnopphold innen tverrfaglig spesialisert rusbehandling (TSB) i 2017. [Inpatients' experiences with interdisciplinary treatment for substance dependence in 2017.].* Oslo: Folkehelseinstituttet (PasOpp-rapport nr. 2017).

Svindseth, M. (2010). *A study of humilitation, narcicissim and treatment outcome in users admittet to psychiatric emergency units. Dokoravhandling (Thesis).* NTNU.

Svindseth, M., Dahl, A., & Hatling, T. (2007). Users' experience of humilation in the admittion process to acute psychiatric wards. *Nordic Journal of Psychiatry, 61*, 47–53.

Tronto, J. (1993). *Moral boundaries, a political argument for an ethic of care.* New York: Routledge.

Van den Hooff, S., & Goossensen, A. (2014). How to increase quality of care during coercive admission? A review of literature. *Scandinavian Journal of Caring Sciences, 28*(3), 425–434.

Verkerk, M. (1999). A care perspective on coercion and autonomy. *Bioethics, 13*, 3/4.

Voskes, Y., Kemper, M., Landeweer, E. G. M., & Widdershoven, G. A. M. (2013). Preventing seclusion in psychiatry: A care ethics perspective on the first five minutes at admission Nursing Ethics. *Online First*. https://doi.org/10.1177/0969733013493217.

Walker, J., & Knauer, V. (2011). Humiliation, self-esteem and violence. *The Journal of Forensic Psychiatry & Psychology, 22*(5), 724–741.

Westrin, C.-G., & Nilstun, T. (2000). Psychiatric ethics and health services research. Concepts and research strategies. *Acta Psychiatrica Scandinavica, 101*, 47–50.