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It is just that people treat you like a human being: The meaning of dignity for patients with substance use disorders

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Abstract

Introduction: Patients who suffer from substance use disorder (SUD) might receive services from different service providers in an opioid maintenance treatment programme (OMT) and have a widespread and complex need for nursing.

Background: Literature reveals that prejudices against people with SUD exist. There is a lack of studies exploring patients with SUD experiences of preserving their dignity in the encounter with healthcare staff. The aim of the study was to gain insight into the meaning of dignity for patients with SUD.

Methods: The research design was descriptive and interpretative. In the interpretation of qualitative in-depth interviews with six patients, a hermeneutical approach based on Gadamer (Truth and method, Sheed & Ward, London, UK, 1989) was used.

Results: Analysis resulted in three mains themes about the meaning of dignity: (a) The material dimension. (b) To be respected by others. (c) The inner experience. Factors enhancing dignity in the encounters were as follows: (a) Being respected and acknowledged. (b) Being cared for. (c) Knowledge and persistent relation. Factors depriving dignity were as follows: (a) Stigma and prejudice. (b) Insufficient relations and lack of confirmation. (c) Experiencing disrespectful/patronising attitudes and lack of knowledge.

Conclusions: The material dimension of dignity containing an aesthetically aspect was important for these patients. Dignity was also experienced as strongly connected to respect. Dignity can be enhanced by treating patients with SUD with understanding and respect, and dignity can be inhibited through stigmatization of patients with SUD, as well as by caregivers' lack of knowledge.

Relevance to clinical practice: The study clarifies a need for more knowledge about SUD among healthcare staff, as well as promotes ethical awareness in encounters with patients regardless of their background.

KEYWORDS

Dignity, Opioid maintenance treatment (OMT), Stigma, Substance use disorder (SUD)

1 | INTRODUCTION

Approximately 29.5 million of the global adult population suffer from drug use disorders (United Nations Office on Drugs (UNODC), 2017). In Norway, a country with a population of 5.2 million people (Statistisk sentralbyrå (SSB), 2017), it is estimated that approximately 8,700–12,300 people have a need for treatment because of intravenous drug use (Biong & Ytrehus, 2012). In the European Union, it is estimated that 1.3 million are high-risk opioid users, and 628,000 opioid users have received substitution treatment (European drug report 2018: trends and developments, 2018). In the USA, an estimated 1 million people receive medication-assisted treatment (MAT) of the 2.5 million Americans who might benefit from it (United States Department of Health and Human Services (HHS), 2015).

Drug use disorder is also known as substance use disorder (SUD; American Psychiatric Association, 2013). Patients who suffer from SUD might receive services from different service providers and have a widespread and complex need for nursing. In this study, the patients were in an opioid maintenance treatment (OMT) programme. In 2016, 7,554 patients were in the OMT programme in Norway (Senter for rus- og avhengighetsforskning (SERAF), 2017). The treatment goal in the OMT programme could be rehabilitation or harm reduction; sometimes it is a combination of both. To stop using substances can be a more long-term goal for the patients (National Institute for Alcohol & Drug Research, 2013).

The patients in this study received their OMT medications administered by home-based nursing. The medications used in OMT are methadone and buprenorphine, both of which have several potential dangers, and the treatment is regulated according to guidelines (Norwegian Directorate of Health, 2013). The medicaments could harm the patient if not taken as prescribed, and these drugs could harm others if they end up in the illicit market. The increase in deaths related to methadone in recent years has been connected to leaks of these medications from the OMT programme (Clausen, 2014).

Based on the desire to normalise the treatment, it is beneficial that the patients in the OMT programme receive their medications at a pharmacy. Half of the patients in the OMT programme in Norway receive their medications in pharmacies (Senter for rus- og avhengighetsforskning (SERAF), 2018). When patients have difficulties getting their OMT medications from a pharmacy, home-based nursing can get the responsibility for the administration. Home-based nursing staff help many different patient groups, and most of the patients are older people. A lack of knowledge about the caring needs of patients with SUD, and the guidelines that regulate the OMT programme could cause challenges and difficulties in these encounters.

What does this paper contribute to the wider global community?

- The material dimension of dignity containing an aesthetical aspect is important for patients with substance use disorder (SUD).
- The study clarifies a need for ethical awareness in encounters with patients with SUD.
- Dignity can be enhanced in encounters when healthcare staff treat each individual patient as a unique human being.

2 | BACKGROUND

Home-based nursing staff may lack knowledge about psychiatry (Flöjt, Le Hir, & Rosengren, 2014; Grönroos & Perälä, 2008). Furåker (2012) stated a need for developing competencies in psychiatric nursing. Updating their competence has been experienced as challenging, as many nurses experienced it as challenging to apply evidence-based knowledge in their work (Grönroos & Perälä, 2008). Howard and Holmshaw (2010) argued that there are less negative attitudes towards patients with mental health problems and SUD among staff who received training in how to work with these patients. Respecting and confirming patients' dignity is a fundamental aspect of high-quality encounters between patients and district nurses (Nygren Zotterman, Skär, Olsson, Söderberg, & Zotterman, 2015).

Nurses and other healthcare staff experience challenges, such as manipulation and/or threats, and they struggle to give care to patients with SUD, who they found provoking at times (Peckover & Chidlaw, 2007). van Boekel, Brouwers, van Weeghel, and Garretsen (2014) argued that healthcare staff have negative attitudes towards patients with SUD. Working with patients with SUD, especially patients who use narcotics, has a low status (Gilchrist et al., 2011). Nurses and other healthcare staff experience challenges as manipulation, threats and struggled to give care to patients who they found provoking in encounters with patients with SUD (Ford, 2011; Ford, Bammer, & Becker, 2008; Johansson & Wiklund-Gustin, 2016; Michaelsen, 2012).

Some nurses have negative attitudes towards patients with SUD and treat these patients with authoritarianism (Howard & Sulki, 2000; Howard & Holmshaw, 2010). Living with SUD is treated as a moral or criminal challenge instead of a health issue (Livingston, Milne, Fang, & Amari, 2011). Michaelsen (2012) stated that nurses distance themselves from patients who provoke them. The challenges nurses experience when caring for patients with SUD lead to the nurses being vigilant in these encounters (Johansson & Wiklund-Gustin, 2016).

In a study that pointed out the care needs of these patients, a need for care that accommodated the patients' need for fellowship and belonging, confirmation and respect appeared (Wiklund, 2008b). Patients in the OMT programme experience challenges with their treatment. The control regimens in the OMT programme lead to a feeling of powerlessness among the patients (Granerud & Toft, 2015). One study revealed that disagreements in attitudes among staff also exist among those who worked in the OMT programme

(Gjersing, Waal, Caplehorn, Gossop, & Clausen, 2010). A study by Go, Dykeman, Santos, and Muxlow (2011) argued that patients in the OMT programme need social support and a holistic approach, and the healthcare staff needs knowledge about the treatment to follow-up with patients who receive OMT. Anstice, Strike, and Brands (2009) stated that it is important that patients in the OMT programme who receive their medications in pharmacies have experiences in which they are met with respect.

The literature search revealed a lack of studies that could shed light on the encounters between patients with SUD and healthcare staff in home-based nursing. It has been stated that different ways of distributing OMT medications should be evaluated qualitatively (SERAF, 2014). We did not find any study exploring persons' experiences of preserving their dignity in the encounter with health care staff. We found it therefore important to carry out the present study.

2.1 | Aim and research questions

The aim of this study was to gain insight into the meaning of dignity for patients with SUD in encounters with home-based nursing staff.

The research questions were as follows: What is dignity for the patient? What could enhance the experience of dignity in the encounters? What could be barriers to the experience of dignity in the encounters?

3 | METHOD

3.1 | Design

The research design was descriptive and interpretative. It was also partly explorative, based on a lack of previous studies regarding the perspective of patients with SUD during their encounters with home-based nursing staff. In the interpretation of the data, a hermeneutical approach based on Gadamer (1989) was used.

3.2 | Participants and data sampling

To contact the participants in the study, an outpatient clinic with responsibility for patients in the OMT programme was contacted, and nurses working in the outpatient clinic became contact persons for the project. The inclusion criteria were as follows: (a) the participants had to receive their OMT medication from home-based nursing; (b) they had been in the OMT programme for at least one year; and (c) they lived within an acceptable distance for conducting the interviews. It was desirable to have a 50/50 gender balance in the study and to include patients with different treatment perspectives, both rehabilitation and harm reduction. As it turned out, it was not possible to recruit as many women as men. The nurses in the OMT programme evaluated that participation in the project would be stressful for many of the women in the OMT programme. The percentage of women in OMT has been approximately 30% in recent years (SERAF, 2017).

It was considered beneficial that the patients' contact persons recruited the participants. The "contact person" was a nurse who had the responsibility for following up patients according to the guidelines in OMT programme in Norway. These nurses knew their patients well according to the strict guidelines including patients in the OMT programme. The nurses asked patients they considered met the inclusion criteria of the study and who they considered would not be harmed by participating. The contact person's relation to the patient provided knowledge about the challenges the individuals could experience in their life and made it possible to determine that participation would not be stressful for the patient. The first author contacted the patients who considered participation in the study by phone or text message. Some of the participants were anxious about answering their phone. To let them know who tried to call them was important to establish contact.

A semi-structured interview guide was used in the data sampling. The interview schedule was developed after literature search developing the project-outline. It was also based on prior experiences of the researchers. The second author has comprehensive experience with qualitative studies, and the researcher who conducted the interviews has experience working with patients with SUD. When designing the interview schedule one of the researchers had a meeting with staff in an outpatient clinic with responsibility for patients in the OMT programme and the staff gave their input.

The interviews were initiated by questions about the service the participants received and what they anticipated from the home-based nursing staff. Then, the participants were asked what the word dignity meant to them, and they were asked to tell about positive and negative experiences in their encounters with healthcare staff. To explore factors that could enhance or be barriers to the meaning of dignity, the participants received an open question regarding this. They were also asked what they thought could influence dignity in meetings with healthcare staff in home-based nursing. The interviews had a duration of approximately 40–130 min.

After completing three interviews, the interview guide was evaluated by the two researchers responsible for the study. It was concluded that it was appropriate for use throughout the whole data collection process.

The interviews were conducted over a period of seven months. There were some challenges recruiting the participants, and many potential participants lived in rural places. In the geographic region where the study was conducted, approximately 50% of the patients in the OMT programme received their medications from pharmacies (SERAF, 2018). Many of the patients who received their OMT medicines from staff in home-based nursing experienced many challenges in their daily life, including mental conditions such as anxiety. This contributed to the assessments that participation in the study could be a burden for many of the OMT patients who received their medications from home-based nursing.

Six patients, four men and two women participated in this study. The ages ranged from 20 to 55 years old, and they had participated

TABLE 1 Overview of the participants in the study

Gender	Age (5-year ranges)	Duration/Time in OMT (years)	Treatment perspective	Type of medication
Female	20–25	3	Rehabilitation	Buprenorphine
Male	35–40	5–10	Rehabilitation and harm reduction	Buprenorphine
Female	40–45	12	Rehabilitation and harm reduction	Methadone
Male	40–45	2–4	Harm reduction	Methadone
Male	45–50	4	Rehabilitation	Buprenorphine
Male	50–55	15	Rehabilitation	Buprenorphine

TABLE 2 Example of analysis process

Textual units	Theme	Sub-theme
[…] dignity is to *have a proper residence*, to have a *proper shower*, *having access to a washing machine*, *keep it clean*, possibilities to do this on my own. That *affects my dignity*. Because I have lived in caravans, trashed houses and anything else..	The meaning of dignity	The material dimension
[…] It is just that *people treat you like a human being* and not as an addict. It is what I appreciate most with *respect*, that even if I have a past with all kind of things. I would like people to *respect me for who I am* […] Because home-based-nursing give me OMT medications and know I have a past with addiction. I like that people enter my door with *understanding*, and tell me that I look good	Factors enhancing dignity	Being respected and acknowledged
[..] I do not appreciate that everyone distrusts me and things like that, just *because of my past*. I know that there are many lies and things like that among people who live with addiction, but you actually change. Many *do not believe the things you tell them to be true*, I do not really like that	Factors depriving dignity	Stigma and prejudices

in the OMT programme between 2 and 15 years. Some of the participants had a treatment perspective that was mainly rehabilitation; for others, it was harm reduction. Some had a treatment perspective that was a combination of both. The participants chose the place for the interview, which was important for the feeling of being in a safe environment. Two participants wanted to be interviewed in their home, two in a meeting room, one on the premises of the outpatient clinic and one in a psychiatric hospital where the patient had been hospitalised earlier (Table 1).

3.3 | Data analysis and interpretation

All interviews were recorded digitally and were transcribed verbatim by the researcher. The raw text data consisted of 123 pages. The researcher who conducted the interviews undertook the analysis and interpretation. The second author read the interviews and had full access to the transcribed text and gave input to analysis and interpretation continuously during the process. The transcribed text was read several times to get an overview of the data material and to be sure that no themes were left out. Substantial themes were written in the margin of the text. Textual units belonging to the same theme were sorted under the respective theme.

Gadamer (1989) states that we must be prepared for the text to tell us something when we try to understand it. As an interpreter we take our own experiences with us into the process of interpretation. When trying to understand we must be aware that these fore-meanings can distract us. The text is also shaped in its own context and have its own horizons that can limit its meaning. Through dialogue between the interpreter and the horizons of the text meaning can be formed. Acquiring a horizon of interpretation requires a fusion of horizons (Gadamer, 1989).

It is important that we from the start are sensitive to the text alterity. Being aware of your own bias is important, this makes it possible for the text to present itself and its truth and assert its truth against our fore-meanings (Gadamer, 1989). In hermeneutic interpretation, parts of a text are seen in the light of the whole text, the hermeneutic circle is described as a dynamic recognition process in trying to understand the individual parts of a text reference to the text as a whole.

Meaning coding, meaning condensation and meaning interpretation, as described by Kvale and Brinkmann (2009), were used to analyse the text. The further text analysis was based on Kvale and Brinkmann's three levels of interpretation: self-understanding, critical common sense understanding and theoretical understanding (Kvale & Brinkmann, 2009). Self-understanding is described as what

the participants perceive as the meaning of their statements formulated by the interpreter in condensed form. This level of interpretation is a paraphrased condensation of the views of the participants as understood by the researcher. At the common sense level, the understanding goes beyond the participants' self-understanding. The theoretical understanding goes further than the two other levels of interpretation and includes theory (Kvale & Brinkmann, 2009; Table 2).

3.4 | Ethical considerations

Prior to the data sampling, the study was evaluated by one of the regional committees for medical and health research ethics in Norway, who concluded that the study could be conducted. The study was also evaluated by the Norwegian Centre for Research Data, who recommended approval of the study. Patients with SUD who are part of the OMT programme are vulnerable. Caution when gathering information from vulnerable groups regarding sensitive subjects is important (Malterud, 2011). It was important to avoid that the participants felt exposed to pressure or risk and that they received adequate information prior to the interviews. The researcher was very careful not adding any pressure on the possible participants prior to the interviews. All participants were offered to have the research questions read up over phone before they decided if they wanted to participate.

The participants received a letter with information about the study that stated that participation was voluntary and that they could withdraw from the study at any time without any consequences. They were informed that all data would be anonymised, that confidentiality was assured and that data would be stored in accordance with the guidelines of the Norwegian Centre for Research Data. All participants provided written, informed consent. One of the fundamental ethical principles of the research ethics of the World Medical Association's Helsinki Declaration is that vulnerable groups should benefit from the results of the research (World Medical Association Declaration of Helsinki, 2013). It has been stated that experiences regarding different ways of distributing OMT medications should be evaluated qualitatively (SERAF, 2014). Many of the participants stated that they experienced participation in the study as important.

3.5 | The phenomena of dignity and stigma

We make use of the phenomena of dignity and stigma in the way that the results are discussed in the light of these phenomena in the discussion section. The reason for this was literature search prior to the study combined with experience in encounters with patients with SUD by one of the researchers working as a nurse in a hospital unit and in a project directed towards patients with SUD. Experiencing that some patients with SUD can be met with prejudices, the researcher wanted to conduct a study to enlighten these patients' experiences of dignity. Stigma was chosen to enlighten the social aspects when living with SUD.

Several researchers describe human dignity as absolute and universal (Edlund, Lindwall, Post, & Lindström, 2013; Eriksson, 1995; Nordenfelt, 2004). Dignity has also been described as subjective and relative, connected to an aesthetic dimension regarding respectable, decent and correct acts (Eriksson, 1995). Nordenfelt (2004) uses the term "dignity of merit" about dignity associated with social status and position. Dignity connected to the body and mind of the individual can change as a result of fellow humans' acts and because of changes in the body and mind of the individual (Nordenfelt, 2004).

Edlund et al., (2013) described relative dignity, which is influenced by culture and society. Part of relative dignity is an exterior, aesthetic dimension of dignity belonging to the bodily dimension of the human being (Edlund et al., 2013).

Stigma is described as the situation of individuals that disqualifies them from a complete social aspect (Goffman, 1963). The author describes three forms of stigma: stigma of group identity connected to race and religion and physical stigma connected to deformities of the body. SUD and mental health problems belong to the stigma of character traits, which is regarded as a result of a weak will or as unnatural. In encounters with others, people who carry a stigma can be uncertain about how they will be met and perceived. People carrying a stigma can go through what Goffman (1963) refers to as "Moral Career." The carrier of the stigma learns what carrying a stigma means and adopts others point of view considering this and its consequences (Appendix S1).

4 | RESULTS

Analysis of the interview text resulted in three main themes about the meaning of dignity: (a) the material dimension, (b) to be respected by others and (c) the inner experience. The interpretation identified factors enhancing dignity in the encounters as: (a) being respected and acknowledged, (b) being cared for and (c) knowledge and a persistent relation. Factors depriving dignity were as follows: (a) stigma and prejudice, (b) insufficient relations and lack of confirmation and (c) experiencing disrespectful/patronising attitudes and lack of knowledge.

4.1 | The meaning of dignity

4.1.1 | The material dimensions

Several participants connected dignity strongly to material things. We live in a society where the standard of living is high, and it may seem that the things you own reflect how successful you are. Similarly, lack of dignity can be experienced as a poor living standard that may indicate someone is unable to manage their life. The participants told about periods in their life where they had few material

goods, poor living standards and a very difficult life. They referred to this way of living as lacking dignity.

> *[…] it has been periods of my life where I have lived in a sleeping bag. Many addicts do that, and then you feel that you lack dignity*
>
> *(Participant 4).*

The participants described having money and material goods and managing practical tasks in daily life as characteristics of people who had dignity. Money was considered a means for realizing things that could be important for experiencing dignity.

An important aspect of the material dimension of dignity was aesthetic. Dignity was connected to having a "proper" place to live and looking "proper." People who had dignity were described as having everything in order and living in clean and tidy surroundings.

> *[…] dignity is to have a proper residence, to have a proper shower, having access to a washing machine, keep it clean, possibilities to do this on my own. That affects my dignity*
>
> *(Participant 6).*

Several of the participants connected dignity with having the same material things as others. An aesthetic aspect was highlighted by describing humans who had dignity; they looked proper and lived their lives in clean, tidy and proper surroundings.

4.1.2 | To be respected by others

The participants experienced dignity as strongly connected to respect; they described the terms dignity and respect as almost synonymous. They emphasised that being respected and trusted by people they meet was very important for their dignity, so important that they described it as being met and treated as a human being.

> *[…] Dignity is … as I told you earlier… that people have trust in what you tell them: Trust that you actually are a human being and not get stuck in your past, that you are treated like a normal human being*
>
> *(Participant 1).*

Dignity was that others meet them with an open attitude, without prejudice and in the same way that they meet all others. Dignity was perceived as being treated in a way that made you feel having individual value. In the encounters with the staff from home-based nursing, it was important to show respect and trust.

4.1.3 | The inner experience

Dignity was also described as a feeling, an inner experience, as something within each individual. Based on this, the participants felt that dignity was something they could contribute to themselves.

> *Difficult to explain… it is just the feeling of how you are*
>
> *(Participant 2).*

Based on the understanding of dignity as an inner experience, each one could influence and alter their own dignity and have responsibility for their own dignity. This aspect of dignity is personal and individual, and it is strongly connected to feelings.

4.2 | Factors enhancing dignity in the encounters

The participants had strong opinions regarding factors that might enhance dignity in the encounters.

4.2.1 | Being respected and acknowledged

The participants connected dignity strongly with respect. In the encounters with healthcare staff, the participants had a desire to be met as the individuals they are.

> *It is just that people treat you like a human being, and not as an addict. This is what I put highest with dignity, even though I have a past, with all kind of things. I would like people to respect me for who I am*
>
> *(Participant 1).*

The participants experienced dignity when they were treated as every other patient is treated. They wanted to be met as fellow human beings; this made them feel equal to the healthcare workers and made it possible to understand and trust each other. The participants felt that they had knowledge that was useful. By being acknowledged for their knowledge about drugs and drug use, they were able to give advice to the healthcare staff about this subject, which made the participants feel that they gave something back.

> *They hear what I have to say, "we didn't know that, that was good to know". So you feel like you contribute a bit to further educating them*
>
> *(Participant 3).*

The staff expressed this recognition through communication with the participants as equals, which was regarded as positive and was experienced as contributing to enhancing dignity.

4.2.2 | Being cared for

The participants appreciated that the staff cared for them. Several participants had been patients for many years and had thoughts

about personal characteristics in staff members that could enhance dignity.

> *[…] I usually stay in my apartment and struggle with depression and things like that. When you get to hear them say "have a nice day", I become happy*
>
> *(Participant 1).*

To be open-minded, have a good mood and show care for the patient were characteristics appreciated by the participants, and they felt it enhanced their dignity.

4.2.3 | Knowledge and persistent relations

The participants considered multiple factors with the organisation of the service that could enhance dignity. Good continuity provided possibilities for the patients and staff to know each other.

> *I prefer that it is not different people every day. When the person actually can give an evaluation on Wednesday, say that I´ve met X every day and think that it has been stable, good. […]. Well now, I only relate to approximately 10 persons. I feel that these caregivers in a way accept me, they have learned to know me, there has been less trouble and those kind of things*
>
> *(Participant 4).*

It was considered beneficial that the staff had knowledge about SUD and the participants' situation. This prevented misunderstandings between the patients and the staff and made it possible for the staff to evaluate each patient's treatment.

4.3 | Factors depriving dignity

4.3.1 | Stigma and prejudices

All participants were diagnosed with opioid addiction and to be met with negative attitudes from others had become a part of their life. They regarded it as expected and natural that healthcare staff were scared meeting something that was unfamiliar. Several of the participants felt that the staff beliefs regarding SUD was a barrier for dignity, because they could be treated differently from other patients. They had experienced being met with prejudice and being stigmatized; they felt that the staff met them with suspicion.

> *I do not appreciate that everyone distrusts me and things like that, just because of my past. I know that there are many lies and things like that among people who live with addiction, but you actually change. Many do not believe the things you tell them to be true, I do not really like that*
>
> *(Participant 1).*

If misunderstandings or faults occurred regarding their OMT medication, the participants felt that the burden of proof always was theirs. This could lead to consequences for the participants when the staff withheld their medication.

> *If they do not believe me, at times I do not get my medicines delivered. The staff claim that I have been drugged … and I have not been intoxicated at all*
>
> *(Participant 4).*

Some of the participants felt that to be addressed in a patronising way and being looked down upon was to be "treated as an addict." It was a barrier for dignity that the staff had decided whom the patients were prior to the encounters, and based on this perception, the patients with SUD were treated differently than other patients.

4.3.2 | Insufficient relations and lack of confirmation

The participants told how they often had to wait for the staff and that they could even be forgotten. They felt that they were given lower priority than other users of the service and that their need for nursing was ignored.

> *Sometimes you have depressive periods where you want to get your medicine. Maybe you feel anxious in the morning. You wake up at eight, then you have to wait for them to come, they don't come by nine, and then you even have to wait two more hours before they arrive… it has happened a couple of times that I had to call them. They had forgotten about me…*
>
> *(Participant 3).*

Factors concerning the organisation of home-based nursing could be a barrier to dignity. It was experienced as negative if more than one caregiver visited for no obvious reason. That many different staff members provided the service made it difficult to get to know particular individuals.

4.3.3 | Experiencing disrespectful/patronising attitudes and lack of knowledge

The participants felt that the healthcare staff lacked knowledge about SUD and had negative attitudes. The staff made assessments regarding whether the patients were affected by drugs based on inadequate knowledge and lacked an understanding of the

psychological aspects of SUD. Several of the participants told about a daily life dominated by anxiety and that the staff's behaviour contributed to strengthening this anxiety.

> *They do not know how the daily life with addiction is. How the anxiety is, how to handle a person with panic attack and social anxiety, when you are scared to death when home-based nursing arrives. Therefore, if they do not know about things like that, they just come rushing in. This is very scary. We were very afraid of people, we were scared a long time before home-based nursing arrived*
>
> *(Participant 2).*

The participants felt that lack of knowledge about the OMT medications influenced the staff's attitude towards their treatment. This led to evaluations that started processes that became troublesome for the patients. The participants told how some of the staff members were negative, rude, lacked respect and were suspicious towards the patients.

> *I have had staff members who, if we started a discussion, slammed the door and left. There are people who treat me like shit*
>
> *(Participant 1).*

The participants felt that lack of knowledge regarding SUD and the OMT led to the staff treating them disrespectfully. This offended the participants and was considered a barrier for dignity.

5 | DISCUSSION

5.1 | The meaning of dignity

The purpose of this study was to gain insight into the meaning of dignity for patients with SUD in the encounter with the home-based nursing staff. Several of the participants experienced dignity as something material. For them, material things reflected whether they had dignity or not. The participants highlighted an aesthetic aspect of material dignity. For the participants, appearing as proper, being able to wear clean clothes and having a tidy home were expressions of dignity. Likewise, aesthetic factors had been a reflection on their inability to cope with life's daily challenges, which made them feel a lack of dignity. This outer aesthetic dignity belongs to the bodily dimension of the human being as described by Edlund et al. (2013).

Several of the participants experienced dignity as something material, which is a dimension of dignity that has not been prominent in discussions about dignity. People in our society who are living ordinary lives, with all the belongings that are regarded as normal, may take this for granted, and they do not consider the material aspect of dignity as important. In the encounters with patients with SUD paying attention to the patients' home and material belongings contributed to an acknowledgement of the patients' dignity.

Being respected by others was strongly connected to dignity by the participants. This experience of dignity was interpersonal and being trusted was important and made the participants feel respected as the human beings they are. This opens the possibility for care that is adapted to each patient and makes it possible for the patients to use their abilities. The experience of being truthful and trusted prevented the patient from feeling silly or incompetent. Eriksson (1995) described a subjective and relative dimension of dignity connected to respectable, decent and correct acts.

Human dignity is described as absolute and universal (Edlund et al., 2013; Eriksson, 1995; Nordenfelt, 2004). The participants described how dignity could be felt individually, as an inner experience, and as something personal. This could lead to patients with SUD feeling responsible for their own dignity, which can be a challenge for them. Prior studies states that patient with SUD can be judged by society and that prejudices can exist among health care staff (Howard & Holmshaw, 2010; Johansson & Wiklund-Gustin, 2016; Peckover & Chidlaw, 2007; van Boekel, Brouwers, van Weeghel, & Garretsen, 2013, 2014).

Being faced with negative attitudes can affect the patient's experience of their own value. It is important to acknowledge the experience of dignity as a feeling. Although the healthcare worker has opinions regarding dignity, the patients could have different opinions. All humans adapt their understanding of dignity based on their own frames of references, and based on this perspective, the inner experience of dignity is important. Dignity can be changed because of fellow human acts and because of changes in the individual's body and mind (Nordenfelt, 2004) and can be influenced by culture and society (Edlund et al., 2013).

5.2 | Factors enhancing dignity in the encounters

It was important for the participants to be met with respect and acknowledged. When the participants were treated in the same way as all other patients, they felt accepted for who they were and their past. Healthcare staff's attitudes are crucial, as patients in the OMT need a holistic approach (Go et al., 2011). Accepting the patients, their lives and their choices is regarded as the key for caregiving to this group of patients (Ford et al., 2008). The patients appreciated that the staff who administered their medication behaved respectful, discreet and accommodating (Anstice et al., 2009). Respecting and confirming patients' dignity is a fundamental aspect of high-quality encounters between patients and district nurses (Nygren Zotterman et al., 2015).

The participants were aware of opinions and attitudes towards people with SUD in society, and they had experienced being stigmatized. Addiction is often treated as a moral or criminal challenge instead of a health issue (Livingston et al., 2011). The need that patients with SUD have for fellowship, belonging, acknowledgement and respect has been described by Wiklund (2008b). When the staff

takes initiative and provides responses, it makes it possible for the patient to recover and feel alive (Wiklund, 2008b).

The participants experienced that being cared for by the staff enhanced dignity. Patients with SUD want knowledge-based care and treatment. In the encounters with this patient group, it is important to promote health and relieve suffering (Wiklund, 2008a). The participants appreciated that the staff was open-minded and in a good mood. That nurses are positive, accepting and supportive enhances the possibility that patients will maintain contact with health services (Go et al., 2011).

Knowledge about SUD and medications used in OMT enhanced dignity by providing staff with a better understanding of the participant's situation. Go et al. (2011) describe the necessary knowledge required to care for patients with SUD as complex. It is important that the nurse understands the signs of withdrawal from the treatment, acknowledges the importance of social support and has familiarity with and an understanding of the harm reduction aspect of the treatment (Go et al., 2011). Several studies describe the importance of knowledge and an understanding of the patients' situation to offer them good care (Ford, 2011; Ford et al., 2008; Peckover & Chidlaw, 2007).

The participants considered continuity in the service important to enhance dignity, it made it easier to build trust and fewer misunderstandings occurred. There is less risk of difficulties in encounters when the patients and healthcare workers know each other (Macdonald, 2007).

5.3 | Factors depriving dignity

Being faced with prejudices and experiencing stigmatization was challenging for the participants. It was hard when the staff had made assumptions about the patients prior to the encounters. Several studies have identified challenges regarding healthcare staff's attitudes towards patients with addiction. Living with SUD is treated as a moral and criminal challenge (Livingston et al., 2011), and stigmatization of the patients leads to nurses not taking notice of the patient's personality (Peckover & Chidlaw, 2007).

In the encounters, the participants felt stigmatized when the healthcare staff were skeptical, negative and lacked respect. Staff behaving differently from what was expected from them in encounters may be connected to attitudes. Working with patients with SUD, especially patients using illegal drugs, had a lower status than working with patients with chronic diseases such as depression and diabetes (Gilchrist et al., 2011). van Boekel et al. (2013) states that healthcare workers showed negative attitudes towards patients with SUD and that factors such as violence, manipulation and low motivation affected health care given to these patients.

Several of the participants expressed an understanding of staff feeling unsecure meeting them. All the participants had lived with addiction for a relatively long time, they had experienced being condemned and some had experienced very difficult life conditions living with violence and criminality. They expected staff to be unsure and scared in the encounters. Goffman (1963) used the term "moral career" to describe the process where an individual learns that they carry a stigma and its consequences.

All the participants felt that the home-based nursing staff lacked knowledge about SUD. A lack of knowledge and understanding of the mental aspect of SUD was considered troublesome. The staff met the patients in an invasive and abrupt manner that was scary for the patients. Participants had experiences in which the staff had withheld their OMT medication based on a suspicion of the patients being under the influence of "something." The practice of withholding OMT medication indicates a lack of knowledge about the harm-reduction perspective in the OMT. The goal is to reduce harm from substance abuse and not necessarily that the patients stop using substances (National Institute for Alcohol & Drug Research, 2013).

Prior studies have shown that healthcare staff could have negative attitudes towards patients with SUD. There is a connection between negative attitudes towards illegal drugs and the staff's therapeutic attitude (Ford et al., 2008). Patients with SUD can be considered dangerous, leading to a practice where there always are two nurses together in the encounter, and therefore, it is hard to attend to the patients' emotional, mental and social needs (Peckover & Chidlaw, 2007). Interpersonal challenges can affect staff in the encounters with patients with SUD; the nurses feel unsecure if experiencing manipulation and violent threats, and they feel it is challenging that the patients do not take care of their own health (Ford, 2011). Patients with SUD can provoke staff, which leads to staff distancing from the patient and make communication between them hard (Michaelsen, 2012).

The participants wished that the staff could attend courses and be educated about SUD. Prior studies have shown that staff in these services may lack knowledge about psychiatry (Flöjt et al., 2014; Furåker, 2012; Grönroos & Perälä, 2008). Staff who receive training in how to work with patients with mental health problems and SUD have less negative attitudes towards the patients (Howard & Holmshaw, 2010).

The empirical data in this study highlight several aspects regarding the lack of knowledge of the healthcare staff that can be a barrier for the patients' experience of dignity. The fact that staff who lacked thorough knowledge about SUD should evaluate the patients' state and withheld their medication was a challenging experience for the participants. The lack of understanding for their situation made the participants feel that the staff was not considerate of their situation. This seems to be a great paradox, as the lack of knowledge among those who should help and support the patients leads to a practice that is demanding for patients. Perhaps a lack of knowledge becomes even more apparent and challenging in encounters with patients with SUD. The healthcare staff not only face an encounter that they may feel is challenging but also experience an encounter that they may fear as something scary and unknown.

5.3.1 | Methodological considerations

The study followed scientific methods of data sampling and analysis (Kvale & Brinkmann, 2009). A sample size of six participants was used to enlighten the research questions. In a study by Guest, Bunce

and Johnson (2006), the researchers tried to find what was an adequate sample size for getting to the point that no new themes were observed in the data. The study showed that most central themes in a qualitative study could be identified after six interviews (Guest, 2006). In our study, it appeared that the themes remained in accordance with what was revealed earlier in the process after four interviews. Two more interviews were conducted, which contributed to additional nuances and adjustments of the themes.

The data sample was evaluated to be adequate to enlighten the research questions. The evaluation was done by the two researchers responsible for the study based on preparatory theoretical work and increased knowledge about the field. The importance of having a suitable data/material, which contains variations but is not too comprehensive to be analysed in a satisfactory way, has been stated by Malterud (2011).

It may not be possible to generalise results based on six interviews. In this study, the participants were recruited to enlighten the research questions in the study, who provided rich information about the subject. Morse (1997) states that it is important that theoretical work makes sense to practitioners and can be relevant in a clinical setting. We consider that the results of the study can be useful for staff who provide health care to patients with SUD.

Kvale and Brinkmann (2009) stated that the validity in conducting interviews is concerned with the quality of the interviews and the participants' credibility. Erlandson, Harris, Skipper and Allen (1993) state the importance of the developed descriptions being true for the members of the settings. The participants were considered sincere in their statements, and the use of follow-up questions contributed to elaboration and confirmation of their stories. The fact that the participants were chosen and recruited by staff who worked with OMT patients on daily basis strengthened the credibility of the study and ensured diversity in the selection of participants. Patients with different treatment perspectives, both genders and various ages participated. Based on the time aspect of the study, we conducted only one interview with each participant. Another interview might be beneficial in further strengthening the credibility of the study.

To ensure transferability, it is important that the process searching for data is guided by a desire to get rich details and seeks to maximise the range of information (Erlandson et al., 1993). In the data-sampling process, the participants had both rehabilitation and harm reduction as treatment perspectives, some received buprenorphine others methadone as medication. The participants were both genders and of different age. Based on the variety of participants and literature search conducted prior the study, it is considered that the results of the study could be transferable to similar contexts.

Erlandson et al., (1993) state that the researcher must make it possible to conduct external checks to ensure dependability. While conducting the study the second author had access to all parts of the project, including the transcribed interview texts and the process of interpretation. Individual interviews were employed in the data sampling because we considered these most appropriate in bringing the participants' stories to the fore and thereby highlighting each participant's perspective. Confirmability was ensured in the way that all findings were based on the participants' response. During the study, we focused on the findings being a result of the interviews and not the bias of the researchers as described by Erlandson et al., (1993).

Participants had lived in several places; thus, their stories were based on experiences from different parts of the country. The participants stated that participating in the study was a positive experience. It could be noted that the patients who agreed to participate in the study might have a more positive experience of being in the OMT programme than patients who did not participate. The nurses in the outpatient clinic did not recruit patients who had challenges following the guidelines in the OMT programme because it was considered that participating in the study could be stressful for these patients. Patients who struggled following the OMT guidelines may have added further perspectives to the study.

6 | CONCLUSION

The material dimension of dignity containing an aesthetically aspect was important for these patients. Dignity was also experienced as strongly connected to respect. Dignity can be enhanced by treating patients with SUD with understanding and respect, and dignity can be inhibited through stigmatization of patients with SUD, as well as by caregivers' lack of knowledge. The study clarifies a need for more knowledge about SUD among healthcare staff, as well as promotes ethical awareness in encounters with patients regardless of their background. Dignity can be enhanced in encounters when healthcare staff truly wish to get to know the patients and treat each individual patient as a unique human being.

7 | RELEVANCE TO CLINICAL PRACTICE

This study contributes to a better insight into the meaning of dignity for patients with SUD. These patients have a widespread and complex need for nursing, and it is challenging to develop a care service who attends to all their needs. Knowledge of patients with SUD experience of dignity and increased ethical awareness among healthcare staff can make healthcare staff more aware of their own attitudes and make it possible to be more considerate in encounters with patients with SUD. This can contribute to healthcare staff having a holistic approach to patients with SUD and preserve the patient's dignity by providing a service suited for each patient's individual needs.

CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

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REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*, 5th ed. Washington, DC: American Psychiatric Association.

Anstice, S., Strike, C. J., & Brands, B. (2009). Supervised methadone consumption: Client issues and stigma. *Substance Use & Misuse*, *44*, 794–808. https://doi.org/10.1080/10826080802483936

Biong, S., & Ytrehus, S. (2012). *Helsehjelp til personer med rusproblemer [Health care for people with substance use disorders]*. Oslo, Norway: Akribe.

Clausen, T. (2014). Hvor Godt Virker LAR, Og Hva Er utfordringene? [how Well does OMT Work, and What is the challenges?] *Norsk Farmaceutisk Tidsskrift*, *10*, 39–42.

Edlund, M., Lindwall, L., Post, I., &Lindström, U. Å. (2013). Concept determination of human dignity. *Nursing Ethics*, *20*(8), 851–860. https://doi.org/10.1177/0969733013487193

Eriksson, K. (1995). *Det lidende menneske [The suffering human being]*. Oslo, Norway: TANO.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). *Doing naturalistic inquiry : A guide to methods*. Newbury Park, CA: Sage.

(2018). *European drug report 2018: Trends and developments*. Luxembourg: Publications Office. http://www.emcdda.europa.eu/publications/edr/trends-developments/2018_en

Flöjt, J., Hir, U. L., & Rosengren, K. (2014). Need for preparedness – nurses' experiences of professional development in home health care. *Home Health Care Management & Practice*, *26*(4), 223–229. https://doi.org/10.1177/1084822314527967

Ford, R. (2011). Interpersonal challenges as a constraint on care: The experience of nurses' care of patients who use illicit drugs. *Contemp Nurse*, *37*(2), 241–252. https://doi.org/10.5172/conu.2011.37.2.241

Ford, R., Bammer, G., & Becker, N. (2008). The determinants of nurses' therapeutic attitude to patients who use illicit drugs and implications for workforce development. *Journal of Clinical Nursing*, *17*(18), 2452–2462. https://doi.org/10.1111/j.1365-2702.2007.02266.x

Furåker, C. (2012). Registered Nurses' views on competencies in home care. *Home Health Care Management & Practice*, *24*(5), 221–227. https://doi.org/10.1177/1084822312439579

Gadamer, H.-G. (1989). *Truth and method* (2nd, rev. ed. translation revised by Joel Weinsheimer and Donald G. Marshall ed.). London, UK: Sheed & Ward.

Gilchrist, G., Moskalewicz, J., Slezakova, S., Okruhlica, L., Torrens, M., Vajd, R., & Baldacchino, A. (2011). Staff regard towards working with substance users: A European multi-centre study. *Addiction*, *106*(6), 1114–1125. https://doi.org/10.1111/j.1360-0443.2011.03407.x

Gjersing, L., Waal, H., Caplehorn, J. R. M., Gossop, M., & Clausen, T. (2010). Staff attitudes and the associations with treatment organisation, clinical practices and outcomes in opioid maintenance treatment. *BMC Health Services Research*, *10*, 194. https://doi.org/10.1186/1472-6963-10-194

Go, F., Dykeman, M., Santos, J., & Muxlow, J. (2011). Supporting clients on methadone maintenance treatment: A systematic review of nurse's role. *Journal of Psychiatric and Mental Health Nursing*, *18*(1), 17–27. https://doi.org/10.1111/j.1365-2850.2010.01628.x

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon & Schuster.

Granerud, A., & Toft, H. (2015). Opioid dependency rehabilitation with the opioid maintenance treatment programme—a qualitative study from the clients perspective. *Substance Abuse Treatment, Prevention and Policy*, *10*(1). https://doi.org/10.1186/s13011-015-0031-4

Grönroos, E., & Perälä, M. L. (2008). Self-reported competence of home nursing staff in Finland. *Journal of Advanced Nursing*, *64*(1), 27–37. https://doi.org/10.1111/j.1365-2648.2008.04747.x

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Howard, M. O. C., & Sulki, S. (2000). Nurses' attitudes toward substance misusers. I. Surveys. *Substance Use & Misuse*, *35*(3), 347–365. https://doi.org/10.3109/10826080009147701

Howard, V., & Holmshaw, J. (2010). Inpatient staff perceptions in providing care to individuals with co-occurring mental health problems and illicit substance use. *Journal of Psychiatric and Mental Health Nursing*, *17*(10), 862–872. https://doi.org/10.1111/j.1365-2850.2010.01620.x

Johansson, L., & Wiklund-Gustin, L. (2016). The multifaceted vigilance – nurses' experiences of caring encounters with patients suffering from substance use disorder. *Scandinavian Journal of Caring Sciences*, *30*(2), 303–311. https://doi.org/10.1111/scs.12244

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing*, 2nd ed. Los Angeles, CA: Sage.

Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2011). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. *Addiction*, *107*, 39–50. https://doi.org/10.1111/j.1360-0443.2011.03601.x

Macdonald, M. (2007). Origins of difficulty in the nurse-patient encounter. *Nurs Ethics*, *14*(4), 510–521. https://doi.org/10.1177/0969733007077885

Malterud, K. (2011). *Kvalitative metoder i medisinsk forskning: En innføring [Qualitative methodes in medical research: An introduction]*. Oslo, Norway: Universitetsforl.

Michaelsen, J. J. (2012). Emotional distance to so-called difficult patients. *Scandinavian Journal of Caring Sciences*, *26*(1), 90–97. https://doi.org/10.1111/j.1471-6712.2011.00908.x

Morse, J. M. (1997). *Completing a qualitative project : Details and dialogue*. Thousand Oaks, CA: Sage Publications.

National Institute for Alcohol and Drug Research. (2013). *Rusmidler i Norge 2013 [Drugs in Norway 2013]*. Retrieved from http://www.sirus.no/wp-content/uploads/2014/12/Rusmidler_i_Norge2013.pdf

Nordenfelt, L. (2004). The varieties of dignity. *Health Care Analysis*, *12*(2), 69–81; discussion 83–89. https://doi.org/10.1023/B:HCAN.0000041183.78435.4b

Norwegian Directorate of Health. (2013). *Veileder for utlevering av substitusjonslegemiddel i og utenfor LAR (legemiddelassistert rehabilitering) (Veileder IS-2022) [Guidelines for administration of OMT- drugs in and outside the OMT- program]*. Oslo, Norway: Helsedirektoratet.

Nygren Zotterman, A., Skär, L., Olsson, M., Söderberg, S., & Zotterman, A. N. (2015). District nurses' views on quality of primary healthcare encounters. *Scandinavian Journal of Caring Sciences*, *29*(3), 418–425. https://doi.org/10.1111/scs.12146

Peckover, S., & Chidlaw, R. G. (2007). Too frightened to care? Accounts by district nurses working with clients who misuse substances. *Health and Social Care in the Community*, *15*(3), 238–245. https://doi.org/10.1111/j.1365-2524.2006.00683.x

Senter for rus- og avhengighetsforskning (SERAF). (2014). *Helseforetakene – et godt sted å være? [Norwegian Centre for Addiction Research: Hospital Trust - a good place to be?]*. Retrieved from: http://www.med.uio.no/klinmed/forskning/sentre/seraf/publikasjoner/rapporter/2014/statusrapport-2013.html

Senter for rus- og avhengighetsforskning (SERAF). (2017). *Statusrapport 2016 - Er kvalitetsforbedring nå viktigere enn kapasitetsutvikling? [Norwegian Centre for Addiction Research: Rapport of status 2016 - Are quality improvement more important than capacity development?]* Retrieved from: https://www.med.uio.no/klinmed/forskning/sentre/seraf/publikasjoner/rapporter/2017/seraf-rapport-nr-2-2017-statusrapport-2016.pdf

Senter for rus- og avhengighetsforskning (SERAF). (2018). *Statusrapport 2017 - LAR 20 år. [Norwegian Centre for Addiction Research: Rapport of status 2017 - OMT in Norway 20 years]*. Retrieved from: https://www.med.uio.no/klinmed/forskning/sentre/seraf/publikasjoner/rapporter/2018/seraf-rapport-nr-3-2018-statusrapport-2017.pdf

Statistisk sentralbyrå (SSB). (2017). *Nøkkeltall for befolkning [Statistics Norway (2017) Key figures for the population]*. Retrieved from https://www.ssb.no/befolkning/nokkeltall/befolkning

United Nations Office on Drugs (UNODC). (2017). *World Drug Report 2017*. https://www.unodc.org/wdr2017/index.html

United States Department of Health and Human Services (HHS). (2015). Opioid Abuse in the United States and Department of Health and Human Services Actions to Address Opioid-Drug-Related Overdoses and Deaths. *Journal of Pain & Palliative Care Pharmacotherapy*, *29*(2), 133–139. https://doi.org/10.3109/15360288.2015.1037530

van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorder and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence*, *131*, 23–35.

van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2014). Comparing stigmatising attitudes towards people with substance use disorder between the general public, GPs, mental health and addiction specialist and clients. *International Journal of Social Psychiatry*, *61*:539–549. https://doi.org/10.1177/0020764014562051

Wiklund, L. (2008a). Existential aspects of living with addiction - part I: Meeting challenges. *Journal of Clinical Nursing*, *17*(18), 2426–2434. https://doi.org/10.1111/j.1365-2702.2008.02356.x

Wiklund, L. (2008b). Existential aspects of living with addiction - part II: Caring needs. A hermeneutic expansion of qualitative findings. *Journal of Clinical Nursing*, *17*(18), 2435–2443. https://doi.org/10.1111/j.1365-2702.2008.02357.x

World Medical Association Declaration of Helsinki. (2013). Ethical principles for medical research involving human subjects. *JAMA*, *310*(20), 2191. https://doi.org/10.1001/jama.2013.281053

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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