MORAL DISTRESS, ASSOCIATIVE STIGMA, AND THE CRISIS OF LEGITIMACY FOR MENTAL HEALTH PROFESSIONALS

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by

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CHAPTER I

INTRODUCTION

In early 2020, 52.9 million adults in the United States (U.S.) reported experiencing a mental illness (Substance Abuse and Mental Health Services Administration (SAMHSA) 2021). This number increased by approximately 9 percent a year later due to economic uncertainty, job loss, illness, and isolation associated with the coronavirus 19 (COVID-19) pandemic (National Institute of Mental Health 2023). Although the federal COVID-19 public health emergency ended in 2023, the pandemic continues to have a significant impact on mental health (MH) (Centers for Disease Control and Prevention (CDC) 2023). According to the KFF/CNN MH in America Survey, 90 percent of the U.S. adult population now believe that our country is facing a MH crisis (Lopes et al. 2022). Symptoms of depression and anxiety, suicide rates, drug overdoses, alcohol-induced mortality, and MH issues in children and teenagers all increased during the pandemic (Lopes et al. 2022; National Alliance of Mental Illness (NAMI) 2023). Recent studies also show that 164 million people live in a designated mental health professional (MHP) shortage area and do not have access to care (NAMI 2023). These issues are clearly concerning, but one could argue that the U.S. was facing a MH crisis long before COVID-19 began.

In 2017, when I first started my dissertation research, over 56 percent of people with a mental illness were not seeking out behavioral health treatment, and 2 in 5 adults (i.e., 13.5 million) with a psychiatric disorder could not afford the cost of care (Bose et al. 2018). Suicide

rates had also increased by more than 30 percent between 1999 and 2016, and drug overdoses had quadrupled from 2000 to 2017 (Bose et al. 2018; Planalp and Lahr 2018; Wilson et al. 2020). Psychiatric service users were still being stigmatized as well. For example, individuals with a mental illness were being portrayed as dangerous, incompetent, violent, frightening, and unpredictable (Phelan et al. 2000; Martin et al. 2000; Corrigan and Kleinlein 2005; Schomerus et al. 2012). They were also more likely to be unemployed and to become homeless (Corrigan and Kleinlein 2005).

On the provider side of the equation, only 4 percent of medical students were applying for residency training in psychiatry prior to the pandemic, portending a shortage of 14,280 to 31,109 psychiatrists by 2025 (Weil 2015; Satiani et al. 2018). MH units were experiencing lower overall staffing levels in comparison to other specialty areas as well. This shortage was and continues to be problematic because studies show that a dearth of providers leads to absenteeism, tardiness, litigation, and turnover (Firth and Britton 1989; Seccombe and Ball 1992; Tully 2004). Staff shortages can also have both physical and psychological consequences for MHPs. Specifically, stress from understaffing has been associated with apprehension, depression, decreased self-esteem, irritability, poor sleep, increased smoking and alcohol consumption, elevated blood pressure, weight gain or loss, gastrointestinal disorders, and coronary heart disease (Maslach 1982; Sullivan 1993; Nolan, Cushway, and Tyler 1995; Snelgrove 1998; Burnard et al. 2000; Edwards et al. 2000; Kipping 2000; McVicar 2003; Jenkin and Elliott 2004; Currid 2009).

Moreover, the literature suggests that MHPs have few social supports and are more likely to experience burnout (often conceptualized as emotional exhaustion) (Tummers et al. 2001; Sahraian et al. 2008). Scholars have attributed higher burnout rates to working with aggressive

and suicidal patients who have a limited chance of sustaining remission and living a normal life (Cronin-Stubbs and Brophy 1985; Landeweerd and Boumans 1988; Cushway et al. 1996; McLeod 1997; Melchior et al. 1997). According to Melchior and colleagues (1997), this can lead to an imbalance between efforts and rewards and become a stressor for MHPs who may have unrealistic expectations for the rehabilitation of their patients. Brown et al. (1995) argues that not being recognized by colleagues and supervisors, due to the lack of social support, can lead MHPs to experience burnout as well. Finally, studies have shown that MHPs are exposed to associative stigma due to their patient population (Verharghe and Bracke 2012). This stigma causes MHPs to be portrayed as neurotic, unable to maintain professional boundaries, drug or alcohol addicted, rigid, controlling, mentally ill, comically inept, uncaring, self-absorbed, and foolish (Rosen et al. 1997; Edney 2004; Halter 2008).

In short, there has long been a MH crisis in the U.S., with implications for both those suffering from mental illness and the providers who care for them. Unfortunately, it wasn't until the pandemic that conversations about mental illness began happening in earnest. For example, MH themes in the media have doubled since the beginning of COVID-19 (Goswami 2023). Broadcasting networks, universities, researchers, workplace organizations, and the government focus most of their attention on the needs of people with a mental illness. Less is paid to the needs of MHPs who play a pivotal role within our MH delivery system. Thus, in order for healthcare organizations to retain current employees, recruit new workers, reduce organizational expenditures, and ensure quality patient care, it's vital to conduct research that examines the issues that MHPs face in their line of work (Firth and Britton 1989; Seccombe and Ball 1992; Tully 2004).

Using 48 semi-structured interviews with psychiatrists (n=3), MH nurse practitioners

(NP) (n=21), and MH registered nurses (RN) (n=24), my dissertation sheds light on the struggles that MHPs encounter as they navigate working in a historically devalued specialty. Specifically, I examine how MHPs perceive and manage stigma. I also explore how MHPs navigate their professional status when they have larger organizational and institutional pressures that delegitimize their work. Although my data was collected in 2018, the topics I discuss below fill gaps in that literature that I argue are potentially even more important post COVID-19 pandemic. My hope is that my findings push other scholars and members of society to turn their attention toward MHPs to address the MH crisis from a provider standpoint.

Before launching into my dissertation, I will outline the demographic characteristics of several MH occupations (i.e., psychiatrists, NPs, and RNs) in the U.S. to help contextualize my sample. Then, I will discuss key highlights in the development of the field of psychiatry. This subsection will offer important context for the rest of the dissertation, but I am in no way a historian. There have been entire books written on the history of psychiatry (see Harrington 2019); therefore, key details may be missing from my recounting. Afterward, I will briefly discuss associative stigma, moral distress, and interprofessional dynamics. This literature will offer background information for chapters III through V. Please note, however, that I provide a more detailed discussion on these topics in the empirical chapters below. Finally, I end this introduction with an outline of the chapters that follow.

Who Are Mental Health Workers?

The MH delivery system is run by a range of behavioral health specialists (i.e., psychiatrists, psychologists, NPs, physician assistants (PA), RNs, counselors, therapists, social workers, recovery coaches, etc.) (U.S. Government Accountability Office 2022). Social workers represent the largest MH occupational group (e.g., over 200,000) followed by nurses (American

Psychiatric Nurses Association (APNA) 2019; National Association of Social Workers 2024). There are approximately 154,000 MH RNs in the U.S., and the median age is 51 (APNA 2019; APNA 2022). Interestingly, there are fewer MH RNs between the ages of 20 and 29 when compared to national RN samples. This suggests that younger nurses are less likely to enter the psychiatric specialty. MH RNs also have a different sexual and racial composition in comparison to the general nursing workforce. For example, approximately 87 percent are female, and 12 percent are male. The national average is 9 percent for male RNs which shows that there are slightly more male nurses in MH. In regard to race, approximately 77 percent of MH RNs are white, 13 percent are Black, and 6 percent are Asian. When compared to the U.S. nursing population, 81 percent are white, 6 percent are Black, and 7 percent are Asian. Thus, the proportion of Black MH RNs is double the national average (APNA 2022).

If we turn our attention to NPs, the literature shows that there are 25,025 with a MH certification (AANP 2024). The average age of a MH NP is 54 which is 5 years older than the overall NP population. In regard to sex composition, 88 percent of MH NPs are female, and 10 percent are male. These percentages are similar to general NP samples. In addition, 80 percent of MH NPs are white, and 10 percent are Black. Only 8 percent of the national NP workforce are Black which means that there are slightly more Black MH NPs. MH NPs are more likely to hold a Doctor of Nursing Practice (DNP) (i.e., 17 percent) in comparison to the general NP population (i.e., 15 percent) as well (APNA 2022).

Looking at psychiatrists, there are approximately 26,500 in the U.S. (U.S. Bureau of Labor Statistics 2022). The average age of a psychiatrist is 55, and they represent the third oldest age group of physicians in medicine (Johnson 2022). Fifty-seven percent of psychiatrists are also female whereas 43 percent are male. This means that females are more likely to choose

psychiatry as a specialty in comparison to males. A similar trend is seen in family medicine, pediatrics, and obstetrics/gynecology (American Medical Association 2015). There are no clear statistics on the breakdown of psychiatrists by race/ethnicity.

A Subspecialty in Crisis

This subsection provides key highlights in the development of the field of psychiatry. In particular, it provides important historical context that will help readers to better understand why the field of psychiatry has been devalued and delegitimized for centuries and how this ultimately impacts MHPs.

Evil spirits, gods, witches, demons, and the devil were once believed to be the source of mental illness. To treat an afflicted person, early cultures relied on exorcisms, trephination, flogging, relics, chanting, holy water, and prayer (Harrington 2019). By the 16th century, hospitals and monasteries were converted into asylums to house people with psychiatric disorders. Unfortunately, facilities, such as Bedlam (i.e., Bethlam hospital), were often overcrowded, and patients were chained up, beaten, and treated like animals (Lafrance and McKensie-Mohr 2013; Casale 2016). The 18th and 19th centuries attempted to make asylums more habitable places through the moral treatment movement and the mental hygiene movement which both encouraged MH institutions in the U.S. and elsewhere to interact with patients, remove their shackles, and improve their living quarters. Despite making these changes, however, asylums failed to offer any promising MH treatment options during this time (Harrington 2019).

In the early 1900s, alienists (i.e., psychiatrists) started to experiment with ways to overcome psychosis by using malaria fever treatment, sterilization, insulin induced comas, Metrazol shock treatment, lobotomies, and electroconvulsive therapy (ECT). In specific cases,

psychiatrists would surgically remove organs that they believed were "infected." Many of these treatment options were inhumane and barbaric, and some caused individuals with a mental illness to die. By 1946, the American MH Act was implemented to provide states with federal support for MH research and professional training. This was the first time that MH started to take more precedence, on a societal level, to prepare MHPs for post-World War II needs (Harrington 2019).

The clinically based biopsychosocial model was dominant among psychiatrists from 1945 until the mid-1970s. This school of thought believed that homosexuality, autism, and schizophrenia were the direct result of overprotective, seductive, cold, and permissive mothers (Lafrance and McKensie-Mohr 2013; Harrington 2019). They also believed that mental illness pertained to "problems in living" such as bad neighborhoods, families, and cultures (Harrington 2019:118). During this same time, the DSM-I and DSM-II were being used by psychiatrists to serve as a guide to treat MH patients. Unfortunately, both DSM editions had "dismal" inter-rater reliability and used "ambiguous criteria" to categorize psychiatric disorders (Wilson 1993; Mayes and Horwitz 2005; Lafrance and McKensie-Mohr 2013:121). As a result, the inconsistencies in the DSM ultimately led the field of psychiatry to experience a crisis of legitimacy on multiple fronts (e.g., scholars).

Scholars.

In the 1960s and 1970s, the field of psychiatry came under fire by scholars such as Szasz (1961), Goffman (1961), Foucault (1967), Scheff (1966), and Rosenhan (1973). Szasz (1961) was a part of the libertarian right who believed that mental illness was a "myth" because there was no biological pathology. He argued that psychiatric labels gave professionals the ability to infringe on the civil liberties of others and control people who were unwilling to conform.

Writing in the same decade, Goffman (1961) believed that mental hospitals resembled prisons and concentration camps more than medical facilities. He suggested that patients lost their personal autonomy and were unable to resist treatment for fear that it would reinforce their mental ineptitude. In addition, Foucault (1967) claimed that mental illness was developed from complex power relations which sought to silence people who displayed nonconforming viewpoints while Scheff (1966) indicated that psychiatric labels were used as a guise for deviant behavior. Although psychiatrists at the time tried to brush off these criticisms, Rosenhan's (1973:12) research made it clear that MHPs could not "distinguish the sane from the insane in psychiatric hospitals." Specifically, in his first study, 9 "sane" people were admitted into a psychiatric hospital for symptoms that had never been reported in the literature. Each participant was noted as "acting normal" while hospitalized, but they were diagnosed with "schizophrenia in remission" upon being released. In Rosenhan's (1973) second, more informal study, a hospital that had heard about his initial research asked him to send pseudopatients to determine if they could identify them. Staff at the hospital identified 41 people they felt were pseudopatients, but Rosenhan (1973) never sent anyone. The claims of Rosenhan, Goffman, Szasz, and others reflect the changes in cultural attitudes and beliefs about the treatment of people with a mental illness in the U.S. in the 1960s. This coincided—perhaps not surprisingly—with the push for deinstitutionalization (Harrington 2019). As famously portrayed in the dramatic film, *One Flew Over the Cuckoo's Nest* (1975), mental facilities were increasingly viewed as prisons, psychiatrists as "mental police," and staff as prison orderlies.

Creating the DSM-III

Although the criticisms above encouraged psychiatry to reassess their diagnostic blind spots, the inclusion of homosexuality, as a mental illness in the DSM-II, ultimately served as a

major catalyst in the development of the DSM-III. From 1970 to 1973 gay rights organizations protested at the yearly American Psychological Association (APA) convention. These activists relentlessly questioned the disease status of homosexuality and put pressure on psychiatrists to change the way they defined psychiatric disorders (Harrington 2019). Robert Spitzer was charged with leading the committee on homosexuality, and he concluded that "for a behavior to be termed a psychiatric disorder it had to be regularly accompanied by subjective distress and/or some generalized impairment in social effectiveness of functioning" (Bayer 1981:127). Many gay individuals did not meet this criterion; therefore, the APA Board of Trustees voted to remove homosexuality from the DSM-II in 1973 (Harrington 2019). This public debate prompted Melvin Sabshin, the APA's medical director, to push for a third revision of the DSM that was spear headed by Spitzer (for the ins and outs on how the DSM-III was made see Decker 2013).

Once the DSM-III was completed in 1980, it was hailed as a "victory for science" because it transitioned away from a biopsychosocial model toward a biomedical model that integrated neuroscience, brain chemistry, and medications (Mayes and Horwitz 2005; Lafrance and McKensie-Mohr 2013; Harrington 2019:135). The new diagnostic framework also placed value on symptoms instead of causes, and it had greater inter-rater reliability compared to the DSM-II. For example, in order for psychiatrists to establish that a patient was mentally ill, patients were required to have a minimum number of symptoms from a checklist (Harrington 2019). The DSM-III gave stakeholders (i.e., healthcare workers, insurance and pharmaceutical companies, and the government) a reason to realign their interests with the field of MH and view psychiatry as a legitimate specialty as well.

The State of the Field Today

It's been 44 years since the DSM-III was first released and although psychiatrists were

optimistic that pharmaceutical drugs and the new diagnostic criteria in the DSM-III (and later the DSM IV) would bring about a revolution in MH treatment, the DSM was not the panacea clinicians had hoped for. The DSM-5 which was published in 2013 and revised in 2022, was meant to create a "grand… paradigm shift in psychiatric diagnosis, based… on the identification of biological markers" (Harrington 2019:278). According to Tom Insel, the director of the National Institute of Mental Health from 2002 to 2015, "biology… never read it" (Belluck and Carey 2013). The science wasn't there to support the biology of psychiatric disorders, and there had been no new findings on biomarkers. This lack of progress has led to several issues (e.g., less money for psychiatric drug development and stigma) that will be discussed below.

Less money for psychiatric drug development.

Although pharmaceutical companies make billions of dollars each year on anti-depressant and antipsychotic drugs, less money is now invested in the development of new psychiatric medications (Sharfstein 2005; Harrington 2019). Specifically, large corporations (AstraZeneca, GlaxoSmithKline, etc.) are finding that DSM checklists are problematic because two people can be diagnosed with an identical disorder without sharing the same symptoms. Thus, when drug companies conduct clinical trials, participants with the same mental illness have vastly different medication responses. If pharmaceutical companies can't determine which individuals would benefit from their drug, then they can't market it to the public. Pharmaceutical companies are also being limited by the European Medicines Agency which requires that all new MH drugs outperform placebos and existing medications. Hence, some corporations have turned their resources toward developing drugs for other areas of medicine (Harrington 2019).

In short, MHPs do their clinical work in a context where there is often no pharmaceutical "magic bullet" that will cure patients of their illness or where pharmacological treatments are

unavailable or prohibitively expensive. MHPs must find ways to legitimize their work within these conditions of uncertainty, something that is made all the more difficult by the stigma that both patients and providers carry in medical settings and beyond.

Stigma.

MHPs and psychiatric service users continue to face negative cultural perceptions from multiple sources. For example, educators, students, and healthcare providers describe psychiatry as the least respected and least attractive specialty (Happell et al. 2013). Studies also show that conditions "having no specific bodily location" such as anxiety, depression, and schizophrenia ranked among the least prestigious in comparison to a heart attack, leukemia, a brain tumor, and testicular cancer (Album and Westin 2008:182). In addition, the media has a lot of influence over how people think and behave. When broadcasting networks use exaggerated, inaccurate, and comical images of individuals with a mental illness, they contribute to MH stigma (Wahl 1995). Even public education campaigns, that are meant to address stigma, have actually done the opposite in some cases. Research shows that MH campaigns can "provoke harsher behavior toward an individual with mental illness… imply[ing] that people with mental illness are… different or less human… [and they] strengthen [the] dangerousness stereotype" (Read et al. 2006:313).

When patients carry this stigma, the toll on MHPs is notable. Providers must manage the associative stigma of caring *for* socially "marked" individuals, but they also face the emotional toll of caring *about* patients who are often mistreated and ignored by the medical system and society writ large (Goffman 1963). As a result, MHPs are susceptible to feeling stigma as well as a sense of moral distress. Fortunately, MHPs and their patients are finding ways to cope with stigma, and Thoits (2011) provides scholars with a framework to understand stigma coping

strategies.

Associative Stigma

There is a significant body of literature that examines the people and groups who experience stigma (Corrigan and Kleinlein 2005; Mahajan et al. 2008; Parcesepe and Cabassa 2014; Grittner and Walsh 2020). Although it is important to understand how these individuals are impacted for holding a discredited attribute, Goffman (1963:30) argues that "the problems faced by stigmatized persons spread out in waves of diminishing intensity among those they come in contact with." This idea is referred to as "courtesy stigma" (Goffman 1963), "associative stigma" (Mehta and Farina 1988), or "stigma by association" (Goldstein and Johnson 1997). For the purposes of this dissertation, I will use the term associative stigma.

The associative stigma literature primarily focuses on informal (i.e., non-paid) and formal (i.e., paid) caregivers who have a direct link to a stigmatized person. Research on non-paid caregivers often examines family members (e.g., parents, siblings, spouses, etc.) who care for individuals with genetic disorders, autism, a disability, or a mental illness (Struening et al. 2001; Gray 2002; Green 2003; Corrigan and Miller 2004; Turner et al. 2007; Mak and Cheung 2008). These studies show that informal caregivers report several penalties due to their connection with a discredited individual such as a loss of status and strained relationships (Green 2003; Corrigan and Miller 2004; Mak and Cheung 2008; Van Der Sanden et al. 2016).

The literature on formal caregivers focuses on healthcare professionals who provide services to people who seek out abortions, take part in sex work, or are diagnosed with HIV/AIDS or a mental illness (Snyder, Omoto, and Crain 1999; Harber, Roby, and High-George 2011; Harris et al. 2011; Phillips et al. 2012; Phillips and Benoit 2013; Treloar et al. 2015; Buertey, Attiogbe, and Aziato 2020; Waddell et al. 2020). For example, Harris and colleagues

(2011) found that doctors who conducted abortions were reluctant to talk about their job in public settings due to the stigma and political polarity that they faced. In another study, Snyder and colleagues (1999) found that volunteers who treated AIDS patients had less social support and greater job turnover than hospice volunteers.

There are very few studies that analyze the associative stigma of MHPs, and the existing research has several limitations (Verhaeghe and Bracke 2012; Catthoor et al. 2014; Yanos et al. 2017; Liyanage et al. 2018; Vayshenker et al. 2018; Lin 2019; Picco et al. 2019; Buertey, Attiogbe, and Aziato 2020; Waddell et al. 2020). For example, all but two studies on the associative stigma of MHPs were conducted outside of the United States. According to Yang and colleagues (2007:1528), "the meanings, practices, and outcomes of stigma differ across cultures." Thus, it's possible that there are differences in how MHPs experience associative stigma depending on their geographical location. In addition, 2 out of the 9 studies employed quantitative methods and none of them examined NPs who play a significant role in the MH delivery system within the United Sates. Chapter III seeks to address these gaps.

Moral Distress

Jameton (1984:6) argues that moral distress occurs when "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action." Wilkinson (1988:16) reworked this definition by suggesting that moral distress was a "psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision." This conceptualization of moral distress surfaced in the current study for MHPs after directly or indirectly witnessing the stigma that their MH patients face and during care situations with clients who have a mental illness.

Studies on moral distress tend to focus on physicians, NPs, nurse anesthetists, RNs, pharmacists, rehabilitation therapists (i.e., occupational and speech), respiratory therapists, social workers, police officers, paramedics, and firefighters (Sporrong et al. 2005; Laabs 2005; Hamric and Blackhall 2007; Brazil, Kassalainen, and Marshal 2010; Radzvin 2011; Trautmann et al. 2015; Mänttäri-van der Kuip 2016; Henrich et al. 2016; Prentice et al. 2016; Fantus et al. 2017; Corradi-Perini, Beltrao, and Vargas de Casto Oliveira Ribeiro 2021; Lentz et al. 2021). For example, pharmacists in Sweden reported moral distress when they had to pick between administrative and care-related tasks as a result of understaffing and/or inadequate time (Sporrong et al. 2005). Similarly, social workers in Finland experienced moral distress due to insufficient resources on the part of their collaborating service providers, budget constraints, and work overload (Mänttäri-van der Kuip 2016). The majority of the literature on moral distress examines RNs, however. These studies are often conducted on neonatal and pediatric intensive care units, medical surgical floors, palliative care units, oncology wards, and the emergency department (Corley et al. 2005; Pauly et al. 2009; Cavaliere et al. 2010; Huffman and Rittenmeyer 2012; Fernandez-Parsons, Rodriguez, and Goyal 2013; Wolf et al. 2015; Oh and Gastmans 2015; Lamiani, Borghi, and Argentero 2015; Henrich et al. 2016; Atashzadeh-Shoorideh et al. 2001; Salari et al. 2022). Research on RNs also show that moral distress can occur when there is short staffing, incompetent colleagues, limited resources, and poor nurse-physician collaboration (Wilkinson 1987; Corley et al. 2005; Lamiani, Borghi, and Argentero 2015; Oh and Gastmans 2015).

There are few studies that investigate the moral distress of MHPs, with some notable exceptions (Ohnishi, Asai, and Akabayashi 2003; Austin, Bergum, and Goldberg 2003; Sturm 2004; Austin et al. 2008; Deady and McCarthy 2010; Musto and Schreiber 2012; Ohnishi et al.

2010; Hamaideh 2014; Ando and Kawano 2016; Upasen and Saengpanya 2021; Upasen et al. 2021; Shehadeh et al. 2022; Tavakol et al. 2023). This gap is discussed in the literature (Oh and Gastmans 2015; Lamiani, Borghi, and Argentero 2015; Rodney 2017). Of the existing research on MHPs, none include NPs and all but two were conducted outside of the United States. Chapter IV will speak to these gaps in the literature.

Interprofessional Dynamics in Mental Health Care: The Case of the Nurse Practitioner

As noted earlier in this chapter, there are a number of different professional groups who provide MH care in the U.S. such as psychiatrists, psychologists, RNs, social workers, and counselors. More recently, NPs have emerged as central to the provision of care, in MH contexts and in medicine more generally. In the 1960s the U.S. healthcare system was experiencing a shortage of primary care doctors due to the baby boom and the formation of Medicare and Medicaid (Fairman 2008; Silver, Ford, and Steady 1967). To address this issue, graduate programs and licensure exams were developed to create the NP occupation (American Association of Nurse Practitioners (AANP) 2023). Today, 27 states and the District of Columbia grant NPs full practice rights, and they can be certified in 6 primary areas (i.e., family, pediatrics, gerontology, psychiatry, neonatal, and women's health) (AANP 2022). There are also 385,000 NPs in the U.S. (AANP 2024).

NPs can perform similar tasks (e.g., assessing patients, making diagnoses, providing treatment, prescribing medications, etc.), and the same quality of care as physicians. For example, the literature consistently shows that patients who receive treatment from NPs have largely the same outcome as those who see doctors (DesRoches et al. 2017; Buerhaus et al. 2018). Hence, as NPs take on more of the work responsibilities once held by physicians, they arguably threaten the status of doctors who sit at the top of the medical hierarchy. Historically

speaking, nurses were restricted from conducting certain tasks without a physician's order (Freidson 2001). Now, jurisdictional boundaries are changing between doctors and NPs and this is creating interprofessional conflict (Abott 1988). It's also making it difficult for NPs to gain professional legitimacy when medical organizations continue to lobby against scope of practice expansions.

LaTonya Trotter, in her book *More than Medicine* and other published work, examines the experiences of NPs through a sociological lens (Trotter 2019; Trotter 2020). Trotter explores the jurisdictional boundary issues between doctors and NPs who work in an outpatient clinic for the elderly. Her findings demonstrate that doctors struggle and often resist working collaboratively with NPs. Doctors also deny job interchangeability with NPs, refuse to do the work of an NP, and make it known that NPs are skilled subordinates. Doing so helps them to maintain their status at the top and ensure that they have "cultural and political power to resist change" (Trotter 2020:4101). Unfortunately, there are no studies in the literature that discuss MH NPs in this context. Chapter V sheds light on this topic and connects it to the crisis of legitimacy that MHPs are currently facing.

Dissertation Framework

Chapter II discusses my research methods. Specifically, I review what led me to my dissertation topic, how participants were recruited, interview and sample information, how my data were analyzed, the validity and rigor of my research, and my positionality statement. In this chapter I include a table that reviews the demographic characteristics of my sample population as well.

Chapter III is titled: "The Impact of Associative Stigma on Mental Health Professionals." In this chapter, I focus on how MHPs are exposed to associative stigma given their patient

population. This concept comes from Mehta and Farina (1988) who based their work on Goffman (1963). I am guided by three questions: (1) how do MHPs experience associative stigma?; (2) how does associative stigma make MHPs feel?; and (3) how do MHPs cope with associative stigma? Most of the data in this section are recollections from respondents about the way they were treated by nursing faculty, classmates, and medical professionals. For example, participants discussed associative stigma situations where they were denied jobs on medical units and told that MH is unscientific and devalued. This chapter also identifies the emotions that arise during associative stigma encounters and the coping strategies MHPs employ. For the coping subsection, I pull from Thoits' (2011) theoretical framework to develop categories for coping. To my knowledge, none of the existing articles on associative stigma and MHPs utilize a theoretical framework on coping. The findings in this chapter are based on semi-structured interviews with psychiatrists, MH NPs, and RNs who work in behavioral health.

Chapter IV is called: "The Moral Distress of Mental Health Professionals." In this chapter, I utilize the moral distress concept which is based on work by Jameton (1984) and Wilkinson (1988). I am guided by three questions: (1) how do MHPs experience moral distress; (2) how does moral distress make MHPs feel?; and (3) how do MHPs cope with morally distressing situations? I show that moral distress can occur when MHPs witness psychiatric service users being stigmatized and while treating MH clients. Thus, moral distress is, in part, a broader implication of stigma in this chapter. I separate moral distress into two subsections: stigma and non-stigma. The findings on stigma-related moral distress focus on substandard care and patient access to non-MH institutions. For non-stigma related moral distress, I examine situations involving inappropriate treatment recommendations, time constraints, and patient death. I also focus on how participants feel during times of moral distress, and the coping

strategies they employ. I base one of my coping categories in this section off of the work of Thoits (2011) discussed below. All data in this chapter are based on semi-structured qualitative interviews with MH NPs and RNs. The small subsample of psychiatrists in my study did not report moral distress.

Chapter V is titled: "The Crisis of Legitimacy for Mental Health Professionals: A Professional, Institutional, and Societal Issue." I am guided by one question: In what way(s) are MHPs struggling to find legitimacy for their specialty given the larger organizational and institutional pressures that delegitimize their work? This chapter contextualizes the stigma faced by MHPs within a larger context of their fight to be recognized as a respected medical specialty. If we seek to combat MH stigma, then it's important to acknowledge the ways that MHPs are struggling to secure legitimacy on a professional, organizational, and societal level. From a professional standpoint, I discuss the jurisdictional boundary issues between psychiatrists and MH NPs (Abbott 1988). In this subsection I show the problems that MH NPs face in their attempt to gain legitimacy for their profession. At an institutional level, I provide examples from participants that show how insurance companies treat mental verse physical health coverage. Finally, from a societal viewpoint I examine the media. Participants discuss how broadcasting networks portray their discipline and how this impacts their ability to gain credibility within healthcare. The information in this chapter is based on semi-structured interviews with psychiatrists, MH NPs, and MH RNs.

In Chapter VI I summarize my findings from all three empirical chapters. I also discuss the similarities and differences between the emotions and coping strategies employed for associative stigma (Chapter III) and moral distress (Chapter IV). I conclude this final chapter by reviewing the contributions and implications for my findings, discussing the limitations of my

study, and providing suggestions for future research. Each one of these chapters helps tell the story of MHPs and sheds light on the unique challenges that they face working in a devalued—yet crucial— medical specialty.

CHAPTER II

METHODOLOGY

Lofland and colleagues suggest that many scholars "start where they are" (2006:9). In other words, they orient their research toward aspects of their personal biography. My specialization in medical sociology and mental health (MH) is directly linked to a childhood experience. At the age of seven, I witnessed a relative having a manic episode. This was my first encounter with mental illness, but as I got older, I repeatedly saw how it affected those around me. When I entered graduate school, my cousin's bipolar disorder influenced me to focus on research that examined the formal (i.e., paid) and informal (i.e., nonpaid) caregivers of the mentally ill. While I was reviewing the broad literature on caregivers for my comprehensive exam, I often had meaningful conversations with my marriage partner about his experiences working in MH as a formal caregiver. It was through these discussions that I sought to understand more about the positives and negatives of being a mental health professional (MHP).

In March of 2017 I began my research on MHPs (Kent State University (KSU) IRB Log Number 17-110: see appendix A). The scientific and scholarly aim of my study was to explore how MHPs navigate the terrain of working in a devalued specialty. Specifically, I wanted to examine how MHPs perceive and manage stigma. I was also interested in how MHPs navigate their professional status when they have larger organizational and institutional pressures that delegitimize what they do. To answer these questions, I developed a study that utilized in-depth qualitative interviews.

Participant Recruitment

Forty-eight MHPs (i.e., psychiatrists, nurse practitioners (NP) with a certification in MH, and registered nurses (RN) who work in MH) were recruited using a gatekeeper (n=28) and snowball sampling (n=20) (Weiss 1994). A gatekeeper is someone who has access to a specific population and helps the researcher gain rapport with potential participants. Nickolas Speeney, my marriage partner, served as the gatekeeper for this study. He has 8 years of experience as an RN in MH, and 6 years as a Doctor of Nursing Practice (DNP) with a MH certification. His work experience and educational background offered him access to MHPs who work in a variety of MH settings (e.g., universities, inpatient federal, state, and private hospitals, outpatient MH services, mental home health services, and MH services in correctional facilities). Nick does not hold a supervisory role vis-à-vis the respondents, and he was approved by the KSU IRB to serve as the gatekeeper for this study.

Nickolas Speeney recruited fifty-eight percent of the sample over the phone, via email, or face-to-face during his lunch breaks, and he followed a premade script that was accepted by the KSU IRB (see appendix B). If an MHP agreed to participate in the study, I was given the respondent's name and preferred method of communication. Once I received this information, I contacted the individual via phone or email to discuss the study and set-up a date, time, and place to conduct an interview (see appendix C and D). Specifically, MHPs were told: (1) what the study was about; (2) what their obligations were; (3) how they would be compensated for their time; and (4) what would happen to their personal information. At the end of each interview, I asked participants whether they knew a psychiatrist, an NP with a MH certification, or an RN in MH who might be interested in the study. Nine of the respondents asked for a recruitment flier (see appendix E) and/or reached out to coworkers, friends, relatives, and past students to

determine if they wanted to be interviewed. Once verbally gaining permission, these 9 individuals sent me the names and contact information of 20 people. After reaching out to potential participants, I discussed the study in detail to ensure that they were making an informed decision. If they still agreed to participate, I set up a date, time, and location for an interview. Approximately 42 percent of the sample was recruited through snowball sampling.

Qualitative Interviews

Data saturation was reached after conducting in-depth interviews with 48 MHPs between March 21, 2018 and November 20, 2018. All study participants were given the option to choose their interview location. Three interviews took place at a participant's home while the remaining 45 were completed over the phone. Interviews were recorded using two digital recording devices in case one malfunctioned. These devices included my personal password protected computer and a voice recorder (see appendix F and G). Interviews lasted between 27 and 142 minutes. The average length was 68 minutes.

Interviews followed a semi-structured guide that consisted of four broad clusters: (1) background information; (2) workplace emotions; (3) societal perceptions; and (4) associative stigma experiences (see appendix H). Each section included several follow-up questions in order to probe for further information. At the end of each interview participants received a $10 Amazon gift card. Six participants chose not to be compensated, and I was awarded $400 from KSU's Graduate Student Senate for participant gift cards.

I transcribed 32 interviews, and a professional transcriptionist completed the remaining 16. Every interview was transcribed verbatim and stored as Word files on my password protected computer. All identifiers were permanently removed from the data during the transcription process. Specifically, I created an excel spreadsheet that contains the real names of participants,

their identifying information, and their assigned pseudonym. Pseudonyms were used within the Word files, and the general location of the study was changed to maintain confidentiality. The professional transcriptionist only had access to a participant's pseudonym. All demographic face sheets were shredded and discarded once the master Excel file was finished. Also, all digital files were erased from my computer and voice recorder after the transcription process was completed.

Sample

Interview participants include 3 psychiatrists, 21 NPs with a MH certification, and 24 RNs (who work in MH) between the ages of 24 and 73. The median age is 44. There are 11 males and 37 females. The majority of the sample is white (n=46), heterosexual (n=45), from the Northeast (n=45), Democrat (n=26), married (n=34), has 1 to 10 years of MH experience (n=28), has a religious affiliation (n=35), and has worked in a specialty outside of MH at some point during their career (n=35). Respondents also worked across a variety of inpatient and outpatient MH environments (i.e., 14 hospital systems, 9 private practice groups, 4 Veterans Affairs (VA) medical centers, 2 community MH clinics, 1 rehab facility, 1 home health organization, and 1 state correctional institution). The demographic breakdown of respondents by occupation is reported in Table 1 below. Participant characteristics are discussed in Table 2 in appendix I.

Table 1. Demographic Characteristics of the Sample Population (N=48)

	Psychiatrists (n=3)	**Nurse Practitioners** (n=21)	**Registered Nurses** (n=24)
Sex			
Female	0	16	21
Male	3	5	3
Sexual Orientation			
Heterosexual	3	20	22
Gay	0	1	1
Bisexual	0	0	1
Race			
Non-Hispanic White	1	21	24

Black	1	0	0
Asian	1	0	0
Age			
24-33	0	4	7
34-43	1	10	6
44-53	1	2	6
54-63	0	3	4
64-73	1	2	1
Marital Status			
Single	1	2	5
Married	2	16	16
Separated	0	0	2
Divorced	0	3	1
Religious Affiliation			
Yes	2	14	19
No	1	6	5
Political Affiliation			
Democrat	1	11	14
Republican	0	5	4
Independent	1	4	1
None	1	1	5
Geographic Location			
Northeast	3	19	23
Midwest	0	1	1
Pacific Southwest	0	1	0
Highest Level of Education			
Associate	0	0	8
Nursing School Diploma	0	0	2
Bachelor	0	0	7
Master	0	8	4
Doctorate	0	13	2
MD/DO	3	0	1
Number of Years in MH			
1-10	1	13	14
11-20	1	4	6
21-30	0	3	2
31-40	1	1	2
Current Clinical Practice Setting			
Inpatient / Prison System	2	3	14
Outpatient / Home Care	0	14	8
Both	1	4	2
Worked Outside of MH Specialty			
Yes	1	18	16
No	2	3	8

Analysis

For this study, I took an inductive approach to analyze the data. What this means is that I did not test theory or start with any preconceived hypotheses. Instead, my analysis is based on emergent themes in the data, and I discerned a pattern and inferred an explanation from the information I collected (Lofland et al. 2006). According to Lofland and colleagues (2006:195), "prior familiarity with other potentially relevant bodies of work, theoretical or empirical, is a necessary condition for developing extensions and refinements" of existing work, but "making those connections should be triggered by one's empirical observations" and data. Although I started my dissertation with knowledge on the stigma and associative stigma literature, my findings on moral distress and jurisdictional boundary work developed by immersing myself in my data and having conversations with my advisor, Dr. Clare Stacey, who pushed me to explore the literature on these sociological ideas.

After each interview was transcribed verbatim, I used a qualitative software program (Atlas.ti) to code, sort, and organize my data. I performed line-by-line coding for 25 interviews. Line-by-line coding allowed me to think about the data in new ways and to see underlying patterns that may be taken for granted. It also helped me determine whether my interview questions needed to be adjusted. Once patterns became apparent, I conducted focused coding based on a refined set of codes. I also completed memos throughout the process which helped me organize the patterns I was observing between the coding and the writing of my findings. The process of coding, recoding, and memoing was repeated until all major themes and relationships were identified (Lofland et al. 2006).

Validity and Rigor

Kirk and Miller (1986) suggest that qualitative research invokes its own procedures for attaining validity that are different than quantitative approaches. For example, Maxwell (1992) developed five categories (e.g., descriptive, interpretive, theoretical, generalizability, and evaluative) for validity that relate to qualitative investigations. My study meets the criteria for descriptive validity which focuses on factual accuracy. "Intersubjective agreement could easily be achieved" through my tape recordings to determine if a participant made a particular statement during an interview (Maxwell 1992:7). I had a robust process for recording, transcribing, and analyzing my data as well which allowed me to present an accurate description in this document. To establish rigor, I also used reflective journaling and peer debriefing (Long and Johnson 2000). I remained reflexive throughout the process of data collection by taking detailed notes after each interview. Writing my thoughts and feelings down after each interview helped me to manage and become more aware of the biases I hold. It also forced me to think like an outsider (Lofland et al. 2006). In addition, Robson (1993:404) describes peer debriefing as "exploring one's analysis and conclusions to a colleague or other peer on a continuous basis." I had countless debriefing sessions with my advisor, Dr. Clare Stacey, over the past several years. She helped me to consider and explore perspectives and explanations at various stages of my dissertation and offered insights into new literature that I had not considered. I also want to note that because over half of the sample was recruited through my marriage partner some participants would say, "oh, I'm sure you know what I mean" or "I'm sure Nick told you about…." When participants made these statements, I reiterated that I wanted them to answer the question from their own point of view. This helped eliminate some bias from the interview process.

Positionality Statement

According to Sultana (2007:380), "it is critical to pay attention to positionality, reflexivity, the production of knowledge, and the power relations that are inherent in research processes in order to undertake ethical research..." For this reason, it is important to discuss the position I have adopted in relation to this research and the sample population. It is undeniable that I hold certain ascribed characteristics that shape my worldview. For example, I am a white female. What this means is that I am a part of a dominant racial group but am considered an "other" in certain contexts due to my sex. During the interview process I was aware of these characteristics and that I would encounter participants who held more or less power than myself. For instance, I have a higher level of education than 60 percent of the respondents that I recruited, and I automatically hold greater power as the interviewer. This means that some participants may have felt intimidated. To alleviate any uneasiness, I was personable throughout each interview and allowed participants to ask questions at any time. Conducting interviews over the phone helped ease some apprehension as well because respondents were unable to determine my demographic characteristics, and they remained "on their own turf (McCoyd and Kerson 2006:399)." There are several limitations that arise from phone interviews, however. For example, there was a loss of nonverbal and contextual data (Novick 2008).

I can relate to MHPs and MH for two reasons: (1) I have a relative who suffers from bipolar disorder and (2) my marriage partner is an MHP. These two relationships bias me to certain ways of thinking about MH work. For example, I hold the assumption that it is difficult to care for and provide treatment to individuals who have a mental illness. Also, I believe that MHPs carry stigma by providing care to psychiatric patients. Thus, in some respects I am "starting where I am" and naturally possess the covert stance or an insider position. The covert stance occurs when a researcher is immersed in the social lives of those being studied. Holding

this position allowed me to develop meaningful interview questions due to holding prior knowledge, but it was disadvantageous because I could have unknowingly biased my data. With that said, I also hold an outsider position (Lofland et al. 2006). I do not have what Adler and Adler (1987) calls "complete membership" because I had to rely on a gatekeeper to gain access to my sample population, and I myself am not an MHP. This was an advantage because participants allowed me to ask questions that insiders may not have been privy to. For example, participants may have been more reluctant to discuss the jurisdictional boundary issues that occur between MHPs (e.g., psychiatrists and NPs) if I myself was an MHP.

CHAPTER III

THE IMPACT OF ASSOCIATIVE STIGMA ON MENTAL HEALTH PROFESSIONALS

In the first chapter of my dissertation, I reviewed key highlights in the development of the field of psychiatry. This information contextualized the unique problems that mental health professionals (MHP) have encountered in their quest to be perceived as a respected medical subfield. One of the problems that I discussed in chapter I is how negative cultural perceptions, from various groups (e.g., scholars, students, educators, healthcare providers, and the media), contribute to mental health (MH) stigma (Szasz 1961; Rosenhan 1973; Wahl 1995; Halter 2008). In this chapter, I extend this conversation on stigma by focusing on how MHPs encounter and are emotionally impacted by associative stigma. In what follows, I will: (1) provide background information on the associative stigma literature; (2) offer empirical evidence that MHPs are experiencing associative stigma; and (3) discuss the feelings and coping strategies that participants experienced due to associative stigma.

INTRODUCTION

Approximately 57.8 million adults and 17.1 million children suffer from a psychiatric disorder in the United States (U.S.) (Merikangas et al. 2010; National Institute of Mental Health (NIMH) 2023). These individuals are often stigmatized because they hold a perceived character deficit (i.e., mental illness) (Goffman 1963). The literature on the stigma of mental illness primarily focuses on: (1) how the general public perceives people with a mental illness (Link et al. 1999; Phelan et al 2000; Martin, Pescosolido, and Touch 2000; Stout et al. 2004; Angermeyer

and Dietrich 2006; Schomerus et al. 2012; Parcesepe and Cabassa 2014) and (2) how MH stereotypes impact psychiatric service users (Link et al. 1997; Corrigan and Kleinlein 2005). For example, despite advancements in MH literacy, the stereotype that individuals with a mental illness are dangerous has endured and even strengthened since 1950 (Phelan et al. 2000). Society also portrays people with a psychiatric disorder as incompetent, violent, frightening, and unpredictable (Phelan et al. 2000; Martin et al. 2000; Corrigan and Kleinlein 2005; Schomerus et al. 2012). These stigmatizing beliefs are problematic because they can influence the personal, social, and economic opportunities that are accessible to psychiatric patients. For instance, individuals labeled with a mental illness are more likely to be unemployed, to live in low-income housing, to become homeless, to receive inadequate medical care, and to be arrested when they show psychotic symptoms (Corrigan and Kleinlein 2005). To cope with the threat of stigma, Thoits (2011) suggests that MH patients utilize: (1) self-stigma; (2) avoidance; (3) self-restoration; (4) challenging; and (5) deflection. Self-stigma means to "accept and internalize" public stereotypes, avoidance implies keeping one's treatment a secret to evade stigma, and self-restoration involves avoiding situations that may lead to failure. In addition, challenging entails fighting against MH stereotypes by overperforming on a difficult task, educating, confronting stigmatizers, and becoming an advocate whereas deflecting happens when someone with a mental illness suggests that they don't reflect stereotypical images or argue that their illness is temporary (Thoits 2011). Other researchers also shed light on these coping strategies (Corrigan and Watson 2002; Thoits and Link 2016; Marcussen and Asencio 2016).

Beyond people with a mental illness, Goffman (1963:42) argues that "individuals who [are] related through the social structure to a stigmatized individual… share some of the discredit of the stigmatized person to whom they are related." This ideology, referred to as "associative

stigma," suggests that the stereotypes directed toward individuals with a mental illness can be directed toward the people they have close connections with. This includes formal (i.e., medical and mental health professionals) and informal caregivers (i.e., parents, siblings, spouses, and children).

Associative stigma research typically examines informal caregivers who help people with disabilities (Green 2003), genetic disorders, (Turner et al. 2007), autism (Gray 2002; Mak and Cheung 2008), and mental illness (Struening et al. 2001; Corrigan and Miller 2004; Mak and Cheung 2008; Van Der Sanden et al. 2016; Tamutiene and Laslett 2016). These studies show that informal caregivers report a loss of status (Mak and Cheung 2008), strained and distant relationships with extended family, friends, and faith communities (Green 2003; Corrigan and Miller 2004; Van Der Sanden et al. 2016), blame for a relative's abnormalities (Corrigan and Miller 2004), and negative interactions with community members (e.g., joking, devaluing remarks, staring, pointing, and intrusive inquiries) (Struening et al. 2001; Gray 2002; Turner et al. 2007) due to their connection with a discredited individual. To cope with these associative stigma experiences family members will educate others, withdrawal socially, conceal imperfections, and adopt an indifferent attitude (Corrigan and Miller 2004; Turner et al. 2007; Tamutiene and Laslett 2016).

Although it is important to understand how stigma is transferred to informal caregivers, there are few studies that investigate the associative stigma encounters of formal caregivers (Snyder, Omoto, and Crain 1999; Phillips et al. 2012; Harber, Roby, and High-George 2011; Harris et al. 2011; Phillips and Benoit 2013; Treloar et al. 2015), especially MHPs (Verhaeghe and Bracke 2012; Catthoor et al. 2014; Yanos et al. 2017; Liyanage et al. 2018; Vayshenker et al. 2018; Lin 2019; Picco et al. 2019; Buertey, Attiogbe, and Aziato 2020; Waddell et al. 2020).

Also, most of the research on MHPs has been conducted outside of the U.S. (i.e., Belgium, Canada, China, Ghana, Singapore, and Sri Lanka) (Verhaeghe and Bracke 2012; Catthoor et al. 2014; Liyanage et al. 2018; Lin 2019; Picco et al. 2019; Buertey, Attiogbe, and Aziato 2020; Waddell et al. 2020), all but two utilize quantitative methods (Vayshenker et al. 2018; Buertey, Attiogbe, and Aziato 2020), none of them connect the associative stigma coping strategies employed by MHPs to theoretical frameworks in the literature, and none of them include nurse practitioners (NP). To date, there are 8 countries (i.e., Australia, Canada, Finland, Ireland, the Netherlands, New Zealand, the four nations of the UK, and the U.S.) that utilize NPs for the provision of healthcare (Maier et al. 2018); hence, moving forward it is important to include this profession in studies on associative stigma.

Informal caregivers to people with a mental illness often maintain their relationship with a stigmatized individual based on love, altruism, duty, and necessity (Verhaeghe and Bracke 2012). Formal caregivers on the other hand develop a professional connection as a function of their occupation. Even though this provider-patient relationship is less personal than the one established with informal caregivers, research shows that an MHP's proximity to someone with a mental illness is enough to produce associative stigma (Verhaeghe and Bracke 2012; Catthoor et al. 2014; Yanos et al. 2017; Liyanage et al. 2018; Vayshenker et al. 2018; Lin 2019; Picco et al. 2019). For example, Halter (2008) found that out of ten disciplines (e.g., pediatrics, maternity, labor and delivery, oncology, operating room, etc.) registered and licensed practical nurses ranked psychiatry at the bottom both personally and socially. These sentiments are often reiterated by medical and nursing educators (Stuhlmiller 2003; Shattell 2009; Stuart et al. 2015) as well as students (Rushworth and Happell 1998; Wells, Ryan, and McElwee 2000; Happell 2002; Malhi et al. 2003; Jansen and Venter 2015; Hunter et al. 2015). Medical students describe

psychiatry as unscientific, ineffective, and depressing (Malhi et al. 2003) while nursing students claim that the MH specialty is perceived as "second class" and "not real nursing" (Wells et al. 2000). A study in Flanders also found that 75.5 percent of trainee psychiatrists experienced denigrating or humiliating remarks about their profession. Participants were not taken seriously by colleagues, and they were told that they are incompetent and not real doctors (Catthoor et al. 2014). In another study, MHPs were told that they are crazy, that they analyze people, that their work is useless, that their patients are dangerous, and that they must have a personal defect (e.g., a bizarre or weird quality) for wanting to work with people who have a mental illness. To manage these stereotypes the participants in the study educated others, used humor, sought out social support from colleagues and friends, and focused on success stories (Vayshenker et al. 2018).

The field of psychiatry has fought for decades to be recognized as a legitimate discipline within the field of medicine. Unlike a bone fracture, however, mental illness cannot be directly observed, and researchers have failed to identify any biomarkers for psychiatric disorders. As a result, behavioral health is often viewed with skepticism. Educators, students, and healthcare providers also rank psychiatry at the bottom compared to other medical specialties (Halter 2008). Unfortunately, this disparagement of MH work fails to recognize the complex and demanding job that is required of MHPs. For example, the MH specialty is often viewed as an "invisible practice" that only utilizes "soft skills" (e.g., establishing therapeutic relationships and specialized assessment) whereas technical or "hard" skills (e.g., surgical procedures, setting a bone, inserting an IV) refer to medical specialties (Fourie et al. 2005; Ng et al. 2010; Happell et al. 2013). According to Ross and Goldner (2009) creating this distinction between mental and physical health is problematic because healthcare providers assign greater value to technical

skills and devalue or stigmatize the specialized skills performed by MHPs. To gain a deeper understanding of this phenomenon, I address below how MHPs are exposed to associative stigma, the consequent emotions they experience, and the coping strategies they employ to manage stigma.

FINDINGS

Among the 48 MHPs that were interviewed for my dissertation, seventy-nine percent (n=38) of the sample reported an associative stigma experience due to their specialty. This number can be broken down into 3 out of 3 psychiatrists (100%), 18 out of 21 nurse practitioners (NP) (~86%), and 18 out of 24 registered nurses (RN) (75%). Although each occupational group in my sample holds a different level of power and status, and they play unique roles within the provision of MH care, my data does not show any meaningful associative stigma differences among psychiatrists, NPs, and RNs. Furthermore, the number of years worked in MH did not determine whether a participant was exposed to associative stigma. Respondents who had less than one year of MH experience were equally as likely to report associative stigma as MHPs who worked in the field for 10 plus years. Given this information, my findings will not be broken down by occupation in this chapter.

With that said, participants were more likely to be stigmatized by nursing faculty, classmates, and medical professionals (i.e., hospital interviewers, managers, RNs, doctors, etc.) than family and friends. For example, MHPs indicated that their family and friends often feared for their safety (n=9) and accused them of "analyzing" off the clock when in casual interactions with others (n=11). These associative stigma incidents caused many participants to have an emotional reaction and to utilize specific coping strategies. In what follows, I will discuss: (1) how participants encountered associative stigma; (2) how it made them feel; and (3) how they

coped with associative stigma.

Associative Stigma Encounters

Thirty-three participants (~69 percent) discussed an associative stigma encounter with faculty and classmates in both nursing and medical school. Respondents expressed feeling like "step-children" or "second-class citizens" who were "put down" or "pushed aside" for showing an interest in MH. At the undergraduate level, respondents reported that nursing instructors made it known that "MH wasn't worth much," and that it wasn't "scientific." Some nursing programs went as far as eliminating MH rotations because faculty felt they were a "waste of time." Instructors would also make tongue and cheek comments to deter students from entering the MH specialty. Specifically, they would tell MH trainees that they "hated psych," that MH units are "scary," and that they should avoid MH because that's where "crazy people go." They would also push nursing students to work in medical surgical. Janice, an RN and nurse educator, said:

> …When you graduate all your instructors…will say… I really think that you need to go do medical surgical. I think that you're going to do yourself a disservice if you don't… because you know it's use it or lose it. Well, it is use it or lose it no matter what you're doing, but the idea that somebody… went into nursing school and… found that MH was the clinical rotation they loved the most, you know, they shouldn't tell them that they need to go and do medical surgical… It's like telling them that doing MH is wrong. That medical surgical is more valuable so you should go do that first… I understand why they tell students that because we're all aware of the stigma that exists. If you don't have medical surgical experience people will treat you like you are less of a nurse… but instructors shouldn't tell students what specialty to enter.

At the graduate level, nursing instructors continued to devalue MH. When participants took

medical related courses (e.g., physiological assessment and pathophysiology), as part of their training, faculty would tell MH NP students that "the material didn't apply to psych people" and that they may not comprehend certain topics. Students working toward a family NP credential would also make "offhand jokes about psychiatry" and infer that their peers seeking a MH certification didn't have "altruistic feelings of helping people" and were just "in it for the money." Given that MHPs are in high demand and can often secure a premium wage for their work, it is not surprising that participants reported fielding disparaging comments about their motivations for entering the MH specialty. According to the U.S. Department of Health and Human Services (2016), there is a current shortage of 2,800 psychiatrists and this number is projected to increase 12 percent by 2025. Hence, the need for MH providers has caused full-time, psych certified, NPs to have the highest median annual base salary in comparison to the top 10 NP clinical focus areas in the U.S. (i.e., family, primary care, urgent care, internal medicine, cardiovascular, geriatrics, women's health/ ob-gyn, oncology/ hematology, and pediatrics) (American Association of Advanced Practice Nurses 2020). Curiously, MHPs in the same sample, reported that medical students operate on the assumption that there is "no money" in MH, that it's an "easy" specialty, and that it's "not desirable." These perceptions may well come from the fact that psychiatrists have one of the lowest average annual compensation rates in the U.S. compared to other physician specialty areas (Doximity 2020). Thus, based on the information reported by MHPs, it is possible that medical and non-MH NP students internalize and reproduce the stigma that they hear from others and carry those beliefs into the workplace.

Respondents in the sample report that they were called "lazy," "crazy," "glorified babysitters," "warm bodies," and "pill pushers" by other medical colleagues. They were told that they "lost" their medical surgical skills, that they have eccentric personalities, and that they are

not “real nurses” or “real doctors.” For example, after a participant’s ophthalmologist found out that she worked in psych he said, “Really? Usually, I can spot you guys from a mile away, but you look quite normal.” Vince, a psychiatrist, also claimed that if you are not “taking a knife and saving a life” than you aren’t respected by physicians. Several RNs were denied jobs on medical units as well. For example, Janice, an RN with medical surgical experience, said:

> I was applying to be a nurse manager on one of the medical surgical floors and… at least one interviewer… said well, what makes you think that you would be able to be a manager for people giving direct care on a medical surgical floor when you’ve spent most of your time in MH and, without getting defensive, I explained [my] experience…I said, I don’t want you to misunderstand that just because my clients are MH clients that… we fail to treat their COPD, asthma, obesity, diabetes, and thyroid problems… We don’t do high level medical care, but we do perpetual medical management and that doesn’t make me incapable as a nurse…[The] question was discriminatory… It did make a statement that the hospital interviewer thought that I didn’t have the same skill set anymore… and I didn’t get the job.

Respondents also suggested that medical professionals questioned the intelligence of MHPs. Participants were told that they entered the MH specialty because they must have been “barely passing nursing school” or were “not smart enough to do anything else.” For example, Andrea, an NP, was told by a physician assistant (PA) student that “she can’t believe [Andrea is] not a nurse anesthetist or something else [because] she knows everything about everything without looking it up.” This student was not questioning her intelligence. Instead, she suggested that Andrea was “too smart” to work in MH and should be investing her skills in another specialty. In another situation when Ella was misidentified as a general NP by her physician colleagues “they

talked more medical tech… and involved [her] in care a little better." Once they found out that her specialty was MH, Ella said several physicians started "talk[ing] different to her." They questioned Ella's medical knowledge and treated her like a layperson due to her specialty. These perceptions are associated with the idea that MHPs don't utilize "hard" skills (e.g., inserting an IV) and only focus on "soft" skills that require less medical knowledge and technique. In fact, MHPs often treat other comorbidities, in conjunction with MH, and as a result they still must have expert medical knowledge and a fundamental understanding of the pathophysiology and anatomy of the human body. For example, chronic medical conditions (e.g., cancer, coronary heart disease, diabetes) are often associated with depression (National Institute of Mental Health (NIMH) 2021).

Emotional Reactions to Associative Stigma

During the interview process emotions often surfaced after a participant's specialty choice and/or medical skills were questioned. This is demonstrated in following exchange with Hayley, an RN:

> Interviewer: When you decided to take a job in the ER, due to your unfavorable working conditions in psych, how did the workers there treat you?
>
> Hayley: At first it was terrible. They all hated me and thought I was a nuisance to their ER, and I had to prove to them that I wasn't JUST a psych nurse…
>
> Interviewer: Are you saying that they treated you this way because you previously worked in psych?
>
> Hayley: Yes…There are two sides to the ER. They always stuck me on the psych side, and they wouldn't let me see any patients that needed medical attention-like anybody with anything worse than their big toe hurt. Everyone there just assumed that I couldn't

handle it… The initial transition from psych to the ER was really rough. Really really rough. Like I would cry and the other nurses there were so mean, but I stuck it out.

Interviewer: Can you tell me more about the feeling and emotions that you were going through?

Hayley: I was really discouraged. I went from my psych coworkers being like family to being isolated and not having anybody to talk to. It was hard. It was scary, but I stuck through it and slowly, but surely you know, like as I got more confident in the position, the feelings of being inadequate, like I was never going to be able to do anything other than psych, went away…

Other MHPs expressed feeling disappointed, annoyed, hurt, angry, discouraged, sad, devalued, unnerved, inadequate, insulted, and irritated after being stigmatized for working in MH. The most common emotion was frustration (n=8). For example, Janice, an RN and nurse educator, said,

I take it personal. I get frustrated because it does seem like this is a common issue, and I probably have to explain myself and my skill more frequently than a medical surgical nurse has to explain their skills… The fact that I was a medical surgical nurse at one point in time doesn't matter anymore because I haven't been one for years or because I don't continue to do the acute medical care anymore so it's frustrating. You feel like you're always trying to explain yourself and convince somebody of your ability. We shouldn't have to do that because like I said they don't ask a medical surgical nurse to defend themselves on how they handle communication with a patient's family members… Nobody asks the med surg nurse to explain how their communication skills are going to help somebody with a mental illness problem. The expectation is that all of

> us nurses are capable of doing that.

Similarly, Andrea, an NP, said:

> I think it's more of a blow to me that they don't see me as the light to help psychiatric patients… Their comments are hurtful because I'd rather them see me and say "oh, you know, I know why you do what you do" and she does it well. I think sometimes it goes through my mind like was I too rushed today, or did they really not get to see the good side of what I do, but…in all honesty, I'm 100 percent comfortable in psych and love what I do…

In addition, when Victor, a psychiatrist, turned down a surgical residency, the physician he worked with told him that he was "crazy" and that "he couldn't believe that he would rather do psychiatry over surgery." In response to this exchange, Victor said he felt "frustrated that that was the kind of value that was placed on psychiatry" and that he "knew he couldn't convert everybody to understand what MH is or what the field needs." When Brooke, an RN and nurse educator, discussed how her colleagues view MH, she said that their comments made her "frustrated" and "disappointed" given their higher levels of education (i.e., master's degree, PhD, and DNP) whereas Dian, an RN, stated that when her graduate instructors made innuendos about MH it "ticked her off because faculty should know better." Finally, it's important to note that five participants did not express an emotional reaction and instead focused on their deep conviction for working in MH. For example, when Anna, an NP, had a community member make offhand jokes about her profession, she said:

> It didn't hurt my feelings to be honest. It didn't. I just was like well this is what I love to do and even if people are like oh, my God you realize how hard that's going to be or why would you want to do that, I'm just like this is what I love to do you know. I find it

> fascinating so that's usually my feelings with it too. It doesn't hurt my feelings, and I just kind of defend it as something I really deeply care about.

Means of Coping with Associative Stigma

The participants in my sample employed a wide range of management strategies to overcome associative stigma. The most common coping methods were disregard, avoidance, challenging, humor, self-care, and social support (Thoits 2011). In what follows, I break down each coping technique to provide a more detailed understanding of how MHPs manage associative stigma.

Disregard.

When MHPs disregard associative stigma, they are ignoring or blocking the negative stereotypes that are often linked to mental illness. These individuals recognize that there is public stigma aimed toward their specialty and patient population, but they do not let it impact their job or personal life. Participants (n=11) who employed this coping strategy felt that MH was an area that not everyone was interested in understanding and, as a result, they did not internalize stigmatizing beliefs. During associative stigma encounters respondents stayed silent, suggested that they didn't share similar beliefs, let comments "roll off [their] shoulders," and viewed stigmatizers as "ignorant" and "closed-minded." For example, Nancy, an NP, said:

> People accept what they want to accept. People believe what they want to believe and nothing I am going to do is going to change that unless they want there to be a change so I have learned where to… spend and burn my energy as opposed to fretting over something I have no control over. I work on the things I can and kind of let go of what I can't.

Likewise, Stan, a psychiatrist, suggested that everyone has a "right to practice their own mind

and pursue their own beliefs." Hence, he doesn't "try to convince" or "argue" with others that his specialty is valuable because he knows that it is. Finally, Tricia, an NP, stated:

> …You can't make everybody get it… I can't make someone understand why their perceptions are inaccurate, and if they don't want to understand than they won't so you either get it or you don't, and I'm not going to let my profession be controlled by… the viewpoints of other people.

Avoidance.

MHPs who utilize this coping strategy are aware of the stereotypes surrounding MH and want to avoid stigmatizing situations. To maintain neutrality during conversations with family, friends, community members, and medical professionals, respondents employed two different methods. In the first approach, participants (n=2) kept their specialty a secret and only revealed their general profession (i.e., doctor, NP, and RN). For example, Ella, an NP, said:

> When people pass certain judgements about my profession it's really hard. Cringe. Like my husband when people ask what he does, he says a physician. He doesn't say a psychiatrist to cope with that. Like I don't add psychiatric after I say that I'm a nurse practitioner… so that's ways of getting around it because you know they won't be as dismissive. It's hard. I don't know if I've figured out a way to fully cope with that or not, and I shouldn't be embarrassed by my field or anything like that, but… I want them to take me seriously as a provider.

In the second technique, participants (n=3) avoided discussing their profession if their specialty was publicly known. Take the following exchange with Harper, an RN, as an example:

> Harper: I guess how people perceive MH has prevented me from talking about my work, and it wasn't too long ago that I was talking about my job, and someone made a

comment, an inappropriate comment, about MH treatment…

Interviewer: Would you mind elaborating on what the incident was and what this person said?

Harper: There's a program at the state hospital where I work… and it helps young adults who have committed violent sexual crimes as a juvenile… The program keeps them off Megan's Law… Most of these people have been abused themselves prior to them abusing someone, and I had made a comment that I might want to work with these individuals. I can't remember exactly what this other person said, but more or less they couldn't believe that I wanted to work with that population because they don't deserve a second chance. After that incident I was done explaining my work because people just don't understand.

In both strategies MHPs conceal a part of their identity to avert associative stigma encounters that may devalue their work.

Challenging.

Unlike disregard where MHPs "ignore" bias actions and attitudes toward mental illness or avoidance where individuals "hide" an aspect of their profession to dodge stigmatizing situations, participants use the strategy of "challenging" to confront stigmatizers head on. Respondents who used this coping strategy focused on education and activism to change public opinions surrounding MH. Regarding education, many participants (n=14) felt that it is important to teach others about MH to "break down the stereotypes." Maria, an RN, introduces important facts surrounding the likelihood of experiencing depression or anxiety to help normalize mental illness whereas others focus on "the illness or the situation itself." Mallorie, an NP, will also "throw down in a comment section on Facebook" when she sees people negatively

and inaccurately talking about MH situations. Kevin, an NP, expanded on the comments above by saying:

> I think just really objectively explaining to people why they're wrong and just trying to promote your profession the best way you can, in the most professional way you can, and showing how it's just as important as cardiology. That's rewarding. It really is. It's kind of a coping mechanism I would say.

Piper, an RN, also stated:

> …people may say things that you kind of take offense to or that aren't so nice and that isn't accurate about our specialty… you can try to educate them a little bit and say, here's some insight into what I actually do and what this sort of thing is. You can attempt that, and see if it changes their mind.

In the second coping strategy, participants (n=3) focused on activism. For instance, Cody, an NP, holds a leadership position within a nursing organization in order to advocate for nurses and patients and reduce the stigma of MH. Additionally, Brooke, an RN and nurse educator, does research on who is running for office. She will only support candidates who "have an interest in expanding MH treatment and services."

Humor.

Using humor, cracking jokes, or being sarcastic helps MHPs to "make light" of an associative stigma encounter. A subset of the participants (n=5) in my sample don't take stigmatizing situations seriously, and they don't hold onto the perceptions of others. They realize that there are misperceptions regarding their specialty, and in many cases, they use this form of coping to "break the ice," normalize their field, and make other people feel more comfortable. For example, when Emily, an RN, shared her specialty at a reunion, past classmates became

fidgety. To make these individuals feel more at ease, Emily used a joke. Specifically, she stated:

> …Over the years of doing this I have felt more comfortable with being a mental health nurse, and I can joke about it. I laugh a little bit with them. I'm like you know I put my pants on the same way you do, one leg at a time, and you know I'm not always a mental health nurse. I'm a regular human being. I just do a different job. Sort of like the garbage man. Not everyone wants to do that job either, but that will just kind of break the ice a little bit so that people don't feel quite as standoffish…

Similarly, Clare, an NP, brings humor to public situations when people accuse her of analyzing them. She often laughs and tells them that she is "off the clock" or only diagnosing them "in her head" to make the encounter more relaxed. Finally, Hannah, an RN, said:

> …I usually have a sense of humor… because you know I think there's still a lot of stigma about… mental illness… so I try to make light of it… and I love what I do so I think that passion shines through, and I always say there would be nothing else I'd rather do. … I kind of joke that it's never a dull day in psych because there's always something going on... Someone has to do the job though so you just have to make light of it…

Self-Care.

The general public often takes part in self-care strategies, regardless of their profession or life circumstances, to maintain their mental, physical, and spiritual well-being (Hansson, Hilleras, and Forsell 2005). MHPs are no different, and my sample consistently discussed the importance of self-care, especially given the negative stereotypes surrounding their chosen specialty. To cope with the feelings that often surfaced after being stigmatized, participants relied on two self-care coping strategies. In the first approach, participants focused on distraction techniques that they enjoy (n=13) (i.e., listening to music, playing video games, watching a

movie, cooking, reading, and/or exercising). In one example, Victor, a psychiatrist, said:

> It's important to take care of myself given how people perceive my profession. I make sure I have time for my own personal interests. You know listening to music, movies, exercising, rock climbing… taking care of my animals… Just things that make me happy… It's just more about making sure I carve out that space and allot myself that time to overcome any negativity.

Similarly, Stephen, an NP, suggested that he uses "a lot of distraction techniques, whether that be listening to music or playing videogames." He also focuses on current events that are not connected to his work.

In the second strategy, participants (n=8) utilized mindfulness, a form of meditation, to focus on the emotions they are feeling after being stigmatized. Mindfulness often involves breathing methods and guided imagery to release tension and emotions. Janice, an RN and nurse educator, uses "a lot of mindfulness practice." Specifically, she said:

> I very… frequently sight the serenity prayer to myself because it's really important… that I remind myself of what I… have control over [and] what I don't have control over… For me it's important for my spiritual beliefs that I ask for the guidance and wisdom to…know what I can control and what I can't and then from there a lot of self-reflection to always make sure that I am keeping myself in check...

Anna, an NP, also uses mindfulness exercises, but she focuses on "positive self-talk" and "deep breathing" whereas Chloe, an NP, talked about the importance of being mindful to "process it out and not take it personally."

Social Support.

After a stigmatizing incident, some participants (n=10) relied on their MH peers (e.g.,

coworkers and classmates) for social support. According to Dian, an RN, her coworkers are a "good support" because "other people don't understand" what MHPs do, "how they're trying to help," and "why their work is important." Her coworkers can relate, however, and they help "lift each other up." Rachel, an NP and nurse educator, made a similar sentiment and suggested that the only people who truly "understand what goes on in MH" are your colleagues; therefore, she leans on them during stigmatizing situations. Furthermore, after Cody, an NP, was called the "sitter police" and a "glorified babysitter" he walked straight to the office to "bitch to his colleagues" and tell them about what he had experienced. Anna, an NP, also utilized her MH NP peers and said:

> After class we would get together with our small group… There's like four or five of us… and I'd say did you guys feel that way too when she said this thing about our specialty so you know kind of using them as my little support system when a comment rubbed me the wrong way.

Beyond the six coping strategies listed above, it's also important to note that, depending on the stigmatizing situation, participants (n=16) may employ multiple coping methods depending on the context. For example, Stephen, an NP, uses social support and both types of self-care (i.e., mindfulness and distraction techniques) while Lauren, an NP and nurse educator, uses disregard and education. Specifically, she said:

> I kind of pick my battles and I'm not going to waste my time on someone that has no understanding or is never going to remember a word about what I just said… so it's knowing your audience and knowing their level of understanding. If it's someone that is truly interested… and really wants to truly understand… I'll have a conversation with them and explain what I do…It depends on the setting.

Regardless of the coping strategy that MHPs use, each approach plays an important role in helping providers manage associative stigma.

DISCUSSION AND CONCLUSION

In line with previous research, the findings demonstrate that more than three-quarters of the MHPs in my sample were subjected to associative stigma (Verhaeghe and Bracke 2012; Catthoor et al. 2014; Yanos et al. 2017; Liyanage et al. 2018; Vayshenker et al. 2018; Lin 2019; Picco et al. 2019; Buertey, Attiogbe, and Aziato 2020; Waddell et al. 2020). Non-MH nursing faculty, student peers, and healthcare professionals were more likely to perpetuate stigma than family and friends. During associative stigma encounters, participants were discouraged from entering the MH specialty, were told MH is unscientific and devalued, were denied jobs on medical units, and were perceived as unintelligent, eccentric, lazy, crazy, glorified babysitters, and pill pushers. Their work and patient population were also considered dangerous. The MHPs (i.e., psychologists, MH therapists, social workers, peer specialists, case managers, and psychiatrists) in Vayshenker and colleagues (2018) study reported several similar assumptions regarding workers in the MH specialty (e.g., crazy, analyze others, hold unique personal characteristics, and hold a dangerous and devalued job). The literature on informal caregivers of the mentally ill also suggests that they encounter devaluing remarks (Gray 2002; Turner et al. 2007). The difference, however, is that MHPs are often degraded for relying on soft skills (e.g., psychotherapy or interactive techniques), in the context of a hospital or a clinic, where direct medical intervention (usually of the human body) is privileged.

Although associative stigma was present among my sample population, there were no meaningful differences between psychiatrists, NPs, and RNs. These findings are somewhat surprising given the power and status distinctions among the occupational groups in my study,

but it's important to note that I had a very small sample of psychiatrists (n=3). This sample size may have prevented me from finding variations between occupational groups, especially psychiatrists and NPs. It is also possible that there were no distinctions between psychiatrists, NPs, and RNs because associative stigma experiences may be present among MH workers in general. For example, Verhaeghe and Bracke (2012) and Vayshenker et al. (2018) collected associative stigma data on a broad range of MH occupations. Neither study discussed any limitations to this collection approach, and, to my knowledge, there are no studies that have shown any associative stigma occupational differences within MH. Future research should be done to further examine this issue.

With that said, the stigmatizing incidents reported in my study often caused respondents to have an emotional reaction. MHPs expressed being frustrated, disappointed, hurt, and angry. To manage these feelings and/or associative stigma encounters, respondents resorted to six primary coping methods: (1) disregard; (2) avoidance; (3) challenging; (4) humor; (5) self-care; and (6) social support. When MHPs disregard associative stigma, they "ignore" it. They don't internalize MH stereotypes and brush them off because they realize that some people will never understand psychiatry. In comparison, avoidance occurs when participants want to "hide" an aspect of their profession. These individuals will either keep their specialty a secret or avoid discussing their job in public to abate stigmatizing encounters. When MHPs want to be more direct, they resort to challenging as a form of coping. In this case, participants would face stereotypes directly via education or activism. Humor is also used to cope because cracking a joke or being sarcastic helps put stigmatizers more at ease by breaking the ice. Furthermore, self-care employs distraction techniques (e.g., exercising, music, video games, etc.) and mindfulness is used to release the emotions that surface from an associative stigma situation. Finally, social

support occurs when participants rely on their MH peers to reassure them after a stigmatizing encounter.

When I applied Thoits (2011) coping strategies on psychiatric service users to my sample population, I found that both groups utilized challenging and avoidance. Specifically, MHPs and their clients use education and activism, within the challenging category, and each group may dodge conversations, or other people who stereotype them, as a form of stigma management. The main difference, within the avoidance strategy, is that MHPs can conceal their specialty and discuss their general occupation (i.e., doctor, RN, and NP) during interactions. By hiding that they work in psychiatry, MHPs can avoid being stigmatized by individuals who devalue their field, and they can maintain the occupational status that comes with being a doctor, NP, and RN. People with a mental illness don't have this added layer of protection, however. The only way for psychiatric patients to preserve their status in society and maintain their public perception is by masking their diagnosis and pretending that they do not have a mental illness. None of the participants in my study used self-stigma, self-restoration, or deflection (Thoits 2011). Instead, I found that MHPs employed disregard, humor, self-care, and social support to help combat associative stigma. Humor and social support are both coping strategies reported in the associative stigma literature on MHPs (Catthoor et al. 2014; Vayshenker et al. 2018). Regarding informal caregivers of the mentally ill, research shows that they withdrawal from the public, conceal defects, ignore, and educate to cope with associative stigma (Corrigan and Miller 2004; Turner et al. 2007; Tamutiene and Laslett 2016). These strategies, including disregard, are similar to what was reported by the MHPs in my study; however, participants did not conceal imperfections. Instead, they hid their specialty. Also, respondents did not withdraw from society. This is likely because it's part of their job responsibility to play an active role in the MH

community. Hence, my findings, in conjunction with several studies reported in the literature, show that MHPs, nonpaid caregivers of the mentally ill, and psychiatric patients all implement several similar coping strategies to combat stigma, with some notable exceptions (Corrigan and Miller 2004; Turner et al. 2007; Thoits 2011; Catthoor et al. 2014; Tamutiene and Laslett 2016; Vayshenker et al. 2018). The management strategy that runs between all three groups is education (Thoits 2011; Turner et al. 2007). According to Thoits, (2011), individuals who educate others on mental illness are often "out" and make it known that they have a connection to MH personally and/or professionally. This link to MH allows them to take part in meaningful conversations that deter or reduce stigma. For example, the MHPs in my study, as well as non-paid MH caregivers and psychiatric patients in the literature, all discussed the prevalence and cause of mental illness, psychiatric treatment, and various resources (e.g., media campaigns) to combat stigma. One difference, however, is that MHPs also use education to defend the significance of their specialty. With that said, I found that MHPs employ an additional way of coping, known as self- care. This emotion management strategy is a potentially interesting discovery that may be applicable to other populations who manage stigma and should be examined in future studies.

These findings have several important implications. First, unaddressed associative stigma has the potential to deter nursing and medical students from entering the MH specialty. Current statistics show that there is a ratio of one MHP per 100,000 people (Kaiser Family Foundation 2017) and that only four percent of medical students are applying for residency training in psychiatry (Weil 2015). This is problematic because one in five psychiatrists are not accepting new patients and, on average, there is a 25-day waiting period for an initial evaluation (Malowney et al. 2015). Given the extended waiting times within the MH delivery system, a

substantial volume of MH patients flock to emergency departments as their primary source of care (Kalter 2019). This is an issue because participants in my study often stated that emergency room (ER) workers "hated psych people" and didn't provide them with proper care. It's also problematic because the COVID-19 pandemic has significantly changed acute care delivery systems to accommodate infected patients (Jeffery et al. 2020). This shift comes during a time when fatal overdoses, depression, and anxiety have surged, and individuals are afraid to seek help at the ER for fear of getting sick (Centers for Disease Control and Prevention 2020; Substance Abuse and Mental Health Services Administration 2021). Although the Biden Administration is set to provide almost $2.5 billion in funding to support substance abuse prevention and treatment programs as well as comprehensive community MH services, now more than ever we need MHPs who can work to address the nation's worsening MH and addiction crisis (Substance Abuse and Mental Health Services Administration 2021). Given these realities, it is imperative that medical systems and organizations work to de-stigmatize MH work.

The second reason these findings are important is because psychiatric service users are indirectly impacted when MHPs experience associative stigma. Although it is unclear whether there is a causal relationship between associative stigma and job exodus, the literature shows that associative stigma can lead to increased burnout and decreased job satisfaction for MHPs (Verhaege and Bracke 2012; Yanos et al. 2020). According to Verhaege and Bracke (2012:27), the job dissatisfaction that results from associative stigma "is directly linked with service user satisfaction." Hence, when MHPs report associative stigma, psychiatric patients describe being unhappy with their treatment. MH clients are also more likely to self-stigmatize (i.e., feel shame and inferiority) (Verhaeghe and Bracke 2012). This is problematic from an organizational standpoint because people with a mental illness are less likely to continue with or seek care

(Vogel, Wade, and Hackler 2007).

Finally, scholars claim that healthcare professionals are in a unique position to reduce the stigma of mental illness through educational programs (e.g., Open the Door, The Depression is Real Campaign, and In Our Own Voice) and interventions (e.g., letter-writing campaigns) (Pinto-Foltz and Logsdon 2009). Although I agree with this sentiment, medical professionals need to assess their own biases toward MH and the role that MHPs play within the U.S. healthcare system before they can play an active role in reducing the stigma of mental illness. This is especially true considering the participants in this study often identified non-MH professionals and educators as perpetrators of associative stigma.

In order to optimize patient care, deter MHPs from being dissatisfied with their jobs, and entice nursing and medical students to work in psychiatry, it is essential that associative stigma is reduced. Policy makers, healthcare organizations, and educational institutions need to implement stigma reduction programs that paint MHPs in a positive light and reduce the stereotypes surrounding mental illness. A study by Martin and colleagues (2020) supports this point by showing that when medical students take part in additional MH training and listen to physicians openly discuss their MH histories, they are more accepting of psychiatry and mental illness. The same can be said for nursing students. When nursing students took part in a 12-week MH residency training program that dispelled myths and highlighted the career opportunities associated with MH, 75 percent were highly interested in pursuing a career in MH, and everyone stated that they would recommend psych to other nurses (Ng et al. 2010). Although educational programs like these show promise in recruiting students and dispelling associative stigma, current MHPs also need to take part in training that teaches them about the stereotypes they may face, given their exposure to a discredited group in society, and how to positively manage

associative stigma. This could be done at national conferences or within healthcare organizations. Having this knowledge may increase the job satisfaction of MHPs and therefore improve patient treatment and recovery.

Finally, Waddell and Graham (2020) suggest that we need to redefine "soft skills" as "essential skills" to shift the perceptions held by medical professionals. Mental illness exists in all domains of medicine; therefore, it's important to place value on soft skills (e.g., empathetic listening and developing therapeutic relationships and de-escalation techniques) to provide proper patient care throughout the healthcare delivery system.

What to Expect in Chapter IV

In the next chapter, I turn to a broader implication of stigma which is moral distress. Moral distress arises when MHPs treat people with a mental illness, but it also occurs when MHPs directly or indirectly witness psychiatric patients being stigmatized and mistreated by non-MH workers and institutions.

CHAPTER IV

THE MORAL DISTRESS OF MENTAL HEALTH PROFESSIONALS

AMBER'S STORY

On a cold winter afternoon in February, I sat down with Amber to talk about her experience as a mental health (MH) registered nurse (RN). While discussing her work background, Amber became tense and visibly frustrated as she told me a gut-wrenching story that forced her to quit her job. In what follows, I present the morally distressing situation that Amber encountered when she fought to advocate for an Autistic patient on an in-patient MH unit.

> We had an autistic 16-year-old young man that was brought into the ER by his mom… She couldn't deal with him anymore [because] he was getting aggressive, [and] she didn't feel safe. He had never had an inpatient admission before for MH, and he wasn't suicidal, but they still admitted him. Less than 48 hours after being admitted, he swung at someone, and he was placed in locked seclusion [i.e., a padded room]… This boy was originally put in there with a mattress, a fitted sheet, and a urinal. He was told that if he needed to… have a bowel movement to knock on the door so that he could use the bathroom… Well, one day I went in, and there was no urinal, and… he was peeing in the drain in the middle of the room. When I asked where his urinal was, I was told that he had thrown the urinal…, and they took it away from him. Someone else told me though that the reason he threw it was because the aid told him to have his bowel movement in

the urinal since there was… no one available to let him out… Well, in my opinion, it would be pretty difficult to have a bowel movement in the urinal… so that's messed up for me… [Also], they eventually took his sheet away from him because they claimed he tried to strangle himself with it… I thought that was interesting because this boy never had a history of trying to kill himself. I never saw anything documented that he tried to kill himself ever in his life… Now here he is, after 8 weeks on an inpatient unit, and he's trying to strangle himself. What does that tell you? I think it drove him crazy being in there, and if anything, it was absolutely not beneficial or therapeutic… This boy came onto our unit saying thank you, please, mam, and sir, and he would make eye contact. After being in locked seclusion for two months, he had basically reverted to fecal smearing, violently masturbating, eating his feces, drinking pee, and not making eye contact. It was animalistic behavior, and I tell you it was wrong on every level…

Other nurses and his social worker would say, "it's so sad how he's treated," so I appealed to the state, and I called somebody within our county's MH system to talk about it. They said to talk about it with other nurses and get them to contact the state and complain, but no one did because they were afraid of losing their job. I even talked to the psychiatrist about it one day and… I said, "doctor this is so wrong that he's locked in there. He has nothing to do," and the doctor said, "I know, but I don't know what to do with him." I truly feel that the doctor… and the hospital administration failed him… Plus, the new assistant director of the unit… was a pathological liar. This man would fabricate and embellish this boy's behavior in order to make it okay for him to stay in locked seclusion. He even claimed that the boy hit a nurse and dislocated her jaw. I spoke to the nurse he was referring to though, and she told me everything was fine, that he grazed her

nose, and that the ER gave her Ibuprofen. There was no mention of her jaw being dislocated. I would [also] read nursing notes that were inaccurate, and I'm thinking, "oh my goodness. I just sat and watched him for 12 hours. He did nothing." Locked seclusion is supposed to be… revisited every 1 to 2 hours. The RNs have to chart every hour on his behavior… and the charting didn't match his real behaviors. The notes would say, "patient continues to be aggressive." Well, he's sleeping. He's not doing anything. Nobody was revisiting it. It was just an ongoing order, and I was told that the hospital administration said that as long as he's in this hospital, he will stay in locked seclusion... Also, a doctor was supposed to lay eyes on this boy every 2 hours and give the order for locked seclusion, but that wasn't happening. Our psychiatrist isn't here 24/7, so we were using the ER physician... He wouldn't even come over and look at the patient. He was in the ER all night, and at the end of the night, we would take a paper over and say, "here doc can you sign off on here," and he would. He would sign off, so all the safeguards put in place to ensure patients were receiving proper care wasn't happening. This kid was supposed to be reassessed every two hours, and it wasn't happening…

It was just disturbing on every level. It was hard for me to be involved in. I didn't agree with anything about the way this patient was being treated. It was inhumane, and it really really disturbed me, and it was something that caused a lot of angst for me while I was at work and after work. I couldn't stop thinking about it. It was just really disturbing to see that things kept going on, and that everybody involved seemed to be… defending the mistreatment of this patient. That's why I appealed to the state department of health multiple times, and as a result, the CFO of the hospital was on a witch hunt to find out who was contacting the state… It was unsettling, but I still felt like this patient deserved

> an advocate, and so I kept trying to advocate for this fella, and then, one of the… RN supervisors… told me that it would be in my best interest to resign because they were out for me… I was applying to other jobs at this point, and that was all I needed to hear to leave, so at that point I resigned and that was that. There was nothing more I could do to help that patient, but I still think about it, and I feel horrible. It makes me sick to my stomach because it was so disturbing… I hated to go into work. I hated to be there during those hours. It was so stressful because I'm in the nurse's station and there he is on the monitor, and I'm watching him rocking back and forth. I'm watching him peeing in the corner. I'm watching him sleeping, and then, staff were charting that he's being aggressive. My blood pressure was high. I could tell it. I was so distraught… It demoralized me. I felt like it was such a bad and negative situation. It was detrimental to me. It brought me down, and I was depressed about it.

I begin this chapter with Amber's story to show what's at stake when mental health professionals (MHP) experience moral distress, and to highlight the substandard care that psychiatric patients sometimes receive. Amber sought out every avenue possible to get her patient the proper treatment he deserved. She talked to colleagues, hospital staff, and state and county representatives, but the system ultimately failed her and her client. Amber's patient was treated like an "other" by the very people who were tasked with providing him care, and as a result, Amber not only resigned from her job, but she felt disturbed, stressed, sick to her stomach, distraught, demoralized, and depressed. Although this is an extreme case, Amber's story illustrates how difficult it is for MHPs to witness psychiatric clients being mistreated, and it highlights an important theme (i.e., substandard patient care) that will be discussed below. In what follows, I will: (1) provide background information on the moral distress literature; (2) look

more systematically across participant interviews to offer empirical evidence that MHPs are experiencing moral distress under certain circumstances; and (3) discuss the feelings and coping strategies participants use to manage moral distress.

INTRODUCTION

Approximately 26.5 million adults utilized MH services (e.g., inpatient/ outpatient treatment or counseling) in 2021 (National Institute of Mental Health (NIMH) 2023). These individuals were provided treatment by over 1.2 million MHPs which include psychiatrists, psychologists, nurse practitioners (NP), physician assistants (PA), RNs, counselors, therapists, and social workers (U.S. Government Accountability Office 2022). Each one of these occupational groups strive to provide high quality patient care in accordance with the ethical standards outlined by their profession. For example, psychiatrists are bound by an ethical code of conduct which states that they must "provide competent medical care with compassion and respect," report deceit, fraud, or deception, and "safeguard patient confidences and privacy" (American Psychiatric Association 2013:2-3). Unfortunately, when MHPs, such as Amber, are unable to uphold the professional values they stand by, especially in regard to patient care, this can lead to moral distress (Kertchok 2015).

The concept of moral distress was first introduced by Jameton (1984:6) to describe situations where "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action." In later publications, Jameton (1993) also added that conflict with coworkers may create obstacles that lead to moral distress. Wilkinson (1988:16) reconceptualized Jameton's (1984) definition and stated that moral distress was a "psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that

decision." Over the last thirty-nine years there has been a growing list of operational definitions from scholars who point out the vagueness of the concept, but the current research on moral distress continues to be based on the two earliest definitions by Jameton (1984) and Wilkinson (1988) (See Hanna 2004; McCarthy and Deady 2008; Ulrich and Grade 2018 for further information).

The moral distress literature includes several occupational groups within and outside of healthcare such as physicians, NPs, nurse anesthetists, RNs, pharmacists, rehabilitation therapists (i.e., occupational and speech), respiratory therapists, social workers, police officers, paramedics, and firefighters (Sporrong et al. 2005; Laabs 2005; Hamric and Blackhall 2007; Brazil, Kassalainen, and Marshal 2010; Radzvin 2011; Trautmann et al. 2015; Mänttäri-van der Kuip 2016; Henrich et al. 2016; Prentice et al. 2016; Fantus et al. 2017; Corradi-Perini, Beltrao, and Vargas de Casto Oliveira Ribeiro 2021; Lentz et al. 2021). Most of the research to date, however, primarily examines RNs working in neonatal and pediatric intensive care (NICU/ PICU), medical surgical, palliative care, oncology, and the emergency department (ED) (Corley et al. 2005; Pauly et al. 2009; Cavaliere et al. 2010; Huffman and Rittenmeyer 2012; Fernandez-Parsons, Rodriguez, and Goyal 2013; Wolf et al. 2015; Oh and Gastmans 2015; Lamiani, Borghi, and Argentero 2015; Henrich et al. 2016; Atashzadeh-Shoorideh et al. 2001; Salari et al. 2022). These studies suggest that RNs experience moral distress during situations that involve short staffing, incompetent colleagues, limited resources and time spent with patients, high client to nurse ratios, conducting invasive or unnecessary tests and treatments, withholding information or lying to patients, not being involved in client decision making, poor nurse-physician collaboration, and lack of support from colleagues (Wilkinson 1988; Corley et al. 2005; Lamiani, Borghi, and Argentero 2015; Oh and Gastmans 2015). RNs also report feeling angry, frustrated,

guilty, lonely, depressed, anxious, emotionless, and powerless, and they resort to talking to colleagues, leaving their job, or denying responsibility for their actions to cope with moral distress (Wilkinson 1988; Huffman and Rittenmeyer 2012; Lamiani, Borghi, and Argentero 2015; Oh and Gastmans 2015).

Like RNs, NPs experience moral distress when they are constrained by organizational time demands, lack of resources, and NP-physician collaboration (Ritchie et al. 2018; Laabs 2005). In one study, physicians disrespected and prevented NPs from providing quality patient care by failing to communicate with them, refusing to sign death certificates, and making inappropriate requests that belittled their scope of practice (Ritchie et al. 2018). NPs also described being morally distressed when patients were noncompliant and had unrealistic demands, when clients questioned their authority to diagnose and treat them, when insurance companies refused to pay for services or certain medications, and when their performance was based on the number of clients seen rather than the quality of care provided (Laabs 2005). These morally distressing situations made NPs feel frustrated and powerless, and they suggested setting boundaries, practicing self-care (e.g., exercise and social event activities), and educating others about their role as ways to cope (Godfrey and Smith 2002; Laabs 2005; Trautmann et al. 2015; Ritchie et al. 2018). Interestingly, one of these coping mechanisms (i.e., education) overlaps with the management strategies that sociologists have identified in the context of stigma. This is something I examined in greater detail in chapter III, but it's important to briefly mention Thoits (2011) whose coping framework for stigma includes a concept, referred to as challenging, where individuals resort to education to manage stigma.

In comparison to RNs and NPs, physicians also experience moral distress when residency doctors or other providers don't deliver good quality care or are incompetent, when unnecessary

testing or aggressive care is requested by family members, when clients are denied information or lied to regarding their condition, at the request of relatives, and when they witness patient's decline after team members fail to communicate with each other (Epstein 2008; Henrich et al. 2016; Quek et al. 2022). These morally distressing incidents cause doctors to feel angry, frustrated, sad, depressed, and guilty, and they cope with excessive alcohol use, practicing mindfulness or meditation, exercising, using rationalization and positive framing, employing team-based discussions, and receiving education or counseling (Quek et al. 2022). Pediatricians often experience the lowest level of moral distress whereas emergency specialists experience the highest (Abbasi et al. 2014). It's also important to note that moral distress measures are consistently higher for RNs than physicians and NPs fall somewhere in between (Hamric and Blackhall 2007; Knifed, Goyal, and Bernstein 2010; Hamric, Borchers, and Epstein 2012; Oh and Gastmans 2015; Trautmann et al. 2015).

Although these findings are important in understanding how certain medical professions (i.e., physicians, NPs, RNs, etc.) and healthcare specialties (i.e., NICU, PICU, ED, etc.) encounter moral distress, there is a small body of literature that focuses on the moral distress of MHPs. For example, studies on psychiatric RNs show that moral distress occurs when: (1) they feel that a patient's rights have been violated (e.g., administering unnecessary tests or treatments, using force or restraints, following the wishes of families instead of the patient, placing clients in seclusion for an extended period of time, psychiatrists failing to listen to their patients, and the people with a mental illness having very little autonomy); (2) there are time constraints and/or short staffing that prevents them from establishing rapport with their clients; (3) insurance companies limit how many times they can see a patient in their home; (4) a client unexpectedly dies and they blame themselves; (5) they can't provide any physical care; (6) they disagree with

patient care decisions; and (7) there is unethical conduct by paid caregivers (e.g., secretly putting medication into a patient's food, not taking action again unethical conduct, and abusing or ridiculing patients) (Ohnishi, Asai, and Akabayashi 2003; Austin, Bergum, and Goldberg 2003; Sturm 2004; Deady and McCarthy 2010; Musto and Schreiber 2012; Ohnishi et al. 2010; Hamaideh 2014; Ando and Kawano 2016; Upasen and Saengpanya 2021; Shehadeh et al. 2022). These morally distressing situations make MH RNs feel sad, frustrated, angry, depressed, annoyed, and disempowered, and they cope by limiting their emotional involvement with patients and their families, refusing to work with certain colleagues, avoiding, denying, or trivializing a problem, changing their job, talking to family and colleagues, using positive self-talk, receiving additional training, and following up on an incident with their superiors (Austin, Bergum, and Goldberg 2003; Sturm 2004; Deady and McCarthy 2010; Musto and Schreiber 2012; Upasen et al. 2020; Upasen and Saengpanya 2021; Tavakol et al. 2023). The most common coping method is talking to patient care team members. In comparison, Austin and colleagues (2008) found that psychiatrists experience moral distress in the context of making patient care decisions. For example, they must strike a fine balance between what a community or family feels is an appropriate treatment recommendation versus what is ethically right for their patient (Austin et al. 2008). Moral distress measures also ranged from moderately high to relatively low depending on the country of origin that was being examined (Ohnishi et al. 2010; Hamaideh 2014).

To date, there are 13 publications on the moral distress of MHPs (Ohnishi, Asai, and Akabayashi 2003; Austin, Bergum, and Goldberg 2003; Sturm 2004; Austin et al. 2008; Deady and McCarthy 2010; Musto and Schreiber 2012; Ohnishi et al. 2010; Hamaideh 2014; Ando and Kawano 2016; Upasen and Saengpanya 2021; Upasen et al. 2021; Shehadeh et al. 2022; Tavakol

et al. 2023). None of these studies examined NPs and only one was conducted in the United States (U.S.). Most of the limited research on moral distress and MHPs has been conducted in Canada, Iran, Ireland, Japan, Jordan, and Thailand. Unlike Canada and Thailand that utilize the national healthcare model or Japan that employs the Bismarck model, the U.S. is a for profit model characterized by diverse and complex delivery systems (Reid 2010). Thus, there may be morally distressing situations that MHPs experience in the U.S. that are unique compared to other countries. In addition, Canada and Ireland are the only countries listed, beyond the U.S., that use NPs in their healthcare delivery system (Maier et al. 2018). NPs in Canada cannot practice in the field of psychiatry; therefore, it's important to examine MH NPs in the U.S. to determine their experience with moral distress (Canadian PA 2022).

In sum, moral distress has been shown to reduce job satisfaction, lead to burnout, negatively impact patient care, cause exhaustion and cynicism, and encourage healthcare workers to resign from their place of employment (Ohnishi et al. 2010; Lamiani et al. 2015; Ando and Kawano 2016; Salari et al. 2022). The MH delivery system is already strained due to short staffing (e.g., less residency students entering psychiatry and psychiatrists retiring) and the demand for services since COVID-19 (Weil 2015; Bethune 2022; Weiner 2022). Thus, now more than ever, it is important to understand how MHPs are impacted by moral distress in order for healthcare organizations to retain current employees. Below I will address how MHPs are exposed to moral distress, the emotions they experience, and the coping strategies they employ to help fill a gap in the literature.

FINDINGS

When doctors and nurses enter their profession, they often profess their devotion to the welfare of their clients through the Hippocratic Oath or the Florence Nightingale Pledge. They

seek to be advocates for their patients, to offer them the best standard of care, to protect them from harm, and to defend them from poor and misguided healthcare. Unfortunately, 34 out of 42 participants (~81%) in this study discussed morally distressing situations that prevented them from helping the patients they vowed to serve. This number can be further broken down into 0 out of 3 psychiatrists (0%), 15 out of 21 nurse practitioners (NPs) (~71%), and 19 out of 24 RNs (~79%). Based on these numbers, the data for this chapter will only be drawn from interviews with NPs and RNs. Although other studies have found that doctors experience moral distress, it was not a salient theme that was mentioned by the small subsample of psychiatrists in my study (Austin et al. 2008). Below I will discuss the specific circumstances that led to moral distress. This section will be broken up into stigma and non-stigma related moral distress for the nurses in the sample. I will also focus on how participants felt during morally distressing situations and the coping strategies they employed.

Stigma-Related Moral Distress

Substandard care due to mental health stigma.

For a subset of my sample, moral distress is tied to directly or indirectly witnessing the stigma that their MH patients face due to possessing a "blemish of individual character" (i.e., mental illness) (Goffman 1963:4). This perceived character deficit has been shown to cause institutional organizations and/or their staff to stigmatize and provide incompetent and inadequate care to people with a mental illness (Thornicroft, Rose, and Kassam 2007; Vistorte et al. 2018). Eighteen participants (~43%) echoed these findings and reported that psychiatric clients receive substandard treatment due to their MH diagnosis or addiction. Specifically, Rebecca, an RN, stated that "the root cause of insufficient care is that medical providers are stigmatizing the patients." This is demonstrated in the following exchange with Kevin, an NP:

> I spent 10 years in the ER, and basically when psych patients came in… you could definitely feel a difference in how an ER doctor and… staff treated them as opposed to medical patients. They didn't see their situation as an emergency… and oftentimes, they didn't provide them with detailed care… For instance, in the ER we'd have people come in with chest pain, and if they revealed they were on anti-depressants or Xanax… medical professionals… wouldn't give them credit and would chalk their chest pain up to anxiety. They'd send them home after doing an EKG and maybe a few blood tests, and they wouldn't admit them for observation. They'd come back in the next day with chest pain, go into cardiac arrest, and they'd die. THEY'D DIE. So staff don't look far enough into it… The symptoms of psych patients don't carry the same weight as they would with somebody else who isn't on Xanax or who doesn't have a MH diagnosis… and over the years I have seen this happen a lot... It's so irritating and frustrating. It really is you know. We hear it all the time. Our patients come in and they'll say… they just don't feel that they're treated as well as someone who may not have a MH diagnosis. That's sad. It's sad when they realize that they're not treated the same because they are on psych meds. These are people who deserve respect like everybody else. Most of them can't help that they're in this position, and it makes me let down that this is the way that medical providers are treating them and that this is the type of care they are getting at hospitals… I don't know how to improve their healthcare experiences. I can't change how they are being treated, and I can't change how medical staff care for them. What do I do, you know?

In another example, Janice, an RN, stated:

> My floor doesn't have medical coverage all day so if one of my patients… needs to see a

> medical provider I sometimes have to take them to our Emergency Department… Many times, more times than I care to remember, our professionals that are working in the ER… will right away stereotype against our mentally ill veterans… I may send somebody over because they fell, and they need to be assessed, but it's clear that they treated them as if "oh, they just want a narc" instead of actually going through the same protocols you'd go through for any other patient who walked in after a fall… They push our substance use disorder patients to the side and say, "here's a Tylenol, go lay down, and don't come back…" It's totally inappropriate to not provide medical care because you tell them they're not worth it… You know, that happens A LOT, and it's a shame because those of us working in the VA, we all have this great respect for our veterans… It kills me. Absolutely kills me that those individuals see that they've got this MH disorder and all of the sudden the stigma's there regardless of any other respect they show for any other veteran. Unbelievable. It makes me so angry.

The RNs and NPs in my sample also observed medical professionals who wouldn't: (1) enter a psychiatric patient's room to provide care; (2) change their wound dressings, or (3) offer them food due to what they perceived as "bad behavior." In one case, Cody, an NP, said:

> Sometimes colleagues use… mental illness as an excuse to not provide adequate medical care… If this is the fifth time that they've seen a patient in the last couple months, because they stopped taking their diabetes meds, continue to do meth, and now they have to have an amputation… nursing staff get so fed up with them that they will avoid them. They won't change their wound dressings as often as they should and that's been somewhat challenging to deal with when medical professionals have these strong biases... These are people who…, in my perspective, lack compassion, and I am so disappointed

> that this is the reaction that they have when a huge chunk of the patients that come to our hospital have some kind of psychiatric illness… It makes me feel sad that that was the experience that MH patients have been getting... That's what makes me ill to my core because they aren't providing the best standard of care. I just feel so bad, and I can't do anything about it… so I always try to provide these patients with the experience that I think that they were hoping for when they are in my care…

Participants also discussed circumstances where medical professionals and staff didn't follow normal hygiene protocols, unnecessarily restrained or physically assaulted patients, and talked negatively about psychiatric clients. For example, Mallorie, an RN, got a consult on a medical floor for a patient with bipolar disorder. When she arrived on the unit, this client was being walked around the hall with makeup smeared all over her face. Mallorie was dumbfounded and took it upon herself to get a washcloth and clean up the patient's face. She said that the nursing staff did not provide this woman with "dignity and respect," due to her MH diagnosis, and that she felt "sad" and "upset" by how poorly the client was treated. Additionally, when Tara, an RN, was in the ER, she saw a substance user free himself from his restraints. When this happened, two police officers became agitated and threw the patient up against the wall until his head was gushing blood. Upon witnessing this, Tara tried to pull the officers off the client and neutralize the situation, but she was unsuccessful. As a result, she was unable to help her patient and became so distraught that she cried. She felt that the officers "lacked empathy and compassion," and that they should have handled the situation differently. In addition, Hayley, an RN, said:

> A medical doctor in the ICU wanted me to assess a patient. He was ICU psychosis… I called and updated the doctor, and I told him I wasn't going to transfer him on a 302...

> [because] they can deal with that… When I got off the phone, I was writing my note in the chart… and the ICU nurse said, you know…, I put him in the ICU and… after a couple of days he was acting up… I told him he was the nicest guy when I brought him in on the elevator and now he's a "fucking demon," and she said, I told him I can't stand MH people. I told him you better wise up or nobody's going to help you out on this unit, and I'm just… looking over at her in disbelief… I said, he can't help it. He's in ICU psychosis. He'll get some medicine, and he'll be fine… I said, you know…, he has no psych history. You understand that right, and I just thought to myself isn't it a shame that medical providers just don't have the wherewithal to even sit down and think about the fact that this is a person and that there's something else possibly going on. It just made me so frustrated. This patient had no MH history and yet he was being told no one was going to help him. It's unbelievable. How can you be an RN and make those comments to a patient?

Another way that MHPs experienced moral distress pertains to themes surrounding medication misuse. In these situations, participants witnessed medical doctors and/or staff who: (1) prescribed narotics to recovering addicts after surgery; (2) brushed off the discomfort of an addict after a surgical procedure and would not provide any pain relief; (3) failed to give patients their psychiatric medicine; and (4) removed and did not replace a clients MH medication. For instance, Janice, an RN and nurse educator, was pulled to a surgical unit due to a staffing shortage. One of her clients was a recovering addict who had orthopedic surgery. His chart clearly stated that he was in recovery, but the doctor failed to provide the patient with a nerve block for pain and instead prescribed him an addictive medication. His actions made Janice "frustrated" because the doctor failed to review the patient's medical history. As a result, she had

to advocate to get her client hot packs, ice packs, and a clergyman because her client was "completly destitute," and felt like he had "nothing left of his humanity." The patient wanted to maintain his sobriety and Janice, as an MHP, sought out any way possible to help him since the surgeon did not. In another situation, Natalie, an NP, said:

> I remember having patients being started on an antibiotic and having all of their psych meds removed because they were incompatible… For me, I understand that the doctor thinks that the antibiotic is going to save the patient's life, but taking them off of all of their psych medication could be fatal as well… So, it's just frustrating because they are careless with regard to psychiatric patients, and they're also careless with regard to the MHPs who put them on that medication regime… The surgeon, the medical doctor, the infectious disease specialist all think that they have bigger, better, more noble goals than psychiatry does... These perceptions can seriously impact a psychiatric patient's well-being and there's nothing I can do about it…

Similarly, Hayley, an RN, stated:

> Oftentimes, we get patients from the ER… and if they were… in restraints or have a history of a MH disorder it's eye rolling. Anybody who's acting out it's medicate them and leave them. Put them in restraints and like nobody goes out of their way to sit down and have a conversation with them to see what is really going on or to assess what they really need… That happens very very often, and I've picked up patients days after they've been admitted and none of their psych medications are ordered. NONE. Well, and they're wondering why this person is acting out. Um, you haven't medicated them in nine days for a medication they've taken for years upon years upon years, and I can't even tell you how many times that's occurred… It's so frustrating because these patients

deserve the same care as someone without a mental illness, and they just aren't getting it. Lastly, Tricia, an NP who provided MH treatment on a palliative care unit, argued that her psychiatric recommendations were often ignored by "oncology primary care teams." She said that their actions were "extremely frustrating because they put up barriers for patients to get back on track to where they need to be." When a client was undergoing cancer treatments, she suggested that they often felt depressed and that it was her job to help them. Unfortunately, Tricia's treatment suggestions were constantly denied and ignored by medical staff, and she eventually left her role because she felt "helpless."

In each one of these depictions, participants highlight how MH stigma impacts patient care and puts MHPs in morally distressing situations. According to Andrea, an NP, MHPs "hurt for their patients." They want them to receive good care. They want people to be more accepting of them and to "meet them where they are." Hence, MHPs feel obligated and responsible to advocate for their patients to ensure they receive proper treatment. This is seen when Hayley wipes off a client's face or when Janice helps a patient maintain his sobriety when no one else will. The problem, however, is that many of the participants in my study could not control the biases held by medical professionals, and this created conflict. When MH stigma is engrained into the fabric of our society, and the field of psychiatry is undervalued by medical professionals, it makes it much more difficult for MHPs to have their voices and concerns heard after witnessing or becoming aware of patient mistreatment (Halter 2008; Parcesepe and Cabassa 2014). Thus, many of these NPs and RNs could not "purse the right course of action" to ensure their clients received the proper care they deserved, and this led to moral distress (Jameton 1984:6). It also caused them to feel frustrated (n=9), sad (n=5), helpless (n=3), hurt/upset (n=3), irritated (n=1), ill (n=1), angry (n=1), let down (n=1), and tearful (n=1).

Institutions deny care to patients due to mental health stigma.

The literature shows that psychiatric patients are often stereotyped as being dangerous, incompetent, violent, frightening, and unpredictable (Phelan et al. 2000; Martin et al. 2000; Corrigan and Kleinlein 2005; Schomerus et al. 2012). This societal stigma toward people with a mental illness, put three participants (7%) in morally distressing situations when their clients were denied access to certain institutions (e.g., nursing homes, retirement communities, and community housing). According to Gia, an NP, she experiences a lot of "frustration" with limited access for patients and said:

> You know some patients just don't belong on a psychiatric unit anymore, but there is nowhere else to go. No one will take them now that they've been to a state hospital. I mean that label comes with a lot of negativity. A specific example would be… we have a building that houses older individuals, so geriatric psych, and there are women there that are bed ridden. I mean they literally need full care, and that's not something that a mental hospital is equipped to handle. It's very frustrating, and it's very sad. Just because they were schizophrenic 50 years ago, they have that label now. They can't get into a retirement home or a personal care home, where they can get that consistent medical care that they need, because of that diagnosis being a part of their history. That kind of thing is just really frustrating when you're trying to advocate for a patient to be moved to a facility equipped for their needs and these institutions just don't want to deal with them and say, "oh, they're where they need to be." They aren't though because we don't have the medical resources to care for them, and they do.

Rebecca, an RN, made a similar sentiment suggesting that MH facilities are not equipped to provide care to dementia patients, who are physically declining, yet they are continuously pushed

on them because no other end of life facilities will take them. She said that it's extremely "frustrating" and "disheartening" because she knows dementia patients deserve better. Holly, an RN, discussed a situation where an intellectually disabled client was admitted onto a psychiatric ward because he wanted to stop taking his dialysis and die. During his time on the unit, Holly describes how everyone became "really close to him" and bought him birthday and Christmas gifts. She said that he "became one of them," and she found it very "sad" and "frustrating" that he was denied housing, due to his illness, and spent six months of his life on a locked inpatient unit. In each example, institutional constraints served as a barrier for the three participants in my study to get their clients the care they deserved, and this ultimately led them to experience moral distress. They felt frustrated, sad, and disheartened that their clients were refused access, to the very establishments that were created to care for them, due to the stigma surrounding their MH diagnosis.

Non-Stigma Related Moral Distress

Inappropriate treatment recommendations.

One participant described a morally distressing situation where she disagreed with the use of electroconvulsive therapy (ECT) for patients in young adulthood. Specifically, Fallon, an RN, said:

> I've worked with people who are very young. When I'd go to work… it was heartbreaking for me to see people in their early twenties missing out on boyfriends, going out, and experiencing their life at such a young age… Instead, they were suffering from their mental illness on… a locked facility with people twice… their age, and it was hard for me. I thought that some of the things that they experienced and some of the situations that occurred there were definitely inappropriate…They were getting ECT…,

> and I disagreed a lot with some of the ECT treatments that were going on in that facility… I know that… many patients had already surpassed their lifetime maximum… and that was hard for me watching them anticipate that electric convulsion treatment… They would worry and pace, and their symptoms would worsen as they approached their treatment… Then, they would start losing their memory which is chronic… It was acute right afterwards too. You would have to reorient them, and it was heartbreaking. It was, and I just didn't agree with it.

In this situation, Fallon was in an inferior position compared to the psychiatrist giving orders. She was forced to follow the psychiatrist's treatment recommendations, even though she could see the negative impact that ECT was having on her younger clients. This was problematic for her and caused her to experience moral distress. She knew that her hands were tied and that she could not challenge the doctor's decisions, even if she didn't agree with them.

The perception of patient failure.

According to the American Nurses Association (ANA) (2001:9), "individuals who become nurses are expected not only to adhere to the ideals and moral norms of the profession, but also to embrace them as part of what it means to be a nurse." Specifically, the *Code of Ethics for Nurses (2001:7-8)* states that nurses should "practice with compassion and respect," "preserve the integrity and safety" of their patients, and "maintain and improve healthcare environments" to ensure "quality healthcare." Unfortunately, seventeen (~40%) NPs and RNs in my sample felt that they were unable to uphold some of these values, and therefore, let their patients down. This perception of failing patients led to moral distress and focused on themes surrounding: (1) time constraints and (2) patient death. Both topics will be discussed below.

Time constraints.

Study participants claimed that "healthcare has become a corporate business" where hospital organizations "only care about their numbers" and fail to acknowledge the needs and job responsibilities of MH workers. When money becomes the primary concern, Stephan, an NP, indicated that quality patient care "gets put aside." As a result, 12 participants (25%) perceived that they were failing their clients because institutional stipulations prevented them from "devoting enough time" to each patient. On inpatient units, participants described feeling like "firefighters" who were constantly "putting out acute fires." For example, Dawn, an RN, said:

> When I first started, I had a patient who was acting out, kicking walls, and punching other people. At the same time, I also had a patient who was banging her head off of the wall near the dresser in her room, and then, I had a patient who had a seizure all at one time... I was the only RN on the unit because we were short staffed, and I had to try to figure out which patient to see first, to prevent the most harm, while the other patients had to wait for me to care for them or give them my attention. It was just a really difficult situation to be in because I just knew that there was no way that I could address all of these patient's needs, and I had to remind myself to calm down and deep breathe, or I would have had an emotional breakdown.

In another case, Cody, an NP, stated:

> The reduction in staffing for my department has been challenging. We had 5 APRNs when I first started, 1 music therapist, and a part-time art therapist, and now, we only have 3 APRNs, no music therapist, no art therapist, and this all has been happening due to financial issues. So, the number of things that we can do for patients in the hospital has been significantly reduced. I don't have time to sit down and talk to somebody about… their anxiety or depression per se because I have to prioritize with people who are

> suicidal and people who are having major behavior issues on the floor. Those are folks I have to see first. Anybody who's experiencing some kind of minor difficulty, that's last tier right now. That's been really hard and frustrating for me because I just can't give patients the time and care they all need.

Other respondents described similar stories, but the one common theme for inpatient MHPs was that short staffing played a major role in their inability to provide quality psychiatric care.

In comparison, respondents working in outpatient clinics felt like they were "herding patients through like cattle." For instance, Nancy, an NP, said:

> It's hard for me, having been a nurse first for 13 years, to not provide a certain standard of care or bedside manner. As a nurse you take the time to listen to your patients. Hear them. You know, kind of discuss things with them, be there for them, and treat them as a whole. Now that I'm in the role of a provider, organizations… just want you to see client after client... I'm seeing someone new every 15 minutes, and you know, sometimes people need a little bit longer than 15 minutes to just feel like they're actually being heard, and you aren't throwing medications at them. It's so frustrating when time constraints make patients feel like they aren't being heard or are just being looked at as a number because that isn't the type of care I'm used to providing.

In another example, Kevin, an NP, stated:

> We see patients every 15 minutes, but other clinics see patients every 20 minutes. This time difference is something that we have brought up several times at our staff meetings, but our CEO just isn't satisfied with making that change. He basically dances around the subject and says, well, if there's an unfilled spot just use that extra time to block off for your patient. He doesn't want to go to 20 minutes though because that's only 3 patients

> an hour as opposed to 4 an hour, and the company would obviously lose money… I find 15-minute appointments to be very overwhelming. We see up to almost 50,000 people a year and… oftentimes, I get backed up on the schedule because a patient ran over their allotted time. There have been times I have had to literally get up and walk out of the room so that a patient would leave… and then, I end up having 3 or 4 people waiting… It's just a frustrating situation to be in. Obviously, I want to provide quality care to my patients. I want to make sure I'm building that trust with my patients and establishing a therapeutic relationship, but it makes it so hard to do that when I'm only given 15 minutes.

Nurses are taught that their primary commitment should always be to their patients (ANA 2001). Unfortunately, healthcare organizations play a major role in determining the type of care that people with a mental illness receive by placing limitations on how much time MHPs can spend with their clients. They create these time constraints by reducing the number of workers on inpatient units and by forcing providers to see a set number of patients every hour. Both situations allow healthcare organizations to stay afloat (and in some cases, generate profit), but they create conflict for MHPs who seek to provide the best standard of care for their clients. When participants were unable to spend quality one-on-one time with their patients, they perceived that they were failing them as nurses. This thought process led to moral distress and caused MHPs to feel frustrated (n=6) because they have no control over organizational policies. Likewise, when MHPs disregarded time-related guidelines, they faced additional problems with both clients and their employer (e.g., patients waiting to be seen, not meeting corporate numbers for patient satisfaction, etc.).

Patient death.

One of the unique circumstances of working in the field of psychiatry is that MHPs often establish a therapeutic alliance with patients who may attempt suicide, commit suicide, or overdose. Given that 109,000 people died of a drug overdose and 47,646 individuals committed suicide in 2021, it's not surprising that 6 participants (12.5%) discussed morally distressing situations involving patient death (Curtin et al. 2022; Ahmad et al. 2023). Specifically, three out of six respondents focused on the aftermath of discovering a client had passed away. For example, Natalie, an NP, said:

> All of us will have a natural end to our lives… when we are 70, 80, 90 years old. Even when there's a person with cancer, you try your best, and they still pass away. That's what cancer does, but if you… have a patient die of suicide or die of an overdose, it's… viewed as a medical failure, because that should never be the outcome… With cancer; however, we know that 60% of these people have a five-year lifespan. The patients we lose are in their 20s and 30s, and it's not supposed to happen that way. Suicide is never understood to be the terminal result of having depression or having bipolar disease. I feel like when we lose a patient, it's enormously more troubling, because as psychiatric providers, we are told that we should be able to prevent it… There's [also] always the question of what could I have done differently? Could I have made an extra phone call? Could I have done a different thing with their medication? Should I have had them seek out a higher level of care? But beyond that, I think that if you're a good psychiatric provider, you feel some connection to your patient, and it ends up being a real loss for you too, because you cared about that person as a human being… We experience tremendous loss and sadness… We get frustrated, and we get angry, because we work really hard as a team… and yet we still have patients that end up… overdosing or

> commiting suicide… so when you have a negative outcome… it's very frustrating, and you question everything.

Janice, an RN, relayed a comparable sentiment and stated:

> When I find out that one of my clients has passed, I feel this very deep intense sadness and sorrow in that moment… You know, despite whatever I was able to provide them with, it clearly wasn't enough for them… You still always wish that there was something more. You know was there some other way that I should have taught them the material so that they had better coping strategies? Could I have changed the outcome if I did something different? Suicide is deeply demanding after there's nothing left to do, but simply hold them in your thoughts… You know, feel their loss and try to overcome the negative thoughts of feeling like you failed them.

The remaining three participants discussed morally distressing situations that focused on finding clients actively attempting suicide on inpatient psychiatric wards. In one case, Hayley, an RN, said:

> I honestly have never been that scared in my life. I found a young kid hanging from the back of his door. I didn't think that me and another nurse were ever going to get him out of the noose. He was heavy and there was only two of us. He was completely limp, and I honestly didn't think that it was going to happen, but we got him up high enough to where he got a breath of air… and I got the noose off of his neck because I was up on a chair. It was such a terrible experience, and afterward, I was having nightmares and not sleeping for weeks. I just kept thinking about what would have happened had I not been able to get him out. Like how I would have felt if he would have died under my care, and I just kept replaying the situation over and over in my head.

Jamie, an RN, reported a similar situation when she found a patient hanging from a breakaway towel bar in the bathroom. She said that she immediately started performing CPR, and she remembered thinking that the bathroom was such a "denigrating place to die." Despite trying to revive the client, he was pronounced dead when the response team arrived. She said that sitting "with the person served on the floor" made it really hard to "desensitize to the situation" and that she felt "helpless." Jamie blamed herself for the patient dying during her shift and questioned what she could have done differently.

In each one of these examples, moral distress occurred because respondents held the perception that they were medical failures. As Natalie suggested, MHPs are told that patient death should be preventable in the field of psychiatry; therefore, moral distress was created when the NPs and RNs in my sample could not "preserve the integrity and safety" of their clients. Although MHPs experience approximately 4 suicides throughout the course of their career (Lopes de Lyra et al. 2021), and participants were aware that they may "lose someone to suicide," it didn't make the losses they experienced any easier. All six participants beat themselves up over "not doing enough" and many of them asked what they could have done differently and what signs they may have missed. They also felt sad (n=2), helpless (n=1), scared (n=1), frustrated (n=1), angry (n=2), and upset (n=2).

Means of Coping with Moral Distress

The participants in my sample employed a wide range of management strategies to overcome moral distress. The most common coping methods were challenging, social support, and self-care. In what follows, I break down each coping technique to provide a more detailed understanding of how MHPs manage moral distress.

Challenging.

In the context of stigma-related moral distress, participants (n=7) coped by utilizing what Thoits (2011) refers to as challenging. This management strategy often entails fighting against MH stereotypes by becoming a patient advocate, confronting stigmatizers, educating, and overperforming on a difficult task (Thoits 2011). The MHPs in my study primarily implemented confrontation and/or education. For example, Janice, an RN, contacted the floor manager after learning that a recovering addict was prescribed opiates by an osteopathic doctor. The manager called a "unit council meeting" where Janice updated other floor staff on the situation and educated them on the importance of thoroughly reviewing patient histories. By reviewing patient charts, Janice argued that it would help staff avoid medical errors and ensure clients, with comorbidities, were receiving proper care. In another example, Cody, an NP, used confrontation and education when he found out that nurses were not changing the wound dressings of a psychiatric patient. Specifically, he stated:

> I let my nursing colleagues know that their actions were completely inappropriate. I called them out on it. Sometimes when I do this they get… upset with me and pissed off, but the next time they interact with me, they know there are things that I will accept and statements and behaviors that I won't accept… I do my very best to educate and explain why their mindset and the way they are treating my patients is really not appropriate. There are challenges… working with folks who just don't want to deal with people with mental illness. One of the biggest things that I tell people is that on any given day at the hospital, on average, 25 percent of our patients, outside of the psychiatric unit, will have a comorbid psychiatric disorder… So when a nurse tells me that… they are not psych trained or they don't know how to deal with psych patients, I turn it back on them, and I tell them "look, that's not true" because if you're taking care of sick patients today, at

least one of your patients will have a psychiatric illness at some point… so you can't tell me that you're not a psych nurse.

Self-Care.

To cope with morally distressing situations, involving patient death, two participants emphasized the importance of self-care. For example, Rachel, an NP and nurse educator, utilized distraction techniques, such as exercising, and said that "she's a big advocate for exercising in order to decompress and think through her feelings." In comparison, Dawn, an RN, focused on mindfulness where she employs "deep breathing in order to calm down and release pent up emotions."

Social Support.

In order to cope with their emotions after a morally distressing incident, some MHPs (n=8) relied on coworkers for social support. According to Holly, an RN, "other nurses in the psych field understand each other's thoughts and feelings;" therefore, her and her colleagues "depend on each other to talk things over and cheer each other up." Mallorie, an NP, made a similar sentiment and stated that she "chats with colleagues and processes situations with them" because they understand. Natalie, an RN, also discussed how important it is to debrief with coworkers when you lose a patient and said that communicating with them helps to "express frustrations and reflect on the patient they lost." Thus, talking with other MHPs that they have an established relationship with was the most valuable way for all eight participants to cope with their moral distress.

It's also important to note that two participants employed more than one coping method when they became morally distressed. For example, Rachel, an NP and nurse educator, relied on social support and self-care after a patient committed suicide. She talked through the situation

with her colleagues, but she also used a distraction technique (i.e., exercising). Furthermore, Cody, an NP, focused on social support for one morally distressing situation and challenging, in the form of confrontation and education, for another morally distressing incident. He changed his coping strategy based on the context surrounding moral distress. These examples demonstrate that MHPs: (1) utilize more than one coping strategy at a time to deal with moral distress and (2) may not use the same coping strategies for every morally distressing situation. In order words, they may change the way they cope depending on the condition (e.g., stigma vs non-stigma related). Regardless of the coping strategy that MHPs use, each of the three methods described above played a role in helping participants manage their moral distress.

DISCUSSION AND CONCLUSION

Approximately 81 percent of the MHPs in my sample were subjected to moral distress. Psychiatrists did not report moral distress; therefore, all the data for this chapter were drawn from psychiatric NP and RN interviews. Respondents from both occupational groups identified two types of moral distress: stigma and non-stigma related. Participants experienced stigma-related moral distress: (1) after witnessing psychiatric service users receive substandard care by other medical professionals and (2) when MH patients were denied access to certain institutions (e.g., retirement homes, nursing homes, community housing) due to their diagnosis. For example, respondents reported that their non-MH colleagues would not change wound dressings, run appropriate testing for physical health aliments, supply MH medications, or take care of patient hygiene. They also called psychiatric patients vulgar names, mistreated clients physically, and prescribed narcotics to recovering addicts. All of these examples created moral distress for the MHPs in my sample. Although the MH literature supports the connection between stigma and inadequate patient care, to my knowledge, there are no studies that show how this is linked

to moral distress among MHPs (Thornicroft, Rose, and Kassam 2007; Vistorte et al. 2018). For instance, a study by Deady and McCarthy (2010) found that MH RNs experienced moral distress when their patients were provided insufficient care, but they focused solely on situations within the MH delivary system, and they did not discuss stigma.

In regard to non-stigma related moral distress, participants identified situations involving: (1) inappropriate treatment recommendations; (2) time constraints; and (3) patient death. For example, a MH RN in my study felt that ECT was causing illness deteroriation, and as a result, she experienced moral distress. Moral distress due to invasive, inapproriate, and/or unecessary care is commonly reported by RNs and physicians in general as well as MHPs (Wilkinson 1988; Ohnishi et al. 2010; Deady and McCarthy 2010; Oh and Gastmans 2015; Epstein 2008; Henrich et al. 2016; Ando and Kawano 2016). In one study, NICU doctors and RNs became morally distressed after aggressive treatments were used on an infant who was already suffering (Epstein 2008). In another study, MH RNs reported high moral distress scores based on futile tests and treatments that patients had undergone (Ando and Kawano 2016). MHPs also identified institutional time constraints as being morally distressing. When inpatient psychiatric wards were understaffed, or outpatient clinics limited how long providers could see their clients, respondents perceived that they were failing as nurses. This type of moral distress is in line with previous research (Austin, Bergum, and Goldberg 2003; Sturm 2004; Laabs 2005; Lamiani, Borghi, and Argentero 2015). For example, a study on primary care NPs supports my findings and shows that when employers only care about the volume of patients seen, it prevents them from addressing client needs and causes moral distress (Laabs 2005).

The final way that respondents encountered moral distress pertains to patient death. When MHPs discovered that one of their clients died or they witnessed a MH patient commit or

attempt suicide, they felt like a professional failure for not keeping them safe and blamed themselves for not doing enough. Upasen and Saengpanya (2021) described this type of moral distress as self-condemnation. In their study, MH RNs also felt responsible for a patient who unexpectedly died while being transported to another facility. Another study on psychiatric RNs didn't discuss suicide or patient death specifically, but Musto and Schriber (2012) examined how safety concerns on inpatient psych wards led to moral distress. This study is similar to my findings in that participants felt it was their primary responsibility to keep patients safe.

During participant interviews, MHPs were never directly asked questions pertaining to moral distress. This theme surfaced while coding and analyzing the subsection referred to as workplace emotions on the interview guide (see appendix H) below. This may partially explain why the three psychiatrists in my sample did not report moral distress. Furthermore, because I was unable to ask follow-up questions after reviewing the data, it was not always clear if moral distress occurred when a participant was an RN or when they started working as an NP. For this reason, I could not separate moral distress by occupation in my findings subsection. With that said, the moral distress literature shows that there are several similarities and differences between physicians, NPs, and RNs. For example, all three healthcare professions report moral distress when there is poor communication among patient care team members (Epstein 2008; Lamiani et al. 2015; Henrich et al. 2016; Ritchie et al. 2018). Research also shows that RNs experience the highest amount of moral distress followed by NPs and doctors (Hamric and Blackhall 2007; Knifed, Goyal, and Bernstein 2010; Hamric, Borchers, and Epstein 2012; Oh and Gastmans 2015; Trautmann et al. 2015). Finally, Austin and colleagues found that there are moral distress differences between psychiatrists and MH RNs, but this is the first study, to my knowledge, that includes psychiatric NPs (Austin, Bergum, and Goldberg 2003; Austin et al. 2008). Thus, future

research needs to take a more comprehensive look at how MHPs in the U.S. experience moral distress to determine if there are any unique occupational differences.

The morally distressing incidents reported in my study often caused participants to have an emotional reaction. NPs and RNs expressed being angry, disheartened, frustrated, heartbroken, helpless, hurt/upset, ill, irritated, let down, sad, scared, and tearful. Several studies conveyed similar findings, but frustration was the most common emotion discussed in the moral distress literature (Wilkinson 1988; Godfrey and Smith 2002; Laabs 2005; Huffman and Rittenmeyer 2012; Lamiani, Borghi, and Argentero 2015; Oh and Gastmans 2015; Trautmann et al. 2015; Ritchie et al. 2018; Quek et al. 2022). To manage the feelings that stem from moral distress, respondents used three primary coping methods: (1) challenging (i.e., confrontation and education); (2) the social support of colleagues; and (3) self-care. Studies on moral distress show that RNs often rely on their colleagues to cope whereas NPs resort to self-care and education (Oh and Gastmans 2015; Ritchie et al. 2018). None of the findings I reviewed discussed challenging, in the form of confrontation, to cope with moral distress. It's possible that this management technique is utilized by MHPs who are more likely to be exposed to stigmatizing situations involving psychiatric service users. Hence, scholars who study moral distress should potentially adapt this concept by Thoits (2011) since coping frameworks for the moral distress literature are understudied.

These findings have two important implications. First, as discussed in earlier chapters, there is a crisis in MH, notably a crisis in the retention and recruitment of MHPs. Unfortunately, Hamaideh (2014) found that there is a direct correlation between moral distress, burnout, and intention to leave among psychiatric RNs, and Corley and colleagues (2001) reported that 15 percent of the nurses in his sample left a previous position due to moral distress. Similarly, two

participants (i.e., Amber and Tricia) in my study conveyed that they left their jobs to overcome the morally distressing situations they experienced. Thus, if moral distress is causing MHPs to resign from their place of employment, it's imperative that healthcare systems and organizations work to address moral distress. Doing so will help them to retain current employees and avoid paying turnover fees which can cost up to $51,700 per RN (Plescia 2021).

The second reason these findings are important is because moral distress can negatively impact the quality of care that psychiatric patients receive. A study by Sturm (2004) found that when insurance companies prevented community MH nurses from providing long-term care to chronically ill patients, they started to reduce their physical and emotional involvement. They would "get in and get out" during visits, and they spent less time focusing on "bringing hope, influence, and direction" to "reclusive and fearful clients" (Sturm 2004:112). Other studies in other specialty contexts reported similar findings and showed that healthcare professionals will emotionally withdrawal from or avoid patients who are in need of care due to moral distress (Corley 2001; Oh and Gastmans 2015). This is a significant problem for healthcare organizations who rely on individuals seeking MH treatment (and patients more generally) to stay afloat financially. If someone with a mental illness does not feel that they are receiving good quality care, they may be less willing to continue using their services.

In order to deter MHPs from leaving their job and ensure that patients are receiving optimal care, healthcare organizations and professional associations (e.g., American Psychiatric Nurses Association, American Psychiatric Association, etc.) need to provide resources (e.g., pamphlets, presentations, trained ethicists, counselors, mentors, etc.) or implement programs that teach MHPs how to recognize and overcome moral distress. For example, Rathert and colleagues (2016:46) studied nurses in a U.S. hospital and found that organizations can "influence moral

distress by enhancing formal and informal support structures." Specifically, participants were less likely to report moral distress when they were provided with ethics resources and when managers and physicians encouraged nursing staff to use those resources (Rathert et al. 2016). In addition, the American Association of Critical Care Nurses (AACN) (2004) developed a program for addressing moral distress called the "4 As to Rise Above Moral Distress." Using this framework, healthcare providers are encouraged to ask, affirm, assess, and act when they confront issues related to moral distress. Thus, if healthcare organizations want to address moral distress among MHPs, then they need to be willing to critically assess their policies and practices and make changes that benefit their employees.

CHAPTER V

THE CRISIS OF LEGITIMACY FOR MENTAL HEALTH PROFESSIONALS: A PROFESSIONAL, INSTITUTIONAL, AND SOCIETAL ISSUE

In chapters III and IV I showed several ways that mental health professionals (MHP) experience stigma. I also demonstrated that their line of work can be emotionally fraught, that they face enumerable pressures and stressors on the job, and that they employ numerous coping strategies when at work. In the current chapter, I look at the ways that the psychiatric specialty struggles to secure legitimacy in the broader field of medicine and the implications of this struggle for MHPs. If we seek to combat mental health (MH) stigma, then it's important to acknowledge the ways that MHPs are still fighting for their work to be valued. In what follows, I will: (1) provide a brief primer on three barriers that contribute to the crisis of legitimacy for MHPs and (2) discuss how the MHPs in my study struggle to secure professional legitimacy given current organizational and institutional realities.

Barriers to Legitimacy for Mental Health Professionals

Educators, students, and healthcare providers describe psychiatry as the least respected and least attractive medical specialty (Happell et al. 2013). Historically, the field has also had to answer the charge that mental illness is a myth rather than a reality of biology (Szasz 1961). In an effort to be perceived as a credible medical specialty, the field of MH has responded by emphasizing the clinically observable and biomedical nature of mental illness (as reflected in the DSM, for example) while also seeking cure through psychiatric medications (Harrington 2019). Despite these changes, MHPs continue to experience problems of legitimacy, as evidenced by

ongoing troubles with insurance companies, their own intraspecialty conflict, and stigmatizing messages about MH work that circulate in the media. I consider each of these below.

Insurance Companies

In the 1960s, Aetna and Blue Cross "reimbursed psychiatric illness dollar for dollar with other medical illnesses, [but] by the mid-1970s… [they] had cut back coverage to 20 outpatient visits and 40 inpatient hospital days per year" (Wilson 1993:403). During this time, insurance companies expressed frustrations over psychiatry's "fluid" and "unstandardized" methods for psychological assessment and treatment (Wilson 1993:403). Not only did insurance companies have no idea whether the different MH services were actually working, they were also spending untenable sums of money on care. According to Robert J. Laur, the Blue Cross Vice-President in 1975, when MH is:

> compared to other types of [medical] services, there is less clarity and uniformity of terminology concerning mental diagnoses, treatment modalities, and types of facilities providing care… One dimension of this problem arises from the latent or private nature of many services; only the patient and the therapist have direct knowledge of what services were provided and why (Wilson 1993:403).

In order to address these concerns, the field of MH developed a new diagnostic framework for the DSM-III in the 1980s. MHPs were optimistic that this change would convince insurance companies to realign their interests with MH, but that wasn't the case. Today, parity has not been established between physical and mental healthcare (MHPAEA Report to Congress 2022). Insurance companies also hold a significant amount of power over psychiatric service users and the MHPs who treat them. Even though an MHP may see value in certain behavioral health treatment options or medications, it's ultimately up to insurance companies to determine

whether they want to cover those services for a MH patient. This has real implications for both the quality of patient care and the work experiences of MHPs.

Interprofessional Dynamics in Mental Health Care

In *The System of Professions*, Abbott (1988) discusses how various groups compete for control over tasks and develop jurisdictional boundaries. Specifically, he states that "[s]ubordinate professionals, nonprofessionals, and members of related, equal professions learn on the job a craft version of given professions' knowledge systems" (Abbott 1988:65). In other words, when workplace assimilation or boundary-blurring occurs some professional groups carry out the tasks of others (Abbott 1988; Allen 1997). This was seen in the 1980s when psychiatrists faced a major occupational dilemma over who laid claim to psychotherapy (Buchanan 2003; Mayes and Horwitz 2005). Psychiatrists wanted to restrict "talk therapy" to their profession, but psychologists, social workers, and counselors argued that they could provide the same quality of psychotherapy for cheaper (Greenburg 1980). This appealed to insurance companies, who were already hemorrhaging money for MH services, and encouraged them to push other MH clinicians to take over psychotherapy. As a result, talk therapy started to become demedicalized (Mayes and Horwitz 2005; Ruffalo 2021). In addition, psychologists were in a "professional war" with psychiatrists over third-party payment (Abbott 1988). This led to a landmark case (i.e., *Virginia Academy of Clinical Psychologists and Robert J. Resnick v. Blue Shield of Virginia)* where it was ruled that requiring licensed psychologists to bill for their services through a doctor was "anticompetitive behavior on the part of psychiatrists are unnecessary to maintain good medical practice" (Mayes and Horwitz 2005:257). The Court also questioned whether psychiatrists should oversee psychologists since the current stipulations by Blue Shield claimed that psychologists could bill through "any doctor" (Mayes and Horwitz 2005). Both of these issues

led to serious problems for psychiatrists because it meant that they needed to re-evaluate their role within the MH delivery system in order to maintain their already shaky status among other medical doctors. At the same time, these changes emboldened non-MDs providing mental healthcare (e.g., clinical psychologists, nurse practitioners (NP), registered nurses (RN), etc.) to practice and bill as autonomous providers with unique skill sets. It also contributed to the jurisdictional boundary issues we see today between doctors and nurses (i.e., NPs and RNs).

Jurisdictional boundary work has been studied at length between doctors and RNs (Allen 1997; Salhani and Coulter 2009; Apesoa-Varano 2013; King et al. 2015; Liberati 2017; Johannessen 2018). One common theme in this research is that healthcare workers will resort to discrediting competing professional groups by questioning their skills, competence, or approach to clinical care, all in an effort to gain jurisdictional control over a field (King et al. 2015). This is seen in a study by Salhani and Coulter (2009) that examined the relations between a MH team in a psychiatric hospital. These researchers found that RNs ignored or refused to honor the care decisions of psychiatrists when they disagreed with their suggestions. RNs also formed a support group, called Mood Busters, with other nonmedical professionals on the unit. This group allowed the nurses in this study to have more control of the decisions that were made on their unit and to garner more respect for all providers involved in patient care (Salhani and Coulter 2009).

More recently, NPs have emerged as central to the provision of care, in MH contexts and in medicine more generally. In 1965, Dr. Loretta Ford and Dr. Henry Silver developed the first NP program at the University of Colorado. In the decades that followed, certification exams, associations (e.g., National Association of Pediatric Nurse Practitioners), academic journals (e.g., Journal of the American Association of Nurse Practitioners), and additional graduate programs were created to help legitimize the NP role within the United States (U.S.) healthcare system

(American Association of Nurse Practitioners (AANP) 2023). Today, 27 states and the District of Columbia grant NPs full practice rights, and they can be certified in 6 primary areas (i.e., family, pediatrics, gerontology, psychiatry, neonatal, and women's health) (AANP 2022). The psychiatry certification, which was established by the American Nurses Credentialing Center in 2001, is the newest specialization among NPs (Bjorklund 2003). Nonetheless, despite having a decades long history and providing the same quality of care as physicians, members of society still fail to understand the training and capabilities of NPs (DesRoches et al. 2017; Buerhaus et al. 2018). As a result, patients often default to doctors who are often viewed as medical experts.

Scholars, such as LaTonya Trotter, explore the jurisdictional boundary issues that occur between doctors and nurse practitioners (NP). In *More than Medicine*, Trotter (2020) examined the experiences of doctors and nurses at an outpatient clinic for the elderly. She found that doctors often resist working collaboratively with NPs, refuse to do the work of an NP, and deny job interchangeability. Physicians also blame clinical problems on NPs, critique their work, and make it known that holding a doctorate degree and/or experience does not give NPs leverage to make decisions (Trotter 2020). These actions helped doctors to preserve their status at the top and solidified their power to resist change within their work environment. In another study, Trotter (2019) explored the boundary work that family NP (FNP) students perform to negotiate their role in medicine. She found that what "fundamentally distinguished" RNs and NPs were the responsibilities each occupational group held within the role of diagnosing and treating patients (Trotter 2019:112). In comparison, NPs suggested that their relationship with physicians were "collaborative" (Trotter 2019:116). Finally, a study on primary care doctors found that they were accepting of NPs practicing independently, but they felt that there should be a degree of supervision over NPs due to the "perceived gaps" in their training. To my knowledge, there are

no publications on the jurisdictional boundary issues that occur between psychiatrists and MH NPs, but it's clear that when healthcare professionals in general compete for control over work related tasks, workplace conflict can occur.

The Perception of Mental Health in the Media

After *One Flew Over the Cuckoo's Nest* was released in 1975 audiences started to view behavioral health facilities as prisons, psychiatrists as "mental police," and staff as prison orderlies (Domino 1983; NAMI 2023). Since then, various forms of media (e.g., advertisements, news media coverage, movies, newspapers, television shows, etc.) have continued to produce negative perceptions of individuals with a mental illness and those who provide them care (Wahl 1992; Gabbard and Gabbard 1999; Stout et al. 2004; Klin and Lemish 2008; Ma 2017). For example, Schneider (1987) found that psychiatrists were portrayed as "Dr. Dippy" (i.e., incompetent), "Dr. Evil" (i.e., manipulative / untrustworthy), and Dr. Wonderful (i.e., crosses boundaries/ unprofessional) in films. The Dr. Evil category is often associated with the movie *Silence of the Lambs* (1991) whereas the sitcom *Frasier* (1993) aligns with the Dr. Dippy label. In comparison, people with a mental illness are depicted as rebellious, free spirited, homicidal maniacs, female seductresses, zoo specimens, and enlightened members of society (Hyler 1991). Studies also suggest that news media coverage from 1995 to 2014 has changed very little and still emphasizes interpersonal violence that is disproportionate to the actual rates (McGinty et al. 2016). On a positive note, advertisements and social media tend to show more objective information and can be used to improve MH literacy and reduce stigma (Ma 2017). Some scholars have suggested that there has been a welcome shift in the way that films portray MH as well. According to Rosen and colleagues (1997:640), "oppressive psychiatrists and zombified victims are giving way to more human encounters and ambiguous, even hopeful, outcomes."

This is a major step for the field of MH, but the negative images that still exist have the potential to tarnish the reputations of real-life MHPs and their patients. Below I will address the hurdles that the MHPs in my sample experienced in their attempt to gain professional, institutional, and societal legitimacy.

FINDINGS

MHPs have faced criticisms from scholars, medical professionals, members of society, insurance companies, and the media who all have questioned the legitimacy of the MH specialty. Below I will discuss how the legitimacy of the MHPs in my sample are questioned at a professional, institutional, and societal level. From a professional standpoint, I will focus on the relationship between psychiatrists and MH NPs, from an institutional level I will concentrate on how insurance companies treat mental verse physical health, and at a societal level I will examine the media. All three of these levels will shed light on the battle that MHPs still face every day as they fight to gain legitimacy for their specialty and overcome MH stigma.

Interprofessional Conflict in Mental Health: Nurse Practitioners and Psychiatrists

Given that mental healthcare (and MH patients) are stigmatized within the broader field of medicine, it is no surprise that the various professional groups providing mental healthcare find themselves jockeying for control and respect. Nurse practitioners face a unique challenge in this regard because their scope of work overlaps considerably with psychiatrists. NP respondents in this study reported that patients often questioned the ability of NPs to render diagnoses and manage care, relative to psychiatrists. For example, when psychiatric service users disagreed with the treatment recommendations offered by MH NPs, participants observed them say, “I wonder if a real doctor would diagnose me differently…,” “I only want to see a doctor,” or “do you know more than the psychiatrist who has been taking care of me?” In addition, Jamie, an

RN, said:

> I have patients that look at the PA and consider them a doctor because they're a physician's assistant that follows the medical model, and they look at the nurse practitioner and consider them a nurse because they follow the nursing model. They essentially rank their preference for PAs higher than NPs, but they always want to be treated by a doctor over anyone else when we are trying to schedule them for their next visit.

Stephen, an NP, adds to these sentiments by stating:

> I've had families say, "oh, what do you do? What are you here for? Are you the nurse?" They really don't even understand what our role is… There's that negative connotation where: (a) we don't know what you do; (b) we know what the psychiatrist does; and (c) we know that they've been around longer and have more experience… There's many factors that play into patients and families being more comfortable with a psychiatrist, but the main one is that they are MDs or DOs who are viewed as being at the top of the medical hierarchy. They hold all of the status, and they have the most recognition at a societal level. Even if I have my doctorate, patients still don't understand... Sometimes they'll say, "well, are you a doctor nurse, or how does that work?" So even though we function almost exactly the same as a psychiatrist, patients still request to see a doctor over an NP because they don't understand our qualifications.

These examples show that respondents feel that some psychiatric clients devalue the expertise of MH NPs and position psychiatrists at the top of the MH hierarchy.

Despite holding status within the MH specialty, however, psychiatrists are still working in a subfield where they are trying to prove themselves within their own profession. To date, the

literature shows that the field of psychiatry is disrespected by doctors in other specialties and that it's perceived as unscientific and ineffective (Malhi et al. 2003; Lambert et al. 2006). Victor, a psychiatrist, adds to these findings by saying:

> I think psychiatry is kind of derided in medical school and seen as an easy or undesirable specialty. There's just such a low rate of medical students attending psychiatric residencies because it's low on the totem pole…, and it doesn't have the same kind of prestige as let's say a neurosurgeon or someone who does surgical procedures.

Hence, because psychiatrists are still trying to gain respect among their peers, they are protective of the status they hold within their own subfield. As a result, twelve (25%) respondents claimed that there is a jurisdictional battle or "power struggle" between psychiatrists and MH NPs. For example, Peggy, an NP, alleged that a communication board was developed by a group of psychiatrists to document all the mistakes made by MH NPs. The psychiatrists sought to present the information in court and use it as leverage to stop MH NPs from being able to practice without a collaborative agreement. By ensuring that MH NPs were limited in their scope of practice, these psychiatrists sought to safeguard their professional status within the MH specialty. In addition, participants stated that psychiatrists have told them that MH NPs "take their clients," "practice beyond their training," "can't handle hard cases," and are "not educated enough." For example, Ella, an NP, said:

> One of the psychiatrists where I work is a member of a Facebook page where she constantly bashes NPs, and she doesn't hide her disdain for us. There's just so much power struggle between the NPs and psychiatrists where I work. They claim that we're taking their jobs and question our education, and it just annoys me because there aren't enough doctors going into psychiatry. There are more than enough jobs for everybody,

> and psychiatrists have this amazing opportunity to foster NPs and teach them, but instead, psychiatrists get annoyed or irritated, at least in my experience, when you ask them for feedback or ask them for help with a case. I have so much respect for my colleagues, and I just don't understand why they can't have that same mentality for my profession.

Similarly, Stephen, an NP, stated:

> Some psychiatrists feel like we're trying to take over their jobs and there are negative feelings there because healthcare organizations can pay us a lower rate to do the same thing. Psychiatrists also feel that the training that NPs get is obviously different from what they get, and sometimes there can be feelings of animosity toward us... This became really apparent to me when I was working with a psychiatrist on a tough case. The psychiatrist basically told me "well, I don't really think you can see this patient because I really don't think you can handle it. You really should just be focusing on simple cases, such as mild depression or general anxiety, because you aren't experienced." Her comment made me feel unnerved at first and really slighted because I have worked really hard to get to where I am as a DNP, and it just really exemplified the type of power struggle so to speak, that—I definitely don't think you can handle this situation. I don't think you're well-equipped because you don't have the same medical training as I do. You didn't have to go to school as long so you're not on the same level as me. I'm better. She just had a harsh reaction which is unfortunate because it should be about working together instead of pitting us against one another.

Respondents also discussed several circumstances where psychiatrists pushed extra tasks on MH NPs and made it known that they only wanted to work with a PA who follows the medical model. In one case, Janice, an RN, reported:

> I get the distinct impression that the head of our MH department, who is a psychiatrist, does not like NPs and that he prefers PAs because whenever we have a PA working as our medical provider, he's very cooperative and helpful to that person and any of the times that he's been forced to accept and hire an NP he loads them up with way more work than is appropriate, and it frustrates them. It makes them worried about their liability, and then, they leave. We currently don't have an assigned medical provider at this point in time as a result. Like we can't keep them because the treatment NPs receive is far different than the treatment PAs receive… Also, this particular psychiatrist I think has an issue because it's that age old battle between medical and nursing models of care. I don't think he likes that an NP still comes… from the nursing model of care… I think instead of looking at them and valuing their experience as a nurse before they became an NP… he's like oh, well, you were a nurse before, and you will never think like a doctor.

In addition, Mallorie, an NP, said:

> We recently got another psychiatrist where I work. He doesn't have his own team, and anytime he doesn't feel like doing some of his work, he attempts to push it off on me. I don't work for him. I have my own caseload, yet he views me as the person who should pick up his slack, and I just don't appreciate that. His actions make it seem like I'm inferior to him and that I'm not as competent or as valued because I'm an NP.

Finally, participants discussed how psychiatrists disrespect MH NPs when they refuse to call them doctors even if they hold doctorate degrees. In one case, Natalie, an NP, stated:

> There are these 18-month fly-by-night CRNP programs, and doctors don't understand the difference between an online 18-month program and a four-year in-a-classroom program.

> NPs in these programs are prepared very differently and yet they sit for the same test and get the same job. As a result, there's a lack of respect by doctors because they think I've got an 18-month degree, and the fact is I sat in the classroom for four years, and I have my doctorate, and God forbid somebody call me doctor, because that just doesn't happen. They call the MDs doctors, but I'm just Natalie. I am not allowed to be called a doctor or doctor Natalie where I work.

In another situation, Lauren, an NP, stated:

> Some of the older psychiatrists don't want nurse practitioners to be called doctors. One doctor in particular kind of made a negative comment to me and said, "all of you psych NPs are know it alls," and he hated that we could be called doctors because he didn't feel that we earned that title in the same way that he had. We did earn that title though. We may not be physicians, but we deserve to be called doctors just like anyone else with a doctorate degree.

In each one of these depictions, participants highlight the ways that they perceive clients and psychiatrists stifle NPs from being able to gain professional legitimacy, status, and power within the MH specialty. When respondents witness psychiatric patients question the qualifications of MH NPs and refuse to work with them over psychiatrists, they feel that they devalue the NP occupation. Likewise, when MHPs observe psychiatrists questioning the training and education of NPs, keeping track of their mistakes, pushing extra work on them, and suggesting that they are not capable of handling complex cases, it creates unnecessary tension and, in some cases, forces NPs to resign from their jobs.

The COVID-19 pandemic created a greater demand for MH service providers during a time when there was already a national shortage of psychiatrists (Weil 2015; Bethune 2022;

Weiner 2022). MH NPs play a vital role in helping to fill a gap within the U.S. healthcare system; therefore, patients need further education on the training and capabilities of MH NPs, and psychiatrists need to focus more on inter professional collaboration and teamwork with MH NPs to meet patient demands. For example, Stan, a psychiatrist, said:

> I have seen the healthcare system changing and… I think the role of doctors will eventually be different. My feeling is that in the next 10 years doctors might not be seeing as many patients directly themselves. Most likely it will be a team approach where there is the physician overseeing the nurse practitioners, and they will be doing the same thing as a psychiatrist. There will be more of an even balance and, honestly…, I think it will be better to supervise two or three of my nurse practitioner colleagues because then I can learn more and work with them on challenging patients. It would be less repetitive everyday, and I think that could be a good thing. There's so much need in mental health, and I see nurse practitioners as being a really positive asset.

Insurance Reimbursement and Access: Impacts on the Work of Mental Health Professionals

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, the Affordable Care Act (ACA), and the expansion of Medicaid by thirty-nine states (including the District of Columbia) were all implimented in an effort to mandate equal mental and physical healthcare coverage (Centers for Medicare & Medicaid Services (CMS) 2023ab). Unfortunately, two federal agencies (i.e., CMS and Employee Benefits Services Administration (EBSA) identified over forty-five parity violations in 2022. For instance, EBSA found a health plan that had no resctrictions on medical/ surgical prescriptions, but refused to cover two medications (i.e., methadone and naltrexone) used to treat substance use disorders (MHPAEA Report to Congress 2022). Additionally, research shows that one in four people do not have access to an in-network

MH therapist compared to one in ten for an in-network medical specialist (i.e., physical, occupational, and speech therapy) (National Alliance on Mental Illness (NAMI) (2016). Medicaid recipients are also more likely than private insurance holders to have access to an in-network MH provider, therapist, and/or psychiatric hospital (NAMI 2016). Thus, private insurance for MH is lagging behind Medicaid. These types of discrepancies in MH coverage were reported by 11 (~23%) participants in my study. For example, Piper, an RN, works on an inpatient MH unit. She suggested that impoverished patients were often brought in by police for threating to kill themselves after committing a crime. According to Piper, these individuals normally had Medicaid and received seven days of inpatient coverage. This made Piper "extremely frustrated" because many of the individuals brought in by police were not "truly suicidal" and were attempting to avoid jail time. Also, her other clients, who were in desperate need of care, had worse MH benefits through their private insurance. To Piper this "wasn't fair" and made her "angry." In another case, Tara, an RN, said:

> I have to beg insurance companies to pay more money to keep psychiatric patients in the hospital when they're clearly still ill... You wouldn't say to somebody that had heart disease, sorry, you're cut off. No more medicine. No more going into the hospital because you used up all of your days. You wouldn't say that to a cancer patient. I mean somebody probably would sue you for discrimination… I just feel that my whole 36 years of doing this that I haven't moved the needle one little bit. It's very sad in that respect. All of the insurance companies in my area only give patients about 7 days if we're lucky, and they can't get anymore days after that… People don't even read their insurance policies to see how many mental health days they get in their lifetime. In one case, I recently had a patient who could keep going back in the hospital every thirty days

> for his COPD, and he had 6 or 7 days covered each time. This could go on for the duration of his life, yet, when he was admitted for psychiatric problems, he could only get 7 days total as a lifetime max. If this example shows anything it's that the people working for insurance companies… don't care about mental illness in comparison to physical health problems, and it's such a shame.

Other MHPs discussed situations where psychiatric service users were denied certain MH treatment options or medications by insurance companies. According to Stan, a psychiatrist, insurance companies make providers feel "powerless" because they often determine the type of medications and/or treatment that patients can receive. For example, if Stan feels that a client could benefit from electroconvulsive therapy (ECT), but an insurance company denies it for being "too uncommon," it makes his options for care more limited. As a result, Stan suggested that he "isn't very vehement on trying less universal treatments options" because he knows they won't be covered by insurance. Ella, an NP, also argued that insurance companies often refuse to cover non-medicine related treatement options, such as therapy, but will often insure physical therapy for someone who has had carpal tunnel surgery. Pam, an RN, adds to Ella's point by suggesting that insurance companies don't want to cover MH medication either. Specifically, she said:

> I think it's sad to see how much insurance companies invest in physical healthcare and how little they invest in trying to help people with a mental illness. There's insurance companies who will not pay for any psychotropic medications. That's ludicrous. They wouldn't dare think of doing that with insulin, blood pressure medicine, or an antibiotic so why aren't they putting psychotropic medications on an equal playing field? Why are they making it so hard for us to help our patients get the medications they need?

This point is also supported when Adam, an NP, stated:

> I had a young kid on Abilify… He had been on it for awhile, and he was doing pretty well. There was a change in his parent's insurance, and the new insurance decided to deny his refill. During the time that my nurse was submitting new claims to his insurance, getting denied, and resubmitting, my patient ran out of Abilify. I tried to fit him into my schedule as soon as I could, but after being off of his medication for a week he was out of control, and he tried to hurt himself. After having a conversation with his parents, we decided it was in his best interest to hospitalize him, but all of this could have been completely avoided if his new insurance had approved him for a medication he was stable on. It's just so frustrating. I had to physically call his insurance myself to try to get answers as to why they kept denying his refill, and they said, and I quote: "we would prefer he use a different medication first." I WAS SO PISSED! What gives insurance companies the right to determine what medications I can and cannot prescribe, especially when a patient is stable and doing well on a medication.

Each one of these examples show that MHPs are witnessing psychiatric service users falling through the cracks and receiving unequal and/or inconsistent coverage from their insurance providers. According to Vince, a psychiatrist:

> MH is always one of the first things that get cut whenever you're talking about any type of political reimbursement or budget balancing. You know, we have shootings all year long, yet most states cut MH funding... It's this odd dichotomy where everyone recognizes the need for MH funding, but no one really wants to provide that funding. I think again you're looking at something that's intangible. It's not like we can report back and say well, we fixed 8 broken bones out of 10; therefore, we have an 80 percent

> success rate… Most of my big success stories will never be publicly shared. You know this person did not go through with a mass shooting, or this person did not kill themselves. Those statistics aren't really recorded or flaunted anywhere… so I think that abstract nature which intrigues me is also a double edge sword because insurance companies don't want to fund it… or pay for it… This abstract nature and our work with MH patients… cause psych to be perceived as low on the totem pole which in turn affects our access to resources...

Thus, insurance companies are delegitimizing mental illness at an institutional level when they don't provide comparable benefits to physical health.

Media and the Work of the Mental Health Professional

Before the Internet became easily accessible worldwide, information was often disseminated through books, magazines, newspapers, the radio, and tv broadcasting. Today, however, more than eight-in-ten people get their news from digital devices (i.e., smartphone, computer, or tablet) via news websites, search engines, social media, or podcasts whereas one-in-three people still get their news from the tv (Shearer 2021). Hence, now more than ever digital media is serving as a central source of information with people consuming approximately seven hours and nineteen minutes each day (Guttmann 2023). This is cause for concern for the field of psychiatry because the media often shows distorted images of mental illness (Stuart 2006; Srivastava et al. 2018). Also, research shows that people who consume a significant amount of tv are more likely to have a negative outlook on MH (Granello and Pauley 2000). These ideas are supported by 11 (~23%) participants who claim that the media often presents MHPs in a damaging light that causes members of society to question their credibility. Specifically, MHPs reported that the media suggests that they "fail people," "are not doing their job," "don't do

enough," "don't actually help people," "are not qualified," "don't have a scientific background," and "don't know what they are doing." For example, Blair, an NP said:

> The things you see about mental health in the media are often biased news reports. I'm not saying that there hasn't been educational material on mental illness, but more times than not what is reported is not subjective. For this reason, some people may be misinformed because I think psych is a little more of a controversial specialty than let's say orthopedics. Orthopedics is pretty clear cut. You do an x-ray, find out someone has a fractured arm, set it, and put a cast on it. Psych is a science as well as an art. It's a little bit different from patient to patient so I think it lends itself to various people in the media maybe misperceiving what we are doing, and I think that that's why we're starting to equate mass societal events, such as shootings, to mental health. We are seeing the media pointing the finger and placing blame on psychiatrists and people working in mental health for not doing enough.

Other participants made similar connections and suggested that MHPs are usually only discussed on media platforms when someone does something bad on a societal level (e.g., murder, suicide, shooting, etc.). For instance, Ella, an NP, said:

> I think the media cherry picks what they want to say about mental health. I mean think about the shooting in Florida. All the media outlets were questioning why the psychiatrist didn't do more and claimed it was this doctor's fault that the shooting happened… That he should have saved this kid. There's a whole culture arguing that psychiatry needs to fix these people, whether or not we know they need help, and they don't care about any social services or who else could have helped this kid… so I think there's like a blame on people who work in mental health when something bad happens. They are treated like

scapegoats in the media.

Similarly, Dian, an RN, stated:

> Oftentimes the coverage on mental health professionals is negative. You normally hear about them when somebody commits a crime or a murder. Like a few years ago a former patient went off his meds and went to a psychiatric hospital and shot several people. He ended up being killed, and I remember that being a major event in the news for quite some time, and all they talked about was who made the mistake, who was at fault, who missed his symptoms? They argued that it was another mental health failure because we failed to help this patient who just went out and shot someone, and I'm sure the people watching that then question whether mental health professionals even matter if we can't prevent psychiatric patients from committing these outrageous crimes, but this situation was completely out of our control. We do our best with trying to assess how patients are doing in the moment, but a lot of times we can't predict how they're going to react if a stressful situation gets to be too much… We hope we impact our patients in a way that they're able to cope with and think out their decisions, but sometimes we can't predict the impulsivity of somebody's decision no matter what we do.

These examples suggest that media outlets are potentially influencing societal viewpoints by broadcasting information that questions the legitimacy of MHPs and the work they perform.

DISCUSSION AND CONCLUSION

The participants in my study identified three ways (i.e., professionally, institutionally, societally) that they still struggle to find legitimacy within the field of psychiatry. From a professional standpoint, NPs discussed how psychiatric service users and psychiatrists negatively impact their occupational status. For example, patients minimize the expertise of MH NPs when

they request to be treated by a psychiatrist. This finding aligns with the literature which shows that patients often prefer to see physicians over NPs based on their qualifications and skills (Leach et al. 2018). Furthermore, in an effort for psychiatrists to maintain their status at the top of the MH hierarchal pyramid, nurses observed psychiatrists micro-managing the mistakes of NPs to use as collateral, pushing extra tasks on NPs, and questioning the education and ability of NPs to handle difficult cases. Psychiatrists were reluctant to call MH NPs doctors as well and nurses witnessed psychiatrists pressuring healthcare organizations to exclusively hire PAs. These actions ultimately created a "power struggle" between psychiatrists and MH NPs. This interprofessional tension is reminiscent of psychiatrists' attempts to prevent psychologists, social workers, and counselors from using psychotherapy in the 1980s (see above) (Greenburg 1980). Research also shows that these tensions are not exclusive to the MH specialty, and jurisdictional conflict happens between physicians and nurses in general as they navigate changing professional boundaries (Salhani and Coulter 2009; Kraus and DuBois 2016; Trotter 2020). For instance, Trotter (2020) found that the NPs in her study were not respected for holding an advanced degree and were undermined at times by physician colleagues. In another study, primary care doctors were accepting of NPs practicing independently, but they still felt that NPs should be supervised (Kraus and DuBois 2016). In comparison, the participants in my sample did not feel that psychiatrists were supportive of NPs having full practice rights. It's possible that this is because psychiatrists are trying to hold onto their status within the MH specialty since they lack standing on a professional level when compared to doctors in other subfields. Unfortunately, this makes it difficult for MH NPs to gain professional legitimacy.

To add to these findings, it's important to note that the MHPs in my sample were never directly asked questions that pertain to jurisdictional boundaries (Abbott 1988). This theme

surfaced while coding and analyzing the subsection referred to as societal perceptions on the interview guide (appendix H) below. This may partially explain why the RNs in my sample did not discuss role blurring between other MH occupations and why the NPs in my study did not discuss boundary-work with RNs. Jurisdictional boundary issues have been studied at length between doctors and RNs and more recently between NPs and other healthcare professionals (Allen 1997; Salhani and Coulter 2009; Trotter Apesoa-Varano 2013; Liberati 2017; Johannessen 2018; Trotter 2019; Trotter 2020). This is the first study to my knowledge, however, that included NPs within the MH specialty. For this reason, future research needs to take a more comprehensive look at the jurisdictional boundary work that's happening between MH NPs and other MHPs.

At an institutional level, MHPs discussed several ways that insurance companies are delegitimizing MH. Specifically, they argued that psychiatric patients are falling through the cracks and not receiving comparable physical and mental health coverage. For example, participants observed clients being denied coverage for therapy and certain treatment options, receiving a very limited number of days for in-patient hospital stays, and Medicaid plans providing better treatment options than private insurance plans. From a historical perspective, this disparity is not surprising since insurance companies stopped reimbursing MH dollar for dollar in a similar manner with physical health in the mid-1970s (Wilson 1993).

The final way that the MHPs in my study experienced a crisis of legitimacy was via the media. Participants reported that broadcasting platforms depict MHPs in a negative light that causes viewers to question their expertise. For example, the media reported that MHPs are unqualified, inept, and unhelpful and that the MH field is unscientific. MHPs also feel that the public blames them for negative mass societal events such as shootings, murders, and suicides on

MHPs. These findings align with the literature which shows that the media still produces negative perceptions of MHPs and portrays them as unskilled and untrustworthy (Schneider 1987; Wahl 1992; Gabbard and Gabbard 1999; Stout et al. 2004; Klin and Lemish 2008; Ma 2017). Thus, although MH stereotypes are used to advance plotlines, improve network ratings, and create entertainment, they can be "incredibly damaging" and cause viewers to develop negative attitudes toward people with a mental illness, MHPs, and psychiatric institutions (Domino 1983; Gabbard and Gabbard 1999; NAMI 2023).

It is important to acknowledge that data in this chapter were collected in 2018. The coronavirus pandemic began two years later, and since then there has been a fundamental shift surrounding MH. For example, there is more media coverage on the worsening MH of U.S. citizens since the COVID-19 outbreak. Some news outlets are even reporting that we are experiencing a major MH crisis, especially among children grades K through 12 (Gramlich 2023). Congress has authorized several bills to provide financial support for behavioral health services as well. For instance, Project AWARE, which offers school-based MH programs and services, has received millions of dollars from the government (Miller et al. 2022). Additionally, 200 million dollars was provided through the Coronavirus Aid, Relief, and Economic Security (CARES) Act for telehealth services (Federal Communications Commission 2023). The limited access to healthcare professionals during the pandemic pushed companies to think outside of the box in order to provide mental and physical health treatment. Thus, more and more MHPs are working with telehealth companies such as Better Help and Grow Therapy. These platforms have been especially helpful for people who live in designated MHP shortage areas. Finally, labor unions, across several industries, recently formed a coalition to encourage federal regulators to enforce the same standards for mental and physical health in the workplace. These unions are

concerned with the rise in MH problems post-pandemic in their work environments, and they want more MH resources (Devlin 2023). Hence, now more than ever there is a greater awareness for behavioral health services due to the COVID-19 pandemic. Despite this recognition, however, the crisis of legitimacy surrounding MHPs likely remains. For instance, most of the attention on psychiatry since the COVID-19 pandemic has focused on people with a mental illness and the MH delivery system. This leaves the needs of MHPs out of the conversation and fails to address the stigma and crisis of legitamcy that they continue to face.

There are three important implications from the data in this chapter. First, when insurance companies fail to establish parity between mental and physical health, it creates barriers to psychiatric care. Specifically, patients end up paying greater out-of-pocket costs for outpatient and inpatient MH treatmeant in comparison to medical services (NAMI 2016). This is problematic because research suggests that 42 percent of adults with a mental illness were unable to receive mental healthcare because they could not afford it (Mental Health America 2023). Also, in 2023, 1.2 million youth with private insurance did not have coverage for mental and emotional difficulties even though suicide is the third leading cause of death among individuals ages 15 to 24 (NAMI 2023; Mental Health America 2023). Finally, not being able to receive psychiatric treatment ultimately has a ripple effect that extends to a psychiatric patient's family, community, and the world. For example, depression and anxiety alone costs the global economy 1 trillion dollars in lost productivity a year (NAMI 2016). Hence, it's vital that MH coverage is legitamized at an institutional level, via health insurance companies, to help place mental and physical healthcare on a more level playing field.

The second reason these findings are important is because the field of psychiatry is experiencing a national workforce shortage. Psychiatrists are not being replaced at the same rate

that they are retiring due to the MH specialties subordinate status (Weil 2015; Bethune 2022; Weiner 2022). As a result, the mental healthcare system is struggling to provide services nationwide, especially since the COVID-19 pandemic. MH NPs are in a unique position to help address the shortage of providers and expand access to care for people with a mental illness (Soltis-Jarret 2023). Unfortunately, the American Medical Association (AMA) continues to fight scope of practice expansions even though research shows that NPs provide safe, high-quality, patient-centered care (Horrocks, Anderson, and Salisbury 2002; Soltis-Jarret 2023; AMA 2023). This is problematic because the power struggle between psychiatrists and MH NPs can impact patient access to care. For example, in states without full practice rights, MH NPs are hindered by restrictive laws and policies (e.g., limited prescriptive authority) and some find it difficult to find a collaborating physician. This can ultimately create a barrier to care for geographical areas experiencing MHP shortages (Soltis-Jarret 2023).

Finally, the misinformation circulated throughout the media can cause people with a mental illness to become noncompliant with their providers. According to Im and Huh (2017), patients who are frequently exposed to health information in the media were more likely to question the benefits of their prescriptions and less likely to adhere to their medication regimens. For this reason, participants in my study stated that they often have to go out of their way to "educate clients" and "gain their trust" in order to overcome "negative societal perceptions" and "get them on the right medication and therapy." In addition, research shows that social media use is correlated with depression, anxiety, poor sleep, and low self-esteem during a time when people are spending approximately 33 percent of their day using digital media (Guttmann 2023; Azem et al, 2023). This fact in and of itself not only shows how harmful mass media can be, but it demonstrates the significant need for MHPs. Thus, the media needs to consider how their

programming can potentially impact psychiatric service users and MHPs.

In order to ensure that psychiatric service users have access to care, MH NPs need to be granted full practice rights in each U.S. state. Doing so would place value on the NP occupation, help encourage psychiatrists to focus on inter professional collaborations with NPs, reduce healthcare costs, improve access and quality of care, and lead to better health outcomes for patients (Poghosyan et al. 2022). Until this happens, however, Soltis-Jarret (2023) suggests that NPs should join professional organizations, attend conferences, work with people who create policies that impact healthcare, and educate nursing students on how laws and policies are developed. Additionally, although the government is attempting to establish parity by monitoring insurance plans, institutional legitimacy will not be fully established for MH until hospital organizations provide insurers equal access to in-network mental and physical health providers and services (NAMI 2016). In order for this to occur, large healthcare systems need to address the gaps in their MH workforce and think about how they can incentivize prospective employees (i.e., pay, time off, etc.). Given the shortage of MHPs, this is a potential challenge for some healthcare institutions; therefore, changes likely need to start within nursing and medical schoools. For example, educational institutions need to consider providing additional MH training that encourages nursing and medical students to think differently about working in the field of psychiatry (Martin et al. 2020). Finally, MH themes in the media have doubled since the beginning of the pandemic, and as a result, journalists are in a unique position to help improve the image of MHPs. For example, Goswami (2023) argues that MH coverage can be improved if broadcasting networks: (1) reimagine MH beyond healthcare; (2) change the narrative of MH stories; (3) provide training to reporters and editors; (4) focus on the why and how of MH

funding; and (5) priotize inclusion and equity in MH. Taking these steps can potentially help to address the crisis of legtimacy that MHPs are currently experiencing and improve MH stigma.

CHAPTER VI

DISCUSSION AND CONCLUSION

Mental health professionals (MHP) are responsible for maintaining a safe and therapeutic milieu for psychiatric patients. They make behavioral observations, respond to physiological and psychological signals, identify complications, manage medications, and guard against violent behavior (Jones et al. 1987; Clarke and Aiken 2003; Gerolamo 2006). Their role is valuable to the millions of psychiatric service users who rely on their care, but their specialty has been criticized and delegitimized for decades. To shed light on the struggles that MHPs encounter, I used semi-structured interviews to examine how psychiatrists, mental health (MH) nurse practitioners (NP), and MH registered nurses (RN) perceive and manage stigma. I also explored how these MHPs navigate their professional status when they have larger organizational and institutional pressures that delegitimize their work. In what follows I will: (1) review the findings from chapters III through V; (2) compare the emotions and coping strategies identified in chapters III and IV; (3) discuss the contributions and implications of my research; (4) list the limitations of my study; and (5) offer suggestions for future research.

Empirical Chapter Findings

In Chapter III I focus on how MHPs themselves are exposed to associative stigma. In this section I am guided by three research questions:

1. How do MHPs experience associative stigma?

2. How does associative stigma make MHPs feel

3. How do MHPs cope with associative stigma?

The MHPs in my sample experienced associative stigma after being discouraged from entering the MH specialty, being denied jobs on medical units, being perceived as unintelligent, eccentric, lazy, crazy, glorified babysitters, and pill pushers, and being told that they are not real nurses or doctors. These findings are in line with the associative stigma literature on formal caregivers of the mentally ill (Vayshenker et al. 2018). Participants identified feeling frustrated, disappointed, hurt, and angry in response to associative stigma. To cope, respondents used disregard, avoidance, challenging, humor, self-care, and social support. When MHPs disregard associative stigma, they ignore it and do not internalize MH stereotypes. In comparison, avoidance occurs when participants hide their specialty to abate stigmatizing encounters. To face associative stigma directly some individuals in my sample utilized challenging in the form of education and activism. They also used humor and cracked a joke. Self-care strategies involved exercising, listening to music, playing video games, and mindfulness whereas participants relied on MH peers for social support. Disregard, avoidance, and challenging are all reported in the coping stigma framework developed by Thoits (2011). Humor and social support are also identified more generally in the associative stigma literature (Catthoor et al. 2014; Vayshenker et al. 2018). To my knowledge, there are no studies on MHPs that discuss self-care as a coping strategy for associative stigma.

Chapter IV discusses the difficult and sometimes gut-wrenching moral distress narratives offered by the nurses (i.e., NPs and RNs) in my sample. It also shows that moral distress is, in part, viewed as a consequence of stigma. I was guided by the following research questions:

1. How do MHPs experience moral distress?

2. How does moral distress make MHPs feel?

3. How do MHPs cope with morally distressing situations?

Regarding question 1, my findings show that MHPs experience two forms of moral distress: stigma and non-stigma. Stigma-related moral distress occurred when participants directly or indirectly witnessed the stigma that their patients face due to holding a "blemish of individual character" (Goffman 1963:4). These morally distressing situations fall into two overarching categories: (1) substandard care and (2) being denied access to non-MH institutions. For example, respondents reported that their non-MH colleagues would prescribe narcotics to recovering addicts, physically mistreat patients, and refuse to run appropriate testing for physical health ailments. These findings are significant because although the literature shows a connection between stigma and inadequate patient care, there are no studies that link this information to the moral distress of MHPs (Thornicroft, Rose, and Kassam 2007; Vistorte et al. 2018). Non-stigma related moral distress occurred during situations involving inappropriate treatment recommendations (i.e., ECT), time constraints, and patient death. For instance, when inpatient psychiatric facilities were understaffed, or outpatient clinics limited how long providers could see their clients, respondents perceived that they were failing as nurses. These findings are in line with previous research (Lamiani, Borghi, and Argentero 2015; Ando and Kawano 2016; Upasen and Saengpanya 2021).

To address the research question of how moral distress made MHPs feel, I found that stigma and non-stigma related moral distress caused the NPs and RNs in my study to feel angry, disheartened, frustrated, heartbroken, helpless, hurt/upset, ill, irritated, let down, sad, scared, and tearful. To manage these emotions, respondents focused on three coping strategies: (1) challenging; (2) social support; and (3) self-care. After morally distressing situations involving stigma and substandard care, participants often resorted to challenging as a form of coping.

Specifically, they would address client mistreatment head on via confrontation and/or education. Social support was used as a general management technique during stigma and non-stigma related moral distress. When a patient died, when institutions (e.g., nursing facilities) refused to take clients, or when patients were mistreated the NPs and RNs in my study relied on their colleagues for social support. Respondents also employed self-care techniques such as exercising and mindfulness when they faced morally distressing situations involving patient death. Although moral distress research identifies education, social support, and self-care as coping methods used by healthcare professionals, there are no studies that identify challenging, in the form of confrontation, as a management strategy (Oh and Gastmans 2015; Ritchie et al. 2018). For this reason, scholars should potentially adapt this concept from Thoits (2011) and consider its use in moral distress research on MHPs.

Chapter V looks at the ways that the psychiatric specialty struggles to secure legitimacy within the broader field of medicine. I was guided by the following research question:

1. In what way(s) are MHPs struggling to find legitimacy for their specialty given the larger organizational and institutional pressures that delegitimize their work?

With this question in mind, my study shows that MHPs are struggling to secure legitimacy on a professional, organizational, and societal level. From a professional standpoint, MHPs discussed the jurisdictional boundary issues between psychiatrists and MH NPs that prevent MH NPs from gaining status and acceptance on a professional level (Abbott 1988). For example, participants observed psychiatrists refusing to call MH NPs doctors, questioning their qualifications and skills, keeping track of their mistakes, pushing extra tasks on them, and encouraging healthcare organizations to exclusively hire PAs. Although there are no studies on MH NPs working in MH care per se, jurisdictional boundary problems have been reported between physicians and NPs in

the literature (Trotter 2019; Trotter 2020). These tensions appeared at play in my sample.

At an institutional level, participants argued that insurance companies do not provide MH coverage comparable to physical health. Specifically, clients were denied coverage for therapy and received inadequate in-patient hospital stays for psychiatric care. Finally, respondents reported that the media portrays MHPs as unqualified, inept, and unhelpful. Broadcasting networks also blame mass societal events (e.g., shootings) on MHPs which cause viewers to potentially question the expertise and value of MHPs. This negative image, as perpetuated in popular culture, is documented in the existing literature on MH (Schneider 1987; Ma 2017).

Feeling and Coping as a Mental Health Professional

Chapter III examined how MHPs themselves are stigmatized for having direct contact with a population that holds a perceived character deficit (i.e., mental illness). In comparison, chapter IV shows that stigma can cause moral distress in certain situations, especially when MHPs witness people with a mental illness being stigmatized and mistreated by healthcare workers. Together these chapters emphasized themes surrounding emotions and coping. For example, MHPs reported being frustrated, hurt, and angry in both chapters. The difference, however, is that after morally distressing situations, participants expressed several additional emotions (i.e., disheartened, heartbroken, helpless, ill, irritated, let down, sad, scared, and tearful). As discussed above, MHPs seek to provide high quality patient care in accordance with the ethical standards and scope of practice outlined by their profession. It's possible that moral distress affected the MHPs in my sample on a more personal level than associative stigma because, in some cases, they couldn't protect MH patients. As a result, they expressed more emotions. In regard to coping, both chapters show that MHPs utilized challenging, social support, and self-care. Challenging is a concept within a larger stigma coping framework that

was developed by Thoits (2011) (See chapter III). Although this framework was created to explain the stigma coping strategies used by people with a mental illness, some of the concepts very clearly apply to stigma-related moral distress and associative stigma. For moral distress, participants utilized education and confrontation within the challenging coping strategy whereas for associative stigma respondents used education and activism. Education is a common theme in chapter III and IV, but confrontation was only used during moral distress. MHPs may have felt more pressed to confront non-MHPs after witnessing people with a mental illness receive substandard care in comparison to hearing negative remarks about their specialty since, in the former condition, MHPs hold responsibility for the well-being of patients. Furthermore, during associative stigma situations respondents utilized disregard, avoidance, and humor to cope. These coping methods were not reported by participants for moral distress.

Sociology of Mental Health: Where are the Caregivers?

"All of us need care as young children, most of us will need care again as we near the end of our lives, and many of us will need care of varying levels of intensity for longer or shorter periods in between" (Duffy, Armenia, and Stacey 2015:5). Providing high quality mental healthcare to those in need is part of a broader "infrastructure of care" that scholars and policy makers have long called for (Duffy et al. 2015). In order to realize this goal, we must examine formal caregivers who play a direct role in treating people across the lifespan. This includes MHPs who work in a specialty that is often devalued and misunderstood by other medical disciplines (Malhi et al. 2003; Halter 2008). Currently, sociologists are rightly preoccupied with understanding the needs of those who live with a mental illness (Burr and Chapman 2004; Beauboeuf-Lafontant 2008; Milbourn et al. 2015). This research is an important part of the MH equation, but now more than ever scholars need to pivot the conversation toward formal

caregivers of the mentally ill. MHPs play an important role within the U.S. MH delivery system, but their voices and needs are being ignored by the healthcare organizations they work for and academics within the field of medical sociology and MH. My dissertation places a critical spotlight on MHPs, especially nurses. My study also applies sociological frameworks (e.g., associative stigma, moral distress, coping, jurisdictional boundaries) to MHPs to better understand their experiences. These are all important contributions to the medical sociology and MH literature.

Implications of Research

In this dissertation, I show that moral distress and associative stigma can cause MHPs to resign from their job or be dissatisfied with their work, that associative stigma can deter nursing and medical students from entering psychiatry, and that moral distress, associative stigma, and jurisdictional boundary issues can create barriers to psychiatric care. These implications are all problematic for healthcare systems. For example, when an MHP leaves their job, it can cost medical organizations over $51,000 in turnover fees (Plescia 2021). Also, if nursing and medical students don't pursue psychiatry and fill vacancies within the MH delivery system this can lead to staff shortages. Additionally, healthcare institutions rely on patients to stay afloat financially. If someone doesn't feel that they are receiving quality mental healthcare, they may be less willing to continue seeking treatment. To address these issues, I offer two big picture suggestions.

First, healthcare systems should invest in interprofessional training that emphasizes the value and importance of mental healthcare. Studies show that 6 percent of adult ER visits are due to MH issues and that 80 percent of psychiatric patients seek out treatment from a primary care doctor at least once a year (Narrow et al. 1993; Advent Health 2023). Based on this information,

it's very likely that medical professionals are providing care to people with a mental illness on a regular basis whether they know it or not. To ensure that all healthcare professionals have the skills to treat psychiatric service users, doctors and nurses (regardless of their specialty) need MH training similar to the way that all physicians across specialties are now encouraged to practice primary palliative care to support the needs of seriously ill and dying patients (von Gunten 2002). This training should start in nursing and medical school, but it should also happen throughout the careers of medical professionals via on-the-job training. Recently, the Biden-Harris administration announced that 5.4 million dollars would be given to universities across the U.S. to ensure that students in health profession programs receive substance use disorder (SUD) education early on in their academic careers (U.S. Department of Health and Human Services 2024). This is such an important first step in training healthcare professionals. Research also suggests that MH training may help persuade medical and nursing students to pursue a career in psychiatry (Ng et al. 2010; Martin et al. 2020). This information alone further supports the significance of MH training given the shortage of psychiatrists and lower overall staffing levels on MH units (Satiani et al. 2018).

To add to this point, if healthcare organizations want to deter MHPs from being dissatisfied with their jobs and leaving, they need to be willing to critically assess their policies and practices and make changes that benefit their employees. More specifically, they need to focus on how to make the work lives of MHPs better and ensure that all of their healthcare workforce has access to affordable mental healthcare services. According to the Centers for Disease Control and Prevention (CDC) (2022), 69 percent of physicians report experiencing depression and 13 percent have had thoughts of suicide. One-third of psychiatrists also suggest that they have experienced a mental illness (Yasgur 2019). Nonetheless, 29 states (including

Ohio) have MH disclosure requirements on their licensing applications that cause doctors and nurses to hide their mental illness for fear that people would doubt their abilities or turn them into their employer or boards (Henry 2023; Houghton 2024). This is where stigma operates for all doctors and nurses on a professional level. Healthcare systems are in a unique position to be able to address this issue by lobbying for all states to support changes to licensing applications. If healthcare professionals no longer have to check a box regarding their MH, in order to be licensed, they may feel safer seeking out care for MH or SUD. In addition, medical systems need to create training and programs that work to destigmatize mental healthcare so that it is seen as part of the job as opposed to something that healthcare professionals need to feel ashamed about. They can also support their workers by providing paid days off for MH and offering resources that help individuals easily find MH services. If unions are currently pushing for workplace standards regarding MH, then shouldn't the healthcare organizations that employ the people providing those services be doing the same thing for their workers (Devlin 2023)?

Limitations

The participants in my dissertation were recruited using a gatekeeper (n=28) and snowball sampling (n=20). Although gatekeepers play an invaluable role in qualitative research, it's important to acknowledge that they hold bias and may limit the diversity of the respondents recruited. According to Cohen and Arieli (2011:428), "gatekeepers may have their own reasons, personal or otherwise, for referring or not referring the researcher to potential respondents." Also, gatekeepers can only recruit prospective interviewees from their social networks which means that some individuals may be excluded. Hence, using Nick as my gatekeeper may have been a limitation since I was only able to gain access to the MHPs that he had direct contact with through his work experience and educational background. To add to this point, I used snowball

sampling from the individuals that Nick put me in contact with. Even though word-of-mouth techniques helped me locate 20 MHPs, it may have created selection bias. For example, individuals could have referred me to other MHPs who are similar to them in regard to their race, sex, age, or orientation to work. This pattern is seen within my demographic data.

As noted in chapter I, the MH RN workforce is more diverse by sex and race than the general RN population. For instance, there are double the number of Black RNs and a larger number of male nurses in MH (APNA 2022). When you compare these demographic trends to the MH RNs in my sample, I lack participant diversity. Only around 12 percent of my sample was male (n=3) and all the MH RN participants are white. Looking at MH NP respondents, all of them are white and approximately 76 percent are female. The national average for MH NPs in the U.S. is 84 percent white, 10 percent Black, and 90 percent female (APNA 2022). Based on these numbers, my sample has a slightly higher percentage of male MH NPs, but there is no racial diversity. In addition, I had a very small number of psychiatrists (n=3) in my study and all of them are male. Nationally, more psychiatrists are likely to be female (American Medical Association 2015). Having a more diverse sample would have allowed for an intersectional examination of how MHPs experience moral distress and associative stigma and struggle to find legitimacy for their specialty (Crenshaw 1989). The interconnectedness of socially-constructed identities (e.g., race, sex, class, occupation, etc.) collectively shapes the way that people experience their work as MHPs and because my sample wasn't diverse, I couldn't implement a true intersectional approach (Abrams et al. 2020). For example, having a small number of psychiatrists made it difficult to make distinctions between the three occupational groups in my study. Specifically, psychiatrists did not discuss situations involving moral distress, and I was unable to show any professional associative stigma differences. Subsequent research should look

at this in a more intersectional way.

Another potential limitation to my study is that respondents were recruited from a range of healthcare settings with little attention to the logic of comparison. Participants were employed across a variety of MH settings including hospital systems, private practice groups, VA medical centers, community MH clinics, rehab facilities, home health organizations, and state correctional institutions. My decision to snowball across various MH work sites means that I was unable to look more systematically at how the type of work environment shapes the moral distress and stigma experiences of MHPs. Future research should consider how different types of behavioral health work settings impact the work experience of MHPs.

The final limitation in my dissertation is that approximately 94 percent (n=45) of the semi-structured interviews were conducted over the phone. Using this data collection method was beneficial because it made it easier to reach geographically dispersed respondents. It also helped ease some apprehension because respondents were unable to determine my demographic characteristics, and they remained "on their own turf (McCoyd and Kerson 2006:399)." There were several disadvantages to using phone interviews, however. For example, there was a loss of nonverbal and contextual data (Novick 2008). Also, some participants spoke with me during their commute home from work which led to a poor cell signal at times.

Future Research

As discussed above, future research needs to take a renewed interest in studying MHPs, especially MH NPs. The current study is the only one in the U.S. to my knowledge that includes MH NPs to explore issues involving moral distress, associative stigma, and jurisdictional boundary work. Subsequent research should also consider using one MH work setting and using other data collection methods in conjunction with in-depth interviews. For example, diary studies

or conducting participant observation could provide a deeper understanding into what MHPs endure while working in a devalued specialty. Also, focusing on one behavioral health site may make it easier to see the moral distress and associative stigma intricacies that occur within a particular MH work environment. Scholars would benefit from taking an intersectional approach to studying MHPs as well. My study does not speak to how race and sex contribute to the experiences of formal caregivers of the mentally ill. Finally, future research should consider examining the mental well-being of MHPs and whether or not they feel comfortable seeking out care for their own MH or SUD. Healthcare professionals often feel stigma for having a mental illness, and sometimes they are afraid to seek help due to MH disclosure requirements. Further examination of this issue is warranted.

Conclusion

The greater demand for behavioral health services since COVID-19 makes clear that MH has a seat at the table with other medical disciplines. MH is not a myth and there are millions of psychiatric service users (including healthcare professionals) who rely on MHPs for their care (Szasz 1961). Although there are still gaps in our understanding within the field of MH, the work of MHPs matters. My dissertation places formal caregivers of the mentally ill at center stage in order for members of society to see the value in their job and to understand the struggles that they endure working in a devalued specialty. Not only do MHPs experience moral distress and associative stigma, but they also deal with barriers on a professional, institutional, and societal level. My hope is that this research pushes scholars to turn their attention toward MHPs in order to develop policies that address their unique needs.

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APPENDIX A

HUMAN SUBJECTS APPROVAL FORMS

RE: IRB # 17-110 entitled "The Emotional Labor of Mental Health Professionals"

I am pleased to inform you that the Kent State University Institutional Review Board reviewed and approved your Application for Approval to Use Human Research Participants as a Level II/Expedited, category 6,7 project. Approval is effective for a twelve-month period:

March 13, 2017 through March 12, 2018

For compliance with:

- DHHS regulations for the protection of human subjects (Title 45 part 46), subparts A, B, C, D & E

**If applicable, a copy of the IRB approved consent form is attached to this email. This "stamped" copy is the consent form that you must use for your research participants. It is important for you to also keep an unstamped text copy (i.e., Microsoft Word version) of your consent form for subsequent submissions.*

Federal regulations and Kent State University IRB policy require that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB tries to send you annual review reminder notice by email as a courtesy. However, please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials. Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date. Visit our website for forms.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact the Office of Research Compliance at Researchcompliance@kent.eduor 330-672-2704 or 330-672-8058.

Doug Delahanty | IRB Chair |330.672.2395 | ddelahan@kent.edu
Tricia Sloan | Coordinator |330.672.2181 | psloan1@kent.edu
Kevin McCreary | Assistant Director | 330.672.8058 | kmccrea1@kent.edu

Paulette Washko | Director |330.672.2704| pwashko@kent.edu

RE: IRB # 17-110 entitled "THE EMOTIONAL LABOR OF MENTAL HEALTH PROFESSIONALS"

Hello,
The Kent State University Institutional Review Board (IRB) has reviewed and approved your Annual Review and Progress Report for continuing review purposes. It is understood that the research is continuing with modifications including [*added questions, slight change to consent, procedures, and HIPPA section*]. The protocol approval has been extended and is effective**:**

March 13, 2018 through March 12, 2019

For compliance with:

- DHHS regulations for the protection of human subjects (Title 45 part 46), subparts A, B, C, D & E

**A copy of the IRB approved consent form is attached to this email. This "stamped" copy is the consent form that you must use for your research participants. It is important for you to also keep an unstamped text copy (i.e., Microsoft Word version) of your consent form for subsequent submissions.*

Federal regulations and Kent State University IRB policy requires that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB will try to send you an annual review reminder notice by email as a courtesy. However, please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials. Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact me at 330-672-2704
or pwashko@kent.edu.

APPENDIX B

GATEKEEPER RECRUITMENT SCRIPT

Hey _____,

I am helping Paige Bosich, a Kent State University graduate student, recruit mental health professionals for a research project. The purpose of the study is to learn more about the experiences associated with providing care to psychiatric patients. Your participation is completely voluntary, and your only requirement would be to take part in an interview with Paige that will last between 45 minutes and an hour. Because you are a (psychiatrist/ nurse practitioner/ nurse/ licensed practical nurse), I was wondering if you might be interested in learning more about the study or becoming a participant?

A. *If yes-*

Would you mind if I provided Paige with your contact information?

If yes-

What would be the best way for her to contact you?

[Gather information]

Paige will contact you within the next week.

B. *If no-*

Okay, no problem.

APPENDIX C

EMAIL RECRUITMENT SCRIPT

Hi _____,

My name is Paige Bosich, and I am a graduate student in the Sociology Department at Kent State University. Dr. Clare Stacey (advisor and co-investigator) and I (the principal investigator) are conducting a study entitled "The Emotional Labor of Mental Health Professionals." Nickolas Speeney approached you about the study, and you gave him your email for me to contact you.

I want to start off by thanking you for showing an interest in this research project, and I want to provide you with some additional information. For this study, I am focusing on the experiences of mental health professionals, such as yourself, to learn more about the positive and negative experiences associated with providing care to psychiatric patients. If you choose to take part in this study, you will be asked to participate in an interview with me. The interview will be conducted at a location that is convenient for you, and it may last anywhere from 45 minutes to 2 hours (the average time is 1 hour). During the interview, I will ask you some background information about what led you to work in the mental health field, your work environment, the tasks associated with your job, and the interactions that occur among staff and patients. Also, your personal information will be kept confidential within the limits of the law. Any identifying information will be permanently removed from the data and destroyed, and I will be the only one, beyond the principal investigator, who has access to the data. Finally, if you decide to participate in the study, you will receive a $10 gift card at the end of the interview.

If you still wish to participate in this study, please email me back at your earliest convenience to set-up a date, time, and place for an interview.

Thank you for your consideration and have a great day!

Best,

Paige Bosich, M.A.
Doctorial Candidate and Graduate Instructor
Kent State University
Department of Sociology
Email: pbosich@kent.edu

APPENDIX D

TELEPHONE RECRUITMENT SCRIPT

Hello, is this _____?

[pause and wait for a response]

If yes, then continue. If no, ask if you could speak to _____.

Hi, my name is Paige Bosich, and I am a graduate student in the Sociology Department at Kent State University. Dr. Clare Stacey and I are conducting a study entitled "The Emotional Labor of Mental Health Professionals." Nickolas Speeney approached you about the study, and you gave him your phone number for me to contact you. Is this a good time?

[pause and wait for a response]

If yes, then continue. If no, ask when would be a good time to call back.

Would you like to know a little more about the study?

If yes, then continue. If no, skip to the end and ask if they still wish to participate.

For this study, I am focusing on the experiences of mental health professionals, such as yourself, to learn more about the positive and negative experiences associated with providing care to psychiatric patients. If you choose to take part in this study, you will be asked to participate in an interview with me. The interview will be conducted at a location that is convenient for you, and will last approximately one hour. During the interview, I will ask you some background information about what led you to work in the mental health field, your work environment, the tasks associated with your job, and the interactions that occur among staff and patients. Any identifying information will be permanently removed from the data and destroyed, and I will be the only one, beyond the principle investigator, who has access to the data. Furthermore, you will receive a $10 gift card at the end of the interview if you decide to participate in the study.

Wait and see it there are any questions that arise or how the individual responds. If there are any questions that do arise then answer those questions. If there are no questions, then proceed.

Are you still interested in participating in this study?

A. *If they agree-*

   Great! When would be a good date, time, and place to schedule an interview*?*

   After scheduling-

   Thank you and have a good day!

B. *If they decide not to participate-*

   I understand. Thank you for your time and have a great rest of your day.

APPENDIX E

RECRUITMENT FLIER FOR SNOWBALL SAMPLING

The Experience of Mental Health Professionals

Be part of an important research study on mental health professionals

- Are you between the ages of 18 and 65?
- Are you a psychiatrist, psychiatric-mental health advanced practice registered nurse (PMH-APRN), psychiatric mental health registered nurse (PMH-RN), or psychiatric licensed practical nurse (PLPN)?

If you answered YES to these questions, you may be eligible to participate in a research project that is designed to learn more about the positive and negative experiences associated with providing care to mentally ill patients.

You will be asked to take part in a one-hour interview with the lead investigator, Paige Bosich, and answer questions about your interest in the mental health field, your work environment, the daily tasks associated with your job, and the interactions that occur among staff and patients. You will earn a $10 gift card for your participation.

If you would like to learn more, please contact Paige Bosich at

724-600-4465 or pbosich@kent.edu

APPENDIX F

INFORMED CONSENT FORM

Study Title
The Emotional Cost of Associative Stigma Among Mental Health Professionals

Principal and Co-Investigator
Paige Bosich, M.A. and Dr. Clare Stacey

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose of Study
This study will focus on mental health professionals (MHP) (e.g. psychiatrists, nurse practitioners, and registered nurses) to learn more about the positive and negative experiences associated with providing care to psychiatric patients.

Procedure
If you decide to take part in this study, you will be asked to participate in an interview with the Principal Investigator, Paige Bosich. Interviews will be conducted at a location convenient to your home, place of employment, a quiet public place such as a library, or via phone and last anywhere from 30 minutes to 2 hours.

During the interview, I will ask you about the following broad topics: professional background, workplace emotions, and societal perceptions regarding the field of mental health and your profession.

Risks
There are no anticipated risks beyond those encountered in everyday life.

Audio Recording
Interviews will be documented using a voice recorder on the Principle Investigators password protected computer. All interviews will be transcribed verbatim and then kept as Word files. These files will be uploaded into a data software program to look for themes and patterns. During the transcription process all data will be de-identified which means that each participant will receive a pseudonym (false name). This is done to ensure that the transcribed interviews will not be linked back to participants.

Benefits
This research will not benefit you directly; however, my hope is that it will contribute to the literature on mental health, work and occupations, and emotions and shed light on the work

experiences of mental health professionals.

Privacy and Confidentiality

Your study related information will be kept confidential within the limits of the law. Any identifying information will be kept in a secure location and only the researchers will have access to the data. Research participants will not be identified in any publication or presentation of research results; only aggregate data will be used. Confidentially may not be maintained if you indicate that you may do harm to yourself or may have done harm to others.

The Health Insurance Portability and Accountability Act (HIPPA)

As a mental health professional, you are expected to uphold all HIPPA regulations during the interview process. You cannot discuss any individually identifiable health information including demographic data that relates to: (1) a patient's past, present, or future physical or mental health; (2) the provision of health care to a patient; or (3) the past, present, or future payment for the provision of health care to a patient. Also, you cannot discuss common identifiers such as a patient's name, address, birth date, or Social Security Number.

Compensation

As a token of appreciation for taking part in this study, you will receive a $10 Amazon gift card after completing the interview.

Participation

Taking part in this research study is entirely up to you. You may choose not to participate, or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue as a study participant.

Contact Information

If you have any questions or concerns about this research, you may contact Dr. Clare Stacey at (cstacey@kent.edu) or Paige Bosich at (pbosich@kent.edu). This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330-672-2704.

Consent Statement and Signature

I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

_____ _____

Participant Signature **Date**

APPENDIX G

AUDIO CONSENT FORM

Study Title
The Emotional Cost of Associative Stigma Among Mental Health Professionals

Principal and Co-Investigator
Paige Bosich, M.A. and Dr. Clare Stacey

I agree to participate in an audio-taped/video-taped interview about mental health professionals as part of this project and for the purposes of data analysis. I agree that the Principle Investigator, Paige Bosich, may audiotape/ video-tape this interview. The date, time, and place of the interview will be mutually agreed upon.

_____ _____

Signature Date

I have been told that I have the right to listen to the recording of the interview before it is used. I have decided that I:

____want to listen to the recording ____do not want to listen to the recording

Sign now below if you do not want to listen to the recording. If you want to listen to the recording, you will be asked to sign after listening to them.

Paige Bosich may / may not (circle one) use the audiotapes/ video tapes made of me. The original tapes or copies may be used for:

____this research project _____publications _____presentations at professional meetings

_____ _____

APPENDIX H

INTERVIEW GUIDE

Background Information

[The goal of this section is to get the respondents to talk about why they chose to work in mental health and to discuss their job.]

1. *I became interested in mental health because my partner is a psychiatric nurse practitioner, and I have a relative who suffers from a severe mental illness. Tell me about your story. Why did you decide to work in mental health?*

2. *Walk me through the course of your career as a [Psychiatrist/ NP/ RN].*
    - Have you ever worked on a different specialty unit besides mental health? If yes, what other units have you worked on?
        - What made you decide to change work environments?

3. *Walk me through a typical day at your current place of employment.*

4. *What skills might mental health professionals possess that distinguish them from other healthcare providers?*
    - Are the skills you have recognized or valued?

5. *Tell me about how psychiatric nurse practitioners and registered nurses are similar and different.*

6. *Tell me about how psychiatrists and psychiatric nurse practitioners are similar and different.*

7. *Tell me about the most demanding and the most rewarding aspects of your job. Be specific.*

Workplace Emotions

[The goal of this section is to understand the emotions that respondents experience as a [Psychiatrist/ NP/ RN] and how they manage those emotions.

1. *Describe some of the emotions that arise for you in a typical workday.*
    - Can you provide an example of a time when you were feeling said emotion?
        - How did you manage that particular emotion?

2. *Tell me about an emotionally demanding incident that you encountered as a mental health provider.*

- Who did you rely on for support during this incident?
- How did you manage the emotions that you were feeling?

Societal Perceptions

[The goal of this section is to get the respondents to talk about how others perceive the field of mental health and the work they do.]

1. *When you were training to become a [Psychiatrist/ NP/ RN] describe how your classmates and faculty perceived the field of mental health.*
    - If an instructor: How do nursing students and faculty view the field of mental health and the psychiatry rotation?

2. *Describe how family, friends, healthcare professionals, and/ or community members react when they discover that you work in mental health.*
    - What do they say, and how do you respond?

3. *Tell me about how your family and friends perceive the work that you do?*
    - If individual has a partner: How does your partner perceive the work that do you?
    - If single: How does a date react whenever he/she/they discovers that you work in mental health as a [Psychiatrist/ NP/ RN]?

4. *Tell me about how healthcare professionals, outside of mental health, perceive the work that you do?*

5. *Are there any sub-specialty areas within psychiatry such as substance abuse, severe mental illness, child, adult, etc. that are viewed as more or less desirable than the others?*

6. *Walk me through the different mental health occupations that make-up your workplace.*
    - How does each group perceive your profession as a [Psychiatrist/ NP/ RN]?

7. *Tell me about how patients and/ or their family members perceive the field of mental health.*
    - If Psychiatrist or NP: How do patients and/ or their families view your profession as a [Psychiatrist / NP] in comparison to a [Psychiatrist/ NP]?
    - If RN: How do patients and/ or their families view your profession as a psychiatric RN in comparison to NPs and psychiatrists?

8. *How do you think the public and/or the media portrays mental health professionals? Can you think of a concrete example?*
    - Can you describe how mental health professionals are portrayed in a song, movie, newspaper article, or tv show that you have come across?

- If the movie *One Flew Over the Cuckoo's Nest* is stated: Have you or anyone you work with ever been called nurse ratchet? If yes, can you elaborate on the incident?

9. *What goes through your head when others make inaccurate perceptions about the field of mental health or your job as a [Psychiatrist/ NP/ RN]?*

10. *How do the inaccurate perceptions of others, regarding mental health, serve as a barrier to perform your job and provide treatment to patients?*

11. *How do the inaccurate perceptions of others, regarding mental health, potentially impact your personal life when you are not in a work setting?*

Associative Stigma

[The goal of this section is to get respondents to talk about their own experience(s) of being stigmatized due to their profession and patient population.]

1. *Has there ever been a time when you were directly or indirectly stereotyped for working in the field of mental health or being a [Psychiatrist/ NP/ RN]? Can you provide a concrete example?*
    - *Has anyone you know ever been stereotyped for working in the field of mental health or being a [Psychiatrist/ NP/ RN]?*

2. *Tell me about how you reacted or felt whenever you were stereotyped?*

3. *Describe the coping strategies you use to manage the stereotypes that are associated to your specialty and patient population.*

Other

[The goal of this section is to get respondents to elaborate on certain concepts if they came up at any point throughout the interview.]

1. If the word burnout comes up:
    - Tell me about what burnout means to you.
    - Are there any unique aspects to mental health that would make providers susceptible to burnout?
    - Discuss two or three things that might lead to burnout.
    - Are Psychiatrists, NPs, or RNs more susceptible to burnout or are their burnout experiences similar?

2. If the word empathy comes up:
    - How do you show empathy?

- How does the empathy you show differ from other healthcare professionals outside of mental health, if any?
- What are the advantages and disadvantages of showing empathy?
- Can you provide an example of a time when you were empathetic at work?

APPENDIX I

DEMOGRAPHIC CHARACTERISTICS OF EACH PARTICIPANT

Table 2. Demographic Characteristics of Each Participant (N=48)

Pseudonym	*Sex*[1]	*Sexual Orientation*[2]	*Age*	*Race*[3]	*Political Affiliation*[4]	*Religious Affiliation*	*Marital Status*	*Level of Education*[5]	*Occupation*[6]	*Years in MH*
Adam	M	H	38	White	R	Yes	Divorced	Doctorate	NP- DC	7
Amber	F	H	39	White	None	Yes	Married	Bachelor	RN	6
Andrea	F	H	43	White	R	Yes	Married	Master	NP	22
Anna	F	H	52	White	D	Yes	Married	Doctorate	NP	15
Blair	F	H	62	White	I	Yes	Divorced	Master	NP	4
Brooke	F	H	43	White	D	Yes	Married	Master	RN / NE	6
Chloe	F	H	42	White	D	No	Married	Doctorate	NP	5
Clare	F	H	37	White	D	No	Married	Master	NP	~3
Cody	M	Gay	38	White	D	No	Married	Master	NP- DC	4
Dawn	F	H	32	White	D	Yes	Married	Associate	RN	8.5
Dian	F	H	61	White	D	Yes	Single	Bachelor	RN	18
Dylan	M	H	40	White	I	Yes	Single	Doctorate	NP	1
Ella	F	H	33	White	D	Yes	Married	Master	NP	10
Emily	F	H	54	White	D	Yes	Married	NSD	RN	10.5
Erica	F	H	33	White	D	Yes	Single	Associate	RN	6
Erin	F	H	50	White	D	No	Married	NSD	RN	27
Fallon	F	H	42	White	D	Yes	Married	Associate	RN	5
Gia	F	H	32	White	D	Yes	Married	Master	NP-DC	6
Grace	F	H	47	White	None	No	Married	MD	RN	7
Haley	F	H	29	White	D	Yes	Married	Associate	RN	3.5
Hannah	F	H	31	White	D	Yes	Married	Doctorate	RN	8
Harper	F	H	47	White	None	No	Married	Bachelor	RN	17
Holly	F	H	36	White	R	Yes	Married	Associate	RN	8

Jamie	F	H	59	White	I	Yes	Married	Bachelor	RN	31
Janice	F	Bisexual	47	White	D	Yes	Married	Master	RN / NE	7
Jena	F	H	37	White	D	Yes	Separated	Master	RN	14
Kevin	M	H	44	White	R	Yes	Married	Master	NP	12
Lauren	F	H	55	White	D	Yes	Married	Doctorate	NP / NE	23
Luci	F	H	24	White	R	Yes	Single	Bachelor	RN	~1
Luke	M	H	40	White	R	Yes	Divorced	Associate	RN	2.5
Mallorie	F	H	36	White	D	No	Married	Doctorate	NP	6.5
Maria	F	H	57	White	I	Yes	Married	Doctorate, PHD	NP / NE	8
Nancy	F	H	35	White	R	Yes	Divorced	Doctorate	NP	10.5
Natalie	F	H	43	White	D	Yes	Single	Doctorate	NP	4
Nolan	M	H	57	White	D	Yes	Married	Master	RN	30
Pam	F	H	64	White	None	No	Married	Master	NP- DC	13
Peggy	F	H	64	White	I	Yes	Married	Doctorate	NP-DC / NE	36
Piper	F	H	30	White	None	No	Married	Associate	RN	3
Rachel	F	H	43	White	R	Yes	Married	Doctorate	NP / NE	21
Rebecca	F	H	24	White	D	Yes	Single	Bachelor	RN	4
Sophia	F	H	52	White	R	Yes	Separated	Bachelor	RN	17
Stan	M	H	54	Asian	None	Yes	Married	MD	Psychiatrist	20
Stephen	M	H	29	White	D	No	Married	Doctorate	NP	8
Tara	F	H	70	White	None	Yes	Married	Associate	RN	36
Taylor	M	H	48	White	D	No	Single	Doctorate	RN	15
Tricia	F	H	33	White	D	No	Married	Doctorate	NP	10
Victor	M	H	34	White	I	No	Single	DO	Psychiatrist	7
Vince	M	H	73	AA	D	Yes	Married	MD	Psychiatrist	40

[1]Sex: F= Female; M= Male

[2]Sexual Orientation: H= Heterosexual

[3]Race: AA= African American

[4]Political Affiliation: D=Democrat; R= Republican; I=Independent

[5]Education: MD= Medical Doctor; DO= Doctor of Osteopathy; PHD= Doctor of Philosophy

[6]Occupation: NP= Nurse Practitioner; DC= Dual Certified in Family and Psychiatry; RN= Registered Nurse; NE= Nurse Educator