Nurses’ Perceptions of Discrimination Towards People Living with Mental Illness in General Medical Hospital Settings

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Nurses’ Perceptions of Discrimination Towards People Living with Mental Illness in General Medical Hospital Settings

by

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A THESIS
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Abstract

The research aims were to explore registered nurses’ perceptions of discrimination towards people with mental illness admitted to general medical hospital settings and to better understand the conditions that gave rise to discrimination. An interpretive feminist phenomenological design guided by Merleau-Ponty (1962) philosophy of perception was chosen. Ten semi-structured interviews were conducted in one Canadian urban hospital with registered nurses who cared for people with mental illness and who were admitted to a general medical unit primarily for non-psychiatric health concerns. Interviews were analyzed using Interpretive Phenomenological Analysis. Five major themes emerged: (a) dichotomy of the mind and body, (b) discriminatory nursing practices, (c) tensions between ideals and realities, (d) othering, and (e) gendered perceptions. Discrimination occurred in situations where nurses struggled with balancing the demands of physical nursing care and mental health nursing care, where professional mental health nursing education and training was perceived as lacking, and where work time was insufficient to adequately address patients’ mental health concerns. Consequently, nurses expressed less confidence and feelings of competence in mental health nursing as compared to medical nursing, deferring to more specialized professionals for mental health care. Physical care was prioritized over mental health nursing care with nurses actively and/or passively avoiding, even dismissing psychosocial assessments and interventions. The study findings highlight the challenges of caring for people with mental illness in general medical hospital settings and RN perceptions towards discrimination. A holistic model of health care that emphasizes the importance and contributions of mind body connection to health could guide nursing practices to reduce discrimination towards people living with
mental illness. Furthermore, increased mental health training in the workplace and more supportive resources could help foster a non-discriminatory work environment.

Keywords: nursing, mental health, discrimination, interpretive phenomenology, feminist phenomenology, general medical hospital setting
Preface

In this manuscript-based thesis, the literature review (Chapter 2) and the results chapter (Chapter 4) were written for peer-reviewed publication.
Acknowledgements

I would like to acknowledge my supervisor Dr. Carol Ewashen, as her passion for nursing research has inspired me to continue with my nursing education and research. Not only was she a role model, but she is also one of the most empathetic, kind, caring, and inspiring people that I have ever met.

I would also like to acknowledge my supervisory committee, Dr. Candance Lind and Dr. Aniela dela Cruz, as their guidance and professional knowledge helped me grow as a nurse researcher. I cannot express my gratitude for their assistance and insight during my graduate studies. I sincerely mean it when I say that any future graduate students that have an opportunity to work with them are greatly privileged.

I would like to acknowledge the University of Calgary Faculty of Nursing for providing me with this opportunity to learn and grow in my nursing career. This adventure of undertaking my Master of Nursing has led me through some ups and downs, but I always felt supported by the faculty and staff of the University of Calgary.

Finally, I would like to acknowledge the nursing unit that I recruited participants from and the nurses that agreed to participate in this study. The overwhelming support and enthusiasm for my study is greatly appreciated. Everyone who participated in this study not only helped me conduct this research but has also contributed to the greater body of nursing research.
Dedication

I dedicate this thesis to my late father, who spent much of his life dealing with mental health and addiction issues. He was a loving and caring man who did his best to be a caring father and an amazing person. I miss you Dad.
# Table of Contents

Abstract .................................................................................................................. ii
Preface .................................................................................................................... iv
Acknowledgements .............................................................................................. v
Dedication ............................................................................................................... vi
Table of Contents ................................................................................................ vii
List of Tables .......................................................................................................... x
List of Abbreviations .............................................................................................. x

Chapter 1 Introduction ......................................................................................... Error! Bookmark not defined.
  Background .......................................................................................................... 1
    My personal and professional experience ......................................................... 3
    Definitions of discrimination ............................................................................ 4
    Defining attributes of discrimination ............................................................ 5
  Problem and Significance ................................................................................... 7
  A Critical Feminist Perspective on Discrimination ............................................ 8

Chapter 2 Literature Review ............................................................................... 14
  Title Page ........................................................................................................... 15
  Accessable Summary ........................................................................................ 16
  Abstract .............................................................................................................. 17
  Introduction ......................................................................................................... 19
  Integrative Literature Review .......................................................................... 22
  Method ................................................................................................................ 23
    Problem identification stage .......................................................................... 23
    Literature search stage. ................................................................................. 23
    Data evaluation stage. .................................................................................... 24
    Data analysis stage. ....................................................................................... 24
  Findings .............................................................................................................. 25
    Study selection ............................................................................................... 25
    Negative attitudes as contributors to discrimination .................................... 26
    Institutional barriers as contributors of discrimination .............................. 29
    Physical health as the priority for nursing care ............................................ 31
    Experiences of discrimination as perceived by patients .............................. 33
  Discussion .......................................................................................................... 35
    Implications for nursing and healthcare practice ......................................... 39
    Limitations ....................................................................................................... 43
  Conclusion ......................................................................................................... 44
  References .......................................................................................................... 45
  Table 1 Search terms used ............................................................................... 55
  Table 2 Summary of reviewed studies ............................................................ 56
  Figure 1 Flow diagram of search strategy ......................................................... 77

Chapter 3 Methods ............................................................................................. 78
  Methodological Framework and Philosophical Underpinnings ...................... 78
  Phenomenology. ................................................................................................. 78
Interpretive phenomenology .................................................. 80

Merleau-Ponty and the phenomenology of perception .................. 81
Feminist Theory .................................................................. 83
Interpretive feminist phenomenology .................................... 85
Research design .................................................................... 86
Ethical considerations and research data management ............... 86
Recruitment ......................................................................... 87
Sampling .............................................................................. 87
Participant demographics .................................................... 88
Data collection and management ............................................ 88
Data analysis ......................................................................... 89

Chapter 4 Findings ................................................................ 96
Title Page ........................................................................... 97
Abstract ................................................................................ 99
Impact .................................................................................... 99
What problem did the study address? ..................................... 99
What were the main findings? .............................................. 99
Where and on whom will the research have an impact? .......... 99
Introduction .......................................................................... 101
Background ........................................................................... 101
The Study .............................................................................. 104
Aim. ....................................................................................... 104
Design. ................................................................................. 104
Recruitment, participants, and sample .................................. 105
Data collection ....................................................................... 106
Ethical considerations ........................................................... 106
Data analysis .......................................................................... 106
Rigor ...................................................................................... 107
Findings .................................................................................. 107
Dichotomy of the mind and body .......................................... 107
Caring for the tangible/intangible ......................................... 108
It’s not my job ........................................................................ 109
Discriminatory nursing practices .......................................... 110
Subconscious discrimination .................................................. 110
Conscious discrimination ....................................................... 113
Tensions between ideals and realities ................................... 115
Lacking the skills. ................................................................. 116
Not enough time .................................................................... 117
Discussion ............................................................................. 118
Limitations ............................................................................. 126
Conclusion ............................................................................. 126
Conflict of interest statement ............................................... 126
References .............................................................................. 127
Table 1 Characteristics if participants in this study .................. 134
Table 2 Interview guide ........................................................... 135
Table 3 Steps in the IPA process ............................................ 136
List of Tables

Table 1. *List of Emergent Themes* ................................................................. 90
Table 2. *List of Superordinate Themes* ......................................................... 91
Table 3. *Master Table of Themes* ................................................................. 92
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>APN</td>
<td>Advanced Practice Nurse</td>
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<tr>
<td>CASN</td>
<td>Canadian Association of Schools of Nursing</td>
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<td>CASP</td>
<td>Critical Appraisal Skills Programme</td>
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<td>CINAHL</td>
<td>Cumulative Index to Nursing and Allied Health Literature</td>
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<td>CMHA</td>
<td>Canadian Mental Health Association</td>
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<td>CNA</td>
<td>Canadian Nurses Association</td>
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<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
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<td>IPA</td>
<td>Interpretive Phenomenological Analysis</td>
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<td>RN</td>
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Chapter 1 Introduction

In this thesis, I present an interpretive feminist phenomenological research study to investigate the perceptions of registered nurses (RNs) who work with patients with mental illness in non-mental health hospital settings. Specifically, the study focus was RNs’ perceptions of discrimination towards people living with mental illness. All the RN participants worked on a medical unit in a Canadian urban hospital. The primary research question for this study was: What are nurses’ perceptions of discrimination towards people living with mental illness in non-mental health hospital settings and what are the conditions that give rise to discrimination? The research objectives were to (a) understand non-mental health nurses’ perceptions of working with people living with mental illness and (b) understand the conditions that contribute towards discrimination by nurses towards people living with mental illness in non-mental health care settings.

In Chapter 1, I present a background of the research problem and the research question and objectives. Chapter 2 consists of a manuscript submitted for publication - an integrative review of the literature on discrimination by nurses and other health professionals towards people with mental illness in non-mental health care settings. Chapter 3 is the research method chapter with a detailed discussion of the interpretive feminist phenomenological research methodology. Chapter 4 consists of a results manuscript (to be submitted for publication) as well as discussion of two additional major themes not included in the manuscript. Chapter 5 includes discussion of the results. Chapter 6 is the conclusion.

Background

Mental illness affects many Canadians in their lifetime. Currently, 10% of Canadian adults have a diagnosis of a mental disorder (Institute of Health Economics,
2008), and another 6% are estimated to be currently undiagnosed (Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008). Approximately 3.8% of all hospital admissions in Canada are directly related to anxiety disorders, bipolar disorders, schizophrenia, major depression, personality disorders, eating disorders and suicidal behavior (Health Canada, 2002). It is estimated that 14.7% of acute care medical inpatients, in Canada, have a diagnosis of a mental disorder (Statistics Canada, 2011). Globally, the World Health Organization (WHO) (2013) indicated that mental illness, neurological disorders, and substance use disorders accounted for 14% of the total disease burden in 2004.

Historically, individuals with mental illness have experienced discrimination and mistreatment (Thornicroft, 2006). Often, attitudes towards people living with mental illness are negative and based on stereotypical preconceptions, which can lead to this discrimination (Thornicroft, 2006). This can include segregation, exclusion, avoidance, dehumanization, coercion, or denial of rights (Thornicroft, Rose, & Mehta, 2010). Due to the prevalence of mental illness in Canada, it is important that health care providers provide competent ethical mental health care which includes refraining from discriminating against this population and treating all individuals with equity and respect (Canadian Nurses Association [CNA], 2017; Marchand, Palis, & Oviedo-Joekes, 2016).

Health care providers, including nurses, are not immune from enacting discrimination towards people living with mental illness (Marchand, et al., 2016; Thornicroft, 2006). Discrimination differs from stigma, in that stigma refers to negative attitudes, based on stereotypes and prejudice, which are triggered by signs of illness (Sartorius, 2007). Once stigma is enacted, it is considered discrimination (Gray, 2002). Simply, stigma refers to the negative attitudes triggered by mental illness, and
discrimination refers to the resulting behavior, action, or practice (Canadian Mental Health Association [CMHA], 2018). For example, a person living with mental illness may be denied treatment due to their health care provider’s pessimistic attitudes about recovery, thus the person is discriminated against; the denial of treatment is discrimination.

People living with mental illness experience high rates of medical co-morbidities, with 50% of psychiatric patients having a known physical condition and 35% having an undiagnosed physical condition (Felkner et al., 1996). In this patient population, one in five have a physical illness exacerbating their mental illness (Felkner et al., 1996). When these physical illnesses become acute, these individuals may require medical treatment in non-mental health care settings. Healthcare professionals without formal mental health training are expected to care for people with mental illness in non-mental health care hospital settings (Brunero, Jeon, & Foster, 2012). Previous researchers have identified that nurses who work in medical-surgical inpatient hospital settings feel that they lack the skills and competence to provide adequate care to patients with psychiatric co-morbidities (Atkin, Holmes, & Martin, 2005). Furthermore, people living with mental illness have reported avoiding health services due to the expectation that they will be discriminated against by health care providers (Henderson, Evans-Lacko, & Thornicroft, 2013).

My personal and professional experience.

My interest in this topic evolved from my personal experience working as a registered nurse on a general medical hospital unit in a large urban centre. While working on this unit, I noticed that people living with mental illness were often viewed as
undesirable to work with and were often treated with more disrespect when compared to other patients on the unit. One situation that especially stood out for me was when I was assigned to care for a homeless, First Nations man, who had multiple addiction and mental health issues. He was admitted to the unit for an infection related to intravenous drug use and was being treated with antibiotics. One evening, his girlfriend was at the hospital visiting him, when the charge nurse on duty told me to ask the patient’s girlfriend to leave, as visiting hours were almost over. I politely asked the girlfriend to leave, and she responded with “Just give me ten more minutes so I can say goodbye”, to which I agreed. I then informed the charge nurse of this. The charge nurse then went to the patient’s room and demanded that the patient’s girlfriend leave immediately, which caused her to get upset and start yelling. The charge nurse then called security to escort her out of the hospital. After the whole ordeal, the charge nurse turned to me and stated, “You know what those people are like - if you let them stay, they will stay here all night.” This situation was not typical of how other patients’ families were treated on the unit; highlighting how mental illness, addiction, race, and class may have played a role in the unfair, discriminatory treatment of this patient.

**Definitions of discrimination.**

According to Hamilton et al. (2014), the concept of discrimination is not well understood and requires further clarification. In the literature, discrimination is most often referred to as an unfair treatment or behavior towards someone based on a categorization, in this case, mental illness (Hanafiah & Van Bortel, 2015; Hamilton et al., 2014; Lakeman et al., 2012; Reavley, Morgan, & Jorm, 2016; Skosireva et al, 2014; Thornicroft, 2006). Discrimination is identified as either being “perceived
discrimination” (interpretations of behavior as being discriminatory) or “objective discrimination” (impartial accounts of discrimination) (Hamilton et al., 2014). The definitions of discrimination also vary depending on who is defining the term and are likely to change based on the position of the person describing discrimination, dependent on the perceptions of that person. For the purpose of this study, discrimination is defined as the unfair treatment towards individuals or groups with mental illness, based on actual or perceived labels, by RNs working on a general medical hospital unit (Kassam, Williams, & Patten, 2012).

**Defining attributes of discrimination.**

Four main defining attributes are prevalent throughout the literature focused on discrimination. The first three attributes are behaviors, experiences, and perceptions. The attribute of behavior indicates that discrimination is an action taken by someone, and in this study, actions taken by nurses and the health care organization. These actions are frequently described in the literature as negative and harmful. Thornicroft (2006) defines discrimination as the expression of negative attitudes in an external behavior. For example, prejudicial attitudes that lead to differential treatment towards a group of people. Related to behavior, the term “treatment” can also denote an action, as in the unfair treatment or the negative treatment towards a patient, usually requiring an interpersonal interaction (Hamilton et al., 2014). Other terms used when discussing this attribute were “differential treatment” and “dismissive treatment”.

The second main attribute of discrimination is experience. The relevant literature often described how the patient experienced discrimination with each patient having a unique understanding of the phenomenon. This attribute implies that discrimination is
context-bound and can be experienced differently by everyone. The idea that
discrimination is experienced may also suggest that the act of discrimination is external
to the person being discriminated against, as in it is an action taken upon another.
Lakeman et al. (2012) stated that discrimination is the actual experience of being treated
differently due to mental illness and is linked to how a person understands the situation.

Perceptions were the third main attribute of the concept of discrimination.
Hamilton et al. (2014) warns against the use of the term “perceived discrimination” in
studies as it may imply that the participant is overly sensitive or that their reports are
inferior to objective observations of discrimination. For example, a patient with a mental
illness may perceive subtle differential treatment by a healthcare provider in the form of
dismissive behaviors. Although this discrimination may not be overtly obvious to an
observer, this does not mean that the mentally ill patient’s perceptions of discrimination
are not valid. This highlights that discrimination is an interpretation that cannot be
separated from the lived experience of the person or from the context.

More recently, researchers have also described perceived power inequities as a
fourth defining attribute of discrimination. Gormley & Quinn (2009) found that patients
with mental illness attributed discrimination to a difference in power. The difference in
power associated with discrimination was often accompanied by an authoritarian attitude
and a perceived power hierarchy over the patient (Gormely & Quinn, 2009). Such power
inequities in healthcare can result from a patient’s dependence on healthcare providers to
provide care, thus creating an environment where the health care provider is in position to
treat the patient based on their own perceptions or implicit biases (for example, the
decision to withhold pain medication to someone that may be labeled as drug seeking) (Snowden, 2003).

**Problem and Significance**

Marchand, et al., (2015) found that 10.9% of Canadians aged 15 years or older had experienced prejudice and discrimination from a health care provider and among these individuals, 62.4 % reported having a mental disorder. They found that rates of prejudice and discrimination were significantly higher for respondents with anxiety, concurrent mood or anxiety and substance disorders, and co-occurring mood and anxiety disorders compared to respondents without any mental disorders (Marchand, et al., 2015). Negative attitudes, devaluation of mental illness, and misconceptions related to mental health have been identified as contributing factors to the problem (Ross & Golder, 2009; Hamilton et al., 2014; Howard & Holmshaw, 2010).

Potential consequences of healthcare professionals discriminating against people living with mental illness are deterioration of preexisting mental illness, misdiagnosis and mistreatment of medical conditions, increased mortality, lowered self-esteem, dissatisfaction and avoidance of health services, diminished therapeutic patient-practitioner relationship, and higher health care costs (Hanafiah & Van Bortel, 2015; Harangozo et al., 2014; Ross & Goldner, 2009; Skosireva et al., 2014, Thornicroft, 2006). Discrimination may be unconscious or subtle, but enough for patients to sense unfair treatment (McAllister, Creedy, Moyle, & Farrugia, 2002). Some of the more overt discriminatory practices towards people living with mental illness have been identified by several researchers who found that people living with mental illness are disproportionately more likely to experience higher rates of disability and mortality due
to physical health problems being neglected or mistreated, and people with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population; often related to physical health concerns and suicide (WHO, 2013). Mather, Roche, and Duffield (2014) found that people living with mental illness in non-mental health care settings have lower rates of psychiatric referrals, lower rates of interventions and diagnostic procedures for heart disease and myocardial infarction, lower rates of referrals for costly procedures (such as hip and joint replacement, organ and bone marrow transplants, and pacemaker insertion), lower rates of hospital admissions related to diabetes, higher rates of hospital acquired infections, poorer post-operative outcomes, and increased length of hospital stay. Studies have found positive associations between mental disorders and discrimination (Hamilton et al. 2014; Ross & Goldner, 2009). Björkman, Angelman, and Jönsson (2008) found that nurses who work in non-mental health care settings had more negative attitudes towards people living with mental illness when compared to nurses who work in mental health care settings and that negative attitudes can manifest in discriminatory behaviors with harmful and negative patient outcomes as a consequence (Thornicroft, 2006).

A Critical Feminist Perspective on Discrimination

As a feminist researcher, I feel that it is important to explore some of the critiques of the modern health care system that some feminist scholars have brought to light. This is of relevance to this study, as these perspectives provide some context to the problem of discrimination in healthcare. To wholly appreciate the critical feminist perspective on discrimination towards patients living with mental illness, a historical reflection of women, science, and medicine is necessary. Historically, women were not involved in
medical and scientific research (Rodgers, 2005). Research was standardized to male norms and, most often, men were the subjects of study (Rodgers, 2005). The white middle class male became the prototype of health (Swartz, 2013). This frequently resulted in research findings being misapplied to women (Swartz, 2013). If research studies did find gender differences, the female difference was often judged to be inferior to that of the male (Goicoechea, 2013). This has led feminists to critically examine scientific research and ask how the predominance of male subjects in science has influenced science development (Gerrard & Javed, 1998).

In the mid twentieth century, mental processes and mental illnesses were theorized psycho-dynamically, predominating in psychiatry and mental health services (Kawa & Giordano, 2012). The psychodynamic approach recognized the effects of socio-environmental stressors on mental health, and one’s relationships and experiences (especially childhood experiences) were all seen as potential contributors to mental illness (Kawa & Giordano, 2012; Neitzke, 2015). In the 1960s and the early 1970s, skepticism about psychiatry as a legitimate medical discipline and a lack of differentiation between mental health and illness, lead to criticisms of the prevalent psychodynamic approach to psychiatry (Kawa & Giordano, 2012). As a result, the Diagnostic and Statistical Manual of Mental Disorders third edition (DSM-III), published in 1980, was created to provide more uniformity in psychiatric diagnoses and to create a more biomedical understanding of the causes of mental illness (Malmgren, Radovic, Thoren, & Haglund, 2009; Neitzke, 2015). A main critique of this new DSM edition was that the influence of socio-environmental stressors on one’s mental health was disregarded, and psychiatric diagnoses were reduced to a checklist of ‘disorder’
symptoms (Malmgren et al., 2009; Neitzke, 2015). Subsequent issues of the *Diagnostic and Statistical Manual of Mental Disorders* (the DSM-IV and the DSM-V) have retained the tradition of the primacy of the biomedical model with additional information regarding prevalence, age, and sex differential characteristics of mental illness (Kawa & Giordano, 2012).

Feminist scholars have historically critiqued the biomedical view of mental illness (one that assumes health is the absence of disease and illness is a result of physical and biological pathology with little focus on psychosocial factors that may contribute to illness), arguing that the standard of “normalcy” used in the DSM-III (and subsequent editions) is that of stereotypical male development and ignores external factors that contribute to mental illness (Goicoechea, 2013). They argue against the homogenizing effect of historical biomedical research that generalizes findings, regardless of gender, where deviations from what was often considered the norm (for example, mental illness) was attributed to women’s biology, such as hormonal changes related to menstruation, childbirth, and menopause (Goicoechea, 2013; White, 2002). Historically, it was also assumed that the DSM-III diagnostic criteria used to label mental illness, could be applied objectively to all genders, based on a checklist of symptoms, without fully taking into account lived experiences, historical contexts, and gendered differences (Goicoechea, 2013). Psychiatric diagnoses match clinicians’ assumptions about what mental illness looks like and how it is expressed (Neitzke, 2013). If the objective criteria for diagnosing mental illness are biased toward a masculine normative ideal, aspects of gender expression attributed to femininity are at risk of being labeled pathological, whereas gendered traits typically attributed to masculinity are normalized and deemed
healthy (Goicoechea, 2013). For example, emotionality is frequently labeled as being a
predominately female attribute in Global North societies, therefore individuals of all
genders who are emotionally expressive may be at an increased risk of being
misdiagnosed with depression or borderline personality disorder due to emotionality
being regarded as abnormal, thus pathological (Goicoechea, 2013; Neitzke, 2015).
Researchers have found that women are more likely to be diagnosed with borderline
personality disorder at a ratio of 3:1 when compared to men, although it is not fully
known if this is related to sampling bias or to gender bias (Chapman, Jamil, & Fleisher,
2019; Skodol & Bender, 2003). Feminists have also argued that the DSM diagnostic
categories serve patriarchal interests by reinforcing what is considered normal for women
within a patriarchal social structure that privileges masculinity and therefore a diagnosis
can in effect enforce women’s conformity to the patriarchal structure (Goicoechea, 2013;
Swartz, 2013).

Social, political, historical, environmental, and cultural factors that contribute to
mental illness (such as gender, race, and socio-economic status) are minimized or even
discounted with a primary focus on the biological indicators of disease and disorder
(Feely & Long, 2007). Potentially contributing underlying societal and relational issues
are concealed when the primary treatment modality is psychopharmacologic. When
aligning with a biomedical model of illness and disease, healthcare professionals,
including nurses, learn that mental illness is biological, a symptom of vulnerability, and a
disease state inherent to the person (Feely & Long, 2007). Treatment responsibility is
then placed on the individual to seek help, be compliant with prescribed treatments, and
return to health (Neitzke, 2013). These attitudes, perpetuated by aligning with the
biomedical model, can ultimately set the conditions for discrimination towards this patient population by health care professionals (Thornicroft, 2006). For example, a woman diagnosed with borderline personality disorder based on DSM criteria (intense emotions, unstable relationships, or poor self-image), is labeled as “difficult” and “noncompliant” by her health care providers. In this situation, the patient’s experiences that may contribute to the patient’s mental illness (such as a history of abuse, martial issues, or a recent traumatic event) could be ignored or considered irrelevant, as the primary focus from a biomedical perspective, is understood as patient compliance with prescribed treatment. The patient then runs the risk of receiving a negative label if not compliant and this could lead to discrimination by health care providers.

Feminist scholars have also criticized how labels, such as psychiatric diagnoses, can be understood as a powerful means of social control, a way of disciplining bodies, and perpetuating gendered power imbalances (Gerrard & Javed, 1998; Swartz, 2013). Feminist scholars and sociologists have argued that psychiatric diagnoses in effect, confirm people’s identities as mentally ill and as such, hold the power to reduce the complexities of one’s life into a couple of words (Gerrard & Javed, 1998; Scheff, 1975). When a label is heard, a set of values and beliefs are attributed to it (Gerrard & Javed, 1998). These values and beliefs then influence one’s behaviors towards the labeled person (Gerrard & Javed, 1998). Labels have also been used to undermine social credibility and disempower individuals (Neitzke, 2013). For example, in the case of Sojourner Truth, a former slave, abolitionist, and women’s rights activist who in 1851 in Ohio at a Woman’s Rights Convention gave a speech titled, ‘Ain’t I a Woman’ (National Park Service, 2017). The effect of a reduction in social credibility by virtue of a label
(slave), in the case of this research a psychiatric label, is to make it more socially acceptable for others to discriminate against this patient population (Rosenhan, 1975). For example, a woman with a diagnostic label of schizophrenia may trigger negative attitudes (impatience and anger) and stereotypes (people with schizophrenia are dangerous). This could lead to discriminatory treatment by health care providers.

Feminist scholars have also argued that health care professionals use diagnostic labels (supported by male dominated research and patriarchal agendas) to create a language and practice that differentiates themselves from patients, creating the “other” (Van Den Tillaart, Kurtz, & Cash, 2009). When people are categorized, individuality is lost, subjective experiences get overlooked, and feelings towards that group become generalized (Van Den Tillaart et al., 2009). When a group such as patients living with mental illness are categorized, and considered alike (homogeneous), they are at risk of being marginalized, of becoming the “other” (Van Den Tillaart et al., 2009). This “othering” of groups through different labels confirms that the “other” is different and when in concert with a power differential, there is a reinforcement that the “other” is secondary to or less than, the dominant group (De Beauvoir, 1953). Gerrard & Javed (1998) stated that these types of distinctions (i.e., self and other, them and us), leads to the oppression of groups. For example, a nurse may categorize all patients with eating disorders as alike, homogeneous, and fail to understand how each person’s experiences contribute to their illness and their recovery. This may result in thought and in practice that they are the “other”, different from the nurse, perpetuating misconceptions, intolerance, and discrimination.
Chapter 2 Literature Review

The integrative literature review of this thesis was written for publication in partial completion of a Master of Nursing manuscript-based thesis upon supervisory committee approval. The following is the complete manuscript:
Running head: 1
Discrimination Towards People Living with Mental Illness in Non-Mental Health Care Hospital Settings: An Integrative Literature Review

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Accessible Summary

What is known about the subject?

- Healthcare providers have been identified as perpetuators of discrimination towards patients with mental illness in general hospital settings.
- Nurses play a critical role in addressing discrimination towards people with mental illness.

What this paper adds to the existing knowledge?

- Discrimination by hospital nurses included negative attitudes, avoidance, negative labeling of patient behavior, mistreatment, and misdiagnosis, and prioritizing physical health care to the neglect of mental health care.
- Institutional barriers contribute to discrimination by nurses.

What are the implications for practice?

- As nurses frequently reported that they lacked mental health nursing knowledge, greater emphasis on ongoing professional development mental health education for nurses is required.
- Mental health nurses are well positioned to lead anti-discriminatory education, policy, and practice development to advocate for, and advance, anti-discriminatory, compassionate care for the mentally ill.
Abstract

**Introduction:** Health care providers have been identified as perpetuators of discrimination towards people with mental illness. **Aim:** To explore, from hospital nurses’ perspectives, discrimination towards patients with mental illness. **Method:** An integrative literature review was conducted using the Whittemore and Knafl (2005) systematic approach to integrative literature reviews. **Results:** Four themes emerged from this review: (a) negative attitudes as contributors to discrimination, (b) institutional barriers as contributors to discrimination, (c) physical health care as the priority over mental health care, and (d) patients’ experiences of discrimination. **Discussion:** Discriminatory practices towards people with mental illness were precipitated by nurses’ negative attitudes and by the devaluation of mental health care as legitimate nurses’ work. When nurses felt constrained in the workplace by lack of time or education, discriminatory behaviors were displayed. Patients with mental illness most reported having their physical health problems overlooked and having treatment denied. **Implications:** Greater emphasis on professional development mental health education for nurses could better prepare nurses for nondiscriminatory work with patients with mental illness. Anti-discriminatory workplace policies and practices could be significant in fostering anti-discriminatory workplace environments. The introduction of specialized medical-psychiatric units in hospitals could potentially result in less discrimination towards patients with mental illness.

**Keywords:** Discrimination, Mental Illness, Nursing, Non-psychiatric Setting, Negative Attitudes, Integrative Review
Relevance Statement: In this integrative review, four main contributors to discriminatory nursing practices were found: prioritizing physical care over mental health care, a perceived lack of knowledge about mental health nursing care, workplace time constraints and a lack of clinical support. Mental health nurses are well-positioned as leaders to develop and deliver anti-discriminatory professional development education for nurses in general hospital settings and to advocate for anti-discriminatory workplace policies and practices to foster anti-discriminatory workplace environments.
Introduction

The magnitude of mental illness worldwide is significant and relevant to nurses. The World Health Organization (WHO, 2013) indicated that, in 2004, mental illness, neurological disorders, and substance use disorders accounted for 14% of the total disease burden globally. Other researchers have estimated that globally 264 million people live with depression and approximately 45 million people live with bipolar disorder (GBD 2017 Disease and Injury Incidence and Prevalence Collaborators, 2018).

In Canada, 2.8 million (10.1%) people aged 15 and older reported symptoms consistent with at least one mental health or substance use disorder, including major depressive episode, bipolar disorder, generalized anxiety disorder, and abuse of or dependence on alcohol, cannabis, or other drugs (Pearson, Janz, & Ali, 2012). A higher prevalence of mental illness has been reported in the United States of America with, in 2017, approximately 18.9% of all adults estimated to live with mental illness (National Institute of Mental Health, 2019). The WHO (2015) estimated that mental disorders affect more than a third of the European population every year, with depression and anxiety being the most common.

In Canada, it is estimated that 14.7% of hospital inpatients have a diagnosis of a mental disorder and have an average hospital stay twice as long as those without a diagnosis of a mental disorder (Johansen & Sanmartin, 2015). It is also estimated that acute care hospitalizations of people with a diagnosed mental condition account for 29% of the total hospital admission days in Canada (Johansen & Sanmartin, 2015). Of these admissions, 12.4% (2.5 million) had a primary diagnosis of a mental condition and 16.6%
(3.3 million) had a comorbid diagnosis of a mental condition (Johansen & Sanmartin, 2015).

Significantly, people with mental illness experience disproportionately higher rates of disability and mortality due to physical health problems being neglected or mistreated (WHO, 2013). The WHO (2013) reports that people with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, and this is often related to physical health concerns and suicide. As individuals living with mental illness are at an increased risk for morbidity and mortality related to physical health concerns, it is of importance to nursing to explore some of the factors that may contribute to this problem. Individuals with mental illnesses have a long history of experiencing discrimination and mistreatment (Thornicroft, 2006). Often, attitudes towards people living with mental illness are based on stereotypical preconceptions, which can lead to discrimination (Thornicroft, 2006).

Discrimination has been defined as the unfair treatment towards individuals or groups based on actual or perceived labels or characteristics (Kassam, Williams, & Patten, 2012). Discrimination can include segregation, exclusion, avoidance, dehumanization, coercion, or denial of rights (Thornicroft, Rose, & Mehta, 2010). Discrimination can be further defined as either being “perceived discrimination” (interpretations of behavior as being discriminatory) or “objective discrimination” (impartial accounts of discrimination) (Hamilton et al., 2014).

Studies have found positive associations between mental disorders and discrimination (Hamilton et al. 2014; Ross & Goldner, 2009). Eleven percent of Canadians aged 15 and older report experiencing prejudice and discrimination by a health
care provider (Marchand, Palis, & Oviedo-Joeke, 2016). Mather, Roche, and Duffield (2014) found disparities in the treatment of patients with mental illness in non-psychiatric hospitals, when compared to patients without mental illness. These disparities included lower rates of psychiatric referrals, lower rates of interventions and diagnostic procedures for heart disease and myocardial infarction, lower rates of referrals for costly procedures (such as hip and joint replacement, organ and bone marrow transplants, and pacemaker insertion), lower rates of hospital admissions related to diabetes, higher rates of hospital acquired infections, poorer post-operative outcomes, and increased length of hospital stay (Mather et al., 2014). Evidence suggests that people living with mental illness do experience differential treatment when accessing health care services, treatment that could constitute discrimination by health care professionals. Health care providers’ discriminatory actions towards people with mental illness can result in poor patient outcomes, such as deterioration of preexisting mental illness, increased morbidity and mortality, or misdiagnosis and mistreatment of medical conditions (Mather et al., 2014). Other researchers have found that discrimination can contribute to lowered self-esteem, diminished patient-practitioner therapeutic relationships, non-adherence to treatment plans, dissatisfaction and avoidance of health services, and higher health care costs (often related to avoidance of health services until illnesses deteriorate to the point of requiring more costly services) (Hanafiah & Van Bortel, 2015; Reavley, Morgan, & Jorm, 2016; Thornicroft, 2006).

Björkman, Angelman, and Jönsson (2008) found that nurses who work in a variety of non-mental health care settings in Sweden had more negative attitudes towards people living with mental illness when compared to nurses who work in mental health
care settings and these negative attitudes could manifest in discriminatory behaviors (Thornicroft, 2006). In the literature, negative attitudes such as fear, pessimism, and blame characterize stigma, which is based on stereotypes and prejudice that are triggered by signs of illness (Sartorius, 2007). Once stigma is enacted, the resulting behavior or action is considered discrimination (Gray, 2002). Stigma refers to the negative attitudes triggered by perceptions (often prejudicial) of mental illness, and discrimination (thus enacted stigma) refers to the resulting behavior, action, or practice (CMHA, 2018; Gray, 2002). For example, enacted stigma results in discrimination when a person with mental illness is denied treatment due to the health provider’s pessimistic attitude about chances of recovery. The attitude is discriminatory and if the result is denying treatment, stigma is enacted.

**Integrative Literature Review**

An integrative literature review was conducted to explore general hospital nurses’ perceptions of discrimination towards patients with mental illness. Integrative reviews, being the broadest of research reviews, allows for the inclusion of theoretical and empirical literature (Whittmore, 2005). The review employed a systematic approach to locate literature and to evaluate, analyze, and synthesize data to provide a comprehensive understanding of discrimination by hospital nurses. According to Whittmore and Knafl (2005), the integrative method is the only review approach that allows for the combination of diverse methodologies with potential to capture the complexity of an emergent phenomenon (Hopia, Latvala, & Liimatainen, 2016). As the literature on discrimination by hospital nurses towards patients with mental illness is sparse, this integrative review was intended to provide an exploratory understanding of the little-
known phenomenon. No integrative reviews of discrimination towards patients with mental illness, with a focus on hospital nurses, were found in the literature.

**Method**

The Whittemore and Knafl’s (2005) systematic approach to integrative literature review guided this study.

**Problem Identification Stage**

The first author conducted background reading of peer reviewed nursing literature to learn more about nurses’ discrimination and identify gaps in the literature. There was a lack of peer reviewed literature related to discrimination by hospital nurses towards people with mental illness. The research question that guided this integrative review was: How is discrimination towards the mentally ill perceived by nurses working in non-mental health care hospital settings?

**Literature Search Stage**

In the literature search stage, the greatest number of primary literature sources related to the problem are located (Whittemore & Knafl, 2005). In February 2019, the databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, and PsychINFO were searched, as they contain a large collection of both nursing and mental health literature. The key search terms and search strategy are included in Table 1. Inclusion criteria were: 1) articles that included nurses as discriminators towards people living with mental illness, 2) research primarily focused on non-mental health care hospital settings, 3) qualitative and quantitative peer reviewed articles. Exclusion criteria were: 1) not highlighting discriminatory behavior towards people with mental illness, 2) not focused on nurses who work in non-mental health care
settings, 3) focused on nursing students, 4) focused on children, 5) not written in English, and 6) research from secondary sources.

Initially the search was limited to articles published in the last 10 years, but due to a lack of relevant literature, the search was expanded to include all published articles from 1992 to 2019. This expanded search yielded sufficient literature for review while remaining as current as possible. From the initial searches, titles of articles were scanned for relevance and then the abstracts were reviewed. From this initial scan, selected articles were read in full to determine whether they met the inclusion criteria. Finally, the reference lists of selected articles were scanned using the same method of title review to identify further relevant literature (Figure 1).

**Data Evaluation Stage**

The Critical Appraisal Skills Programme (CASP) (2018) tool is a set of checklists (individualized for different types of studies) to be used while reading research articles to aid the reader in assessing for quality of the research. Both the CASP (2018) qualitative and quantitative checklists were used, depending on the research method, and a combination of both was used for mixed methods studies. All articles were included in the sample (n=14), after quality assessment.

**Data Analysis Stage**

The goal of the data analysis stage is to thoroughly, and without bias, interpret primary sources and synthesize the evidence (Whittemore & Knaf1, 2005). Thematic analysis was undertaken to analyze, identify and report major themes using a step-by-step analytic approach (Braun & Clarke, 2006). While some methods of qualitative data analysis are dependent on a specific theoretical or epistemological approach, thematic
analysis can be applied across a range of approaches (Braun & Clarke, 2006). Given the heterogeneity of the literature, thematic analysis was chosen for its flexibility and theoretical freedom, thus potentially allowing for a rich and detailed account of the data (Braun & Clarke, 2006). This process involved carefully reading each article, identifying noteworthy features of the data, compiling the data into themes, and generating definitions and names for each theme (Braun & Clarke, 2006). A table was created to help organize data analysis according to author, year, country, study aim, study design, sample, data collection, limitations, and summary of key findings (Table 2).

**Findings**

**Study Selection**

A total of 14 articles met the inclusion criteria and included two quantitative studies, 11 qualitative studies, and one mixed methods study. Four of the studies focused on nurses who work in medical-surgical hospital settings, three studies were focused on the patient experience throughout various encounters with health care providers, two were focused on nurses who work in acute care settings with a focus on older adults, two were focused on emergency department nurses, one was focused on nurses who work in rural settings, and one study was focused on nurses who work in a general hospital setting. None of the studies included nurses who work in mental health or primarily identify as mental health nurses. Five of the studies were from the UK, four from Australia, three from Ireland, and two from the USA. All the studies highlighted to some degree healthcare providers’ discrimination towards patients with mental illness, even if this was not the primary focus of the research study. From these studies, four key themes emerged: (a) negative attitudes as contributors to discrimination, (b) institutional barriers as contributors to
discrimination, (c) physical health as the priority of care as opposed to mental health care and (d) patients’ experiences of discrimination.

**Negative Attitudes as Contributors to Discrimination**

A total of 12 articles described hospital nurses’ negative attitudes and how they can contribute to discrimination towards people with mental illness. Several researchers have found that nurses who work in hospital settings generally had negative attitudes towards working with patients with mental illness, leading to avoidance and neglected physical and mental health concerns (Arnold & Mitchell, 2008; Artis & Smith, 2013; Brunero, Buus, & West, 2017; Brunero, Ramjan, Salamonson, & Nicholls, 2018; Doyle, Keogh, & Morrissey, 2007; Harrison & Zohhadi, 2005; MacNeela, Scott, Treacy, Hyde, & O’Mahony, 2012; McDonald et al., 2003; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). Although many nurses reported empathy and a desire to help patients living with mental illness, they often (sometimes unknowingly) gave patients negative labels (such as difficult or aggressive) while being unaware of the negative connotations that underlie such labels (Arnold & Mitchell, 2008; Artis & Smith, 2013). In a study by Harrison & Zohhadi (2005) nurses who were interviewed focused their responses on patients’ weaknesses as opposed to their strengths. This may reflect an unfamiliarity and a lack of confidence when working with this patient population, therefore nurses were less inclined to view patients accurately or favorably. Nurses recognized negative attitudes in others and described colleagues as more likely to engage in discriminatory behaviors than themselves (Artis & Smith, 2013).
These negative attitudes included fear, annoyance, pessimism over prognosis, and blame (Arnold & Mitchell, 2008; Artis & Smith, 2013; Brunero et al., 2017; Brunero et al., 2018; Doyle et al., 2007; Lyons, Hopley, & Horrocks, 2009; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). Nurses who worked in non-mental health care hospital settings most frequently reported being afraid of people living with mental illness and this attitude caused nurses to perceive patients as unpredictable (Brunero et al., 2017; Brunero et al., 2018; Harrison & Zohhadi, 2005; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). This fear led nurses to avoid and distance themselves from patients with mental illness (Brunero et al., 2017; Brunero et al., 2018; Harrison & Zohhadi, 2005; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). Brunero et al. (2018) found that when generalist health professionals felt afraid of patients with mental illness, they were cautious to build relationships with patients and described behaviors that are consistent with wariness. Nurses expressed concerns for their personal safety due to a belief that patients with mental illness are dangerous, leading to a sense of vulnerability (Reed & Fitzgerald, 2005). This impacted nurses’ ability to carry out nursing care and led to further distancing and detachment (Reed & Fitzgerald, 2005).

The severity of the patient’s presentation and the patient’s history impacted how nurses behaved towards patients with mental illness (Artis & Smith, 2013; Doyle et al., 2007). For example, when nurses perceived a patient’s history to be horrific or if an act of self-harm had the potential to be lethal, clinicians felt more sympathy for the patient and spent more time with them (Artis & Smith, 2013). Conversely, when patients were perceived to have no background history to justify their self-harming behaviors or self-
harm was minimal, clinicians expressed frustration and felt that the patient was taking up time that could be better spent on “genuine patients” (Artis & Smith, 2013, pp. 263). Nurses appeared to pass judgement on the genuineness of patients’ suicide attempts, which influenced the care they received (Doyle et al., 2007). Labels such as “frequent attender” and “substance abuser” impacted how thoroughly a clinician assessed a patient and these labels often co-occurred (Van Nieuwenhuizen et al., 2013). For example, one clinician who knew a patient who had multiple emergency department visits and an extensive psychiatric history described feelings of prejudice towards the patient, assuming the patient’s presentation was always related to a psychiatric issue (Van Nieuwenhuizen et al., 2013).

Negative attitudes based on stereotypes led to nurses labeling patients as difficult, burdensome, frustrating, vulnerable, time consuming, dangerous and risky; often leading to further avoidance behaviors towards patients with mental illness (Artis & Smith, 2013; Brunero et al., 2017; Brunero et al. 2018; Harrison & Zohhadi, 2005; McDonald et al., 2003; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). One medical-surgical nurse described how she would attend to patients with mental illness last, making them less of a priority, and this was due to her labeling of this patient population as time consuming (Zolnierek & Clingerman, 2012). Nurses who work in non-mental health care settings often ignored patient’s physical health problems when it was known that a patient had a psychiatric history and labeled them as a “psych patient” (MacNeela et al., 2012; McDonald et al., 2003; Van Nieuwenhuizen et al., 2013). McDonald et al. (2007) suggest this mistreatment of patients is likely attributed to stereotypical attitudes. Brunero et al. (2017) found that
medical-surgical nurses categorized patients as: the managed, the unpredictable, the emotional, and the dangerous. This influenced how nurses reacted to patients. For example, when nurses perceived patients to be managed (i.e., stable on medication), they were justified in ignoring patients’ mental health care needs, as these patients were considered stable (Brunero et al., 2017). Nurses also felt it was reasonable to limit contact with overtly emotional patients, as nurses deemed them too emotionally draining and time consuming; therefore, they felt justified ignoring the patient’s emotional and psychological needs (Brunero et al., 2017). When nurses labeled patients based on their mental illness, nurses felt it was reasonable to treat these patients differently than those without mental illness (Brunero et al., 2017; Reed & Fitzgerald, 2005). This disparity in treatment of patients with mental illness is a form of discrimination, as the nurses provided differential treatment based on health status (Thornicroft, 2006).

**Institutional barriers as contributors to discrimination**

Institutional barriers in the hospital setting at the organizational and governmental level, were contributing factors towards the discrimination of people living with mental illness in 10 of the reviewed articles (Arnold & Mitchell, 2008; Artis & Smith, 2013; Brunero et al., 2017; Brunero et al., 2018; Doyle et al., 2007; Harrison & Zohhadi, 2005; MacNeela et al., 2012; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). Nurses who work in non-mental health care settings perceive patients with mental illness as an undesirable population to work with (Arnold & Mitchell, 2008; MacNeela et al., 2012; Zolnierek & Clingerman, 2012). This perception was often related to feeling unprepared, resulting in further avoidance of this patient population (Arnold & Mitchell, 2008; MacNeela et al., 2012; Van Nieuwenhuizen
et al., 2013; Zolnierek & Clingerman, 2012). Nurses indicated that a lack of training opportunities often left them feeling unconfident in their clinical abilities (Arnold & Mitchell, 2008; Artis & Smith, 2013; Zolnierek & Clingerman, 2012). One nurse felt overwhelmed and underprepared when working with patients with mental illness, leading her to distance herself from these individuals (Zolnierek & Clingerman, 2012). A lack of workplace training in effective mental health care and psychological interventions left nurses uncomfortable with engaging in patient care (Brunero et al. 2017; Brunero et al., 2018; Reed & Fitzgerald, 2005). Often nurses attempted to spend as little time as possible with patients with mental illness from fear of saying or doing the wrong thing and evoking disruptive patient behaviors (Brunero et al. 2017; Brunero et al., 2018; Reed & Fitzgerald, 2005). Nurses voiced the desire for increased support from the organization, improved training, and supportive resources (such as specialized mental health professionals) to assist them when working with patients with mental illness and to improve clinical confidence (Arnold & Mitchell, 2008; Brunero et al., Harrison & Zohhadi, 2005; 2018; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013). Van Nieuwenhuizen et al. (2013) describe how inadequate governmental funding and a lack of political support to fund mental health services have contributed to a lack of parallel psychiatric services to support and assist emergency department staff. Nurses frequently relied on support from peers, rather than formal support in the work setting to help cope with the demands of working with patients with mental illness (Arnold & Mitchell, 2008; Artis & Smith, 2013; Reed & Fitzgerald, 2005). Improved institutional supports could help nurses be more effective and feel more confident in their abilities to work with
patients with mental illness, thus limiting discriminatory behaviors such as avoidance and distancing.

Another factor that contributed to discrimination towards patients with mental illness was time constraints (Arnold & Mitchell, 2008; Brunero et al., 2017; Doyle et al. 2007; Harrison & Zohhadi, 2005; Van Nieuwenhuizen et al., 2013 Zolnierek & Clingerman, 2012). Nurses often perceived this patient population to be too time consuming to be in a non-mental health care setting and acknowledged they were unable to meet the care needs of patients with mental illness and did not fully address patient concerns (Arnold & Mitchell, 2008; Artis & Smith, 2013; Zolnierek & Clingerman, 2012). Nurses described the difficulty in balancing the demands of physical patient care in a busy generalist setting which contributed to nurses neglecting the psychological needs of patients, which were often viewed as less of a priority (Arnold & Mitchell, 2008; Brunero et al., 2017; Brunero et al. 2018; Doyle et al. 2007; Harrison & Zohhadi, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). Van Nieuwenhuizen et al. (2013) identified institutional time targets to see, treat, admit, or discharge patients as a contributor to this. These forced clinicians to limit their time assessing patients with mental illness, causing them to make premature care decisions (Van Nieuwenhuizen et al., 2013). Nurses failed to provide timely emotional support to mentally ill patients, only intervening once the patient became tearful. Delayed emotional support was justified by citing time constraints. Brunero et al. (2018) suggest the excuse of time constraints is dominant in nursing rationale, but Brunero et al. also suggest this is more likely due to the emotional impact on nurses of caring for patients with mental illness. Nurses also reported that even if there were adequate resources and training, time
would still be a barrier to providing equitable care and effective mental health strategies (Artis & Smith, 2013). This led to nurses experiencing a moral conflict and lack of satisfaction with the nursing care provided (Artis & Smith, 2013; Zolnierek & Clingerman, 2012).

**Physical Health as the Priority for Nursing Care**

In eight of the articles, non-mental health nurses devalued mental health and placed more importance on physical health (Arnold & Mitchell, 2008; Artis & Smith, 2013; Brunero et al. 2017; Brunero et al. 2018; Doyle et al., 2007; Harrison & Zohhadi, 2005; MacNeela et al., 2012; Reed & Fitzgerald, 2005). This may reflect a mind/body dualism, where the mind is invisible, therefore of less value than the visible physical body (Rodgers, 2005; Ungar & Knaak, 2013). Non-mental health nurses often stated that mental health care was not part of their role, and that the physical health of patients was their priority, often resulting in neglected mental health care (Artis & Smith, 2013; Doyle et al., 2007; Harrison & Zohhadi, 2005; Reed & Fitzgerald, 2005). This may also be attributed to the previously mentioned institutional time constraints, forcing nurses to be selective in the care that they provided. MacNeela et al. (2012) stated that nurses prioritized functional nursing goals to maintain normative standards and neglected a truly patient centered approach. Psychological nursing interventions were limited to stabilizing the patient to avoid disrupting the unit milieu but did not progress beyond that (MacNeela et al., 2012). Brunero et al. (2018) attributed this problem to the invisibility of mental health work. The tactile and visual nature of physical care was reassuring to health care providers, whereas mental health care is often not immediately obvious, thus less rewarding to the nurses (Artis & Smith, 2013; Brunero et al. 2018; Doyle et al. 2007).
Nurses also described patients with mental illness as not having a legitimate health concern (Artis & Smith, 2013; Harrison & Zohhadi, 2005). Nurses were also found to make a distinction between what they perceived to be real symptoms (i.e., physical) and those that were not (Van Nieuwenhuizen et al., 2013). The prioritization on the observable and physical health of patients in the general care setting led nurses to view patients with mental illness as less in need than the other “genuine” patients (Artis & Smith, 2013; Harrison & Zohhadi, 2005).

**Experiences of Discrimination by Patients**

Several researchers examined health care providers’ discrimination from the perspective of people living with mental illness (Lakeman et al., 2012; Lawn & McMahon, 2015; Lyons et al., 2009). Patients living with mental illness described physicians as the primary discriminators, although nurses and other health professionals were also named as sources of discrimination (Lakeman et al., 2012; Lawn & McMahon, 2015). Patients often reported experiences of being disrespected, having physical problems overlooked, being dismissed, being judged, not being listened to, being refused care, having privacy compromised, not being given enough information, physical abuse, and being avoided (Lakeman et al., 2012; Lawn & McMahon, 2015; Lyons et al., 2009). This caused patients with mental illness to avoid health services, feel dissatisfied with the care they received, and lose trust in health care professionals (Lakeman et al., 2012).

The most commonly reported account of discrimination was having physical problems overlooked (Lakeman et al., 2012; Lawn & McMahon, 2015; Lyons et al., 2009). Patients often felt that health care providers dismissed physical concerns and attributed them to mental health issues (Lakeman et al., 2012; Lawn & McMahon, 2015;
Lyons et al., 2009). This is consistent with other research, where health care professionals failed to adequately address physical health concerns in patients with mental illness due to their diagnostic label (McDonald et al., 2003; Van Nieuwenhuizen et al., 2013). Overlooked physical health problems is also related to patients feeling unheard, as many patients felt that their concerns were ignored (Lakeman et al., 2012; Lawn & McMahon, 2015; Lyons et al., 2009). One individual living with mental illness described being asked about his mood when seeking treatment for throat pain (Lakeman, et al. 2012). This form of discrimination may result in patients feeling dissatisfied with health services, causing them to avoid services and potentially leading to further strain on patients’ mental and physical health (Hanafiah & Van Bortel, 2015; Thornicroft, 2006).

Another commonly reported account of discrimination was the denial of treatment (Lakeman et al., 2012; Lawn & McMahan, 2015; Lyons et al., 2009). Patients reported being offered only medication and denied other interventions, such as psychotherapy (Lakeman et al., 2012). Lawn and McMahon (2015) indicated that patients with borderline personality disorder, seeking treatment for self-injury in emergency departments, waited to be seen by a nurse or physician for almost two and a half times longer than the national average emergency department wait times. This could be indicative of a lack of empathy because of health care providers’ blaming of the patient or a devaluation of mental illness as a legitimate health concern. Regardless of the underlying cause of the discrimination, patients felt their mental illness resulted in differential treatment by nurses, which does not align with the code of ethics (Canadian Nurses Association, 2017).
Discussion

This integrative literature review explored discrimination by hospital nurses towards people living with mental illness using the Whittemore and Knafl (2005) approach to conducting integrative reviews. Although this review focused on hospital nurses, the findings are applicable to all nurses who work with people living with mental illness. Overall, the findings indicated that hospital nurses engage in intentional and unintentional discriminatory practices when working with patients with mental illness. The theme of negative attitudes suggests these attitudes (usually based on fear and unpredictability) play a significant role in nurses’ discrimination against patients with mental illness. Discrimination was most frequently described as avoidance and limited patient contact (Brunero et al., 2017; Brunero et al., 2018; Harrison & Zohhadi, 2005; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). Consistent in the literature, patients were labelled based on widely held stereotypes about mental illness. Ross & Goldner (2009) found that nurses working in non-psychiatric environments held stereotyped attitudes towards patients with mental illness such as the belief that all people with mental illness are aggressive, dangerousness and unpredictable. Other attitudes of annoyance and pessimism over prognosis were also as commonly reported by nurses (Arnold & Mitchell, 2008; Artis & Smith, 2013; Brunero et al., 2017; Brunero et al., 2018; Doyle et al., 2007; Lyons, Hopley, & Horrocks, 2009; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). These negative attitudes may arise from the belief that mental illness is a sign of weak character and the fault of the patient, thus leading to discriminating behaviors (Hanafiah & Van Bortel, 2015; Ross & Goldner, 2009; Thornicroft, 2006).
Discriminatory behavior violates nursing ethical regulation, and merits further investigation.

Findings suggest that organizational and institutional factors contributed to nurses’ discriminatory behaviors. The most frequently reported institutional barrier was a lack of mental health training and educational opportunities. Nurses also felt unprepared to work with patients with mental illness due to a lack of confidence in their mental health clinical skills, thus causing them to further avoid patients with mental illness (Arnold & Mitchell, 2008; Brunero et al., 2017; Brunero et al., 2018; Zolnierek & Clingerman, 2012). Menzies (1960) describes how nurses distance themselves from patients as a means of protecting themselves from the stress and anxiety that is a result of becoming too emotionally close to a patient, thus avoidance behaviors may be used as a form of self-preservation. Ross & Goldner (2009) found that nurses without specialized knowledge in mental health were more likely to discriminate against patients with mental illness. Nurses were afraid to say or do the wrong thing and expressed a desire for more training but stated that these opportunities were limited (Brunero et al., 2017; Brunero et al., 2018; Reed & Fitzgerald, 2005).

Nurses also identified the need for more support, both from management and from specialized mental health services (Arnold & Mitchell, 2008; Brunero et al., Harrison & Zohjadi, 2005; 2018; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013). The reviewed literature highlighted a lack of formal supportive resources in the hospital environment, leaving nurses frustrated and dissatisfied with patient care (Arnold & Mitchell, 2008; Brunero et al., Harrison & Zohjadi, 2005; 2018; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013). Time constraints in the workplace also appeared
to be a barrier to adequate nursing care (Arnold & Mitchell, 2008; Brunero et al., 2017; Doyle et al. 2007; Harrison & Zohhadi, 2005; Van Nieuwenhuizen et al., 2013 Zolnierek & Clingerman, 2012). Perhaps this reflects hospital nurses’ lack of training in effective mental health nursing skills, thus the inability to efficiently provide mental health care. This could also reflect lack of resources (such as staffing levels or parallel psychiatric services) or a culture that prioritizes the speed of assessment, admission, and discharge over the quality of care delivered. Knaak, Mantler, & Szeto (2017) suggest that approaching stigmatizing attitudes from an organizational level is likely to have a positive impact on staff and patient safety.

The third theme was physical health as the priority of nursing care. Several authors found that non-mental health nurses valued physical health over mental health, and prioritized care to meet the physical health needs of patients, often neglecting patients’ psychosocial needs (Arnold & Mitchell, 2008; Harrison & Zohhadi, 2005; MacNeela et al., 2012; Reed & Fitzgerald, 2005). When nurses viewed the mind as separate from the body, the body often became the focus of care (Ross & Goldner, 2009). This dualistic view of mental illness ignores the external factors that contribute to mental illness, often placing blame on the patient (Goicoechea, 2013). External social, political, historical, environmental, and cultural factors that contribute to mental illness are overlooked when the emphasis was placed on the biomedical model of health (Feely & Long, 2007). Nurses risked missing valuable patient assessment information when mental health is viewed as unimportant, which can lead to prejudgment, stereotypes, discrimination, and inadequate delivery of care (Thornicroft, 2006). Harrison and Zohhadi (2005) suggested this may indicate a need for nurses to adopt a more holistic
model of health, where all aspects of patient care are valued equally. Perhaps this issue is a consequence of the predominant biomedical view of health and illness in hospital settings, influencing nurses’ perceptions of mental illness, despite holism being a central concept in nursing theories (Mason, 2014).

The final theme was patients’ experiences of discrimination. It is important to learn about discrimination towards people living with mental illness from the patient’s perspective, as this may shed new light on how to address discrimination. This discrimination dehumanizes, lowers self-esteem, and leads to self-stigmatization (Haragonzo et al., 2014; Thornicroft, 2006). This happens when a person internalizes unfair treatment and develops feelings of shame and inferiority, thus disempowering the person (Lakeman et al., 2012). Patients most reported having their physical problems overlooked (Lakeman et al., 2012; Lawn & McMahon, 2015; Lyons et al., 2009). Thornicroft, Rose, & Kassam (2007) identified this as diagnostic overshadowing, which can lead to underdiagnosis and mistreatment of physical conditions. Patients felt they were not listened to, their concerns were ignored, and they reported being denied treatment (Lakeman et al., 2012; Lawn & McMahon, 2015; Lyons et al., 2009). This is consistent with Mather et al.’s (2014) findings that patients with mental illness presenting with cardiac symptoms were significantly less likely to receive invasive cardiac interventions and were more likely to experience adverse events when receiving treatment for their cardiac symptoms. This highlights an issue that is not only a nursing concern, but also a concern for patient outcomes. Zolnierek (2009) suggests the disparities in clinical outcomes for people living with mental illness in medical-surgical hospital settings should alert nurses to both the opportunity and obligation to improve
patient care and this begins with the promotion of nursing knowledge, positive attitudes, and self-confidence in caring for this patient population.

**Implications for Nursing and Health Care Practice**

Findings from this integrative literature review suggest that changes to nursing education, nursing practice, and workplace environments are required to address nurses’ discrimination towards patients with mental illness. Many of these changes can be facilitated by hospital nurses, who are well positioned to lead anti-discriminatory professional, policy and practice development. Nurses can also advocate for, and advance, anti-discriminatory nursing care for patients with mental illness.

First, education of hospital nurses and undergraduate nursing students about mental health care and discrimination towards people with mental illness could better prepare nurses to work with this patient population, as many hospital nurses were not confident in their mental health skills. Education that emphasizes that importance of mental health care can hopefully diminish negative attitudes towards mental health work and the duality of mind and body, thus shifting the perspective away from physical care being the only priority. The Canadian Association of Schools of Nursing (CASN) (2015) published entry to practice mental health and addiction competencies for undergraduate nursing education in Canada, which outlines that nurses must provide care in accordance with provincial and regulatory standards when promoting mental health and preventing or managing health conditions or addictions. Included in this entry to practice competency is the expectation that nurses recognize stigmatization and discriminatory attitudes regarding mental health conditions in health care professionals and themselves (CASN, 2015). The recognition of stigmatization and discriminatory attitudes is an area where
specialized mental health nurses could offer a valuable contribution to professional development education for nurses; and, for nursing students as clinical preceptors and/or as mental health nursing specialists involved in undergraduate nursing courses.

Researchers have highlighted the need for effective anti-stigma training in healthcare and state that skills-based training models have shown promise in improving confidence, comfort, and understanding of mental illness (Knaak, Modgill, & Patten, 2014).

Thornicroft et al. (2016) found that education, in combination with contact with individuals living with mental illness was effective in reducing stigma towards this population. Increased involvement by specialized mental health nurses in professional nursing education could not only promote a more holistic model of nursing care but would also provide leadership in anti-discriminatory nursing and health care practice to improve patient health outcomes and patient satisfaction while in hospital.

Some nurses described a desire to help people living with mental illness, but just did not have the experience or skills to confidently do so. Further education could take the form of longer mental health clinical rotations for nursing students to allow for more exposure to people living with mental illness and for supervision by specialized mental health nurses. Professional development for hospital nurses could include mental health education days for all registered nurses. Carroll (2018) described an innovative undergraduate nursing curriculum change that involved a contact-based, recovery focused approach, along with reflective activities. Nursing students were given the opportunity to speak with people living with various mental illnesses to reinforce the content of each lecture, coupled with reflective activities that focused on stigma, personal biases, and changes in their perceptions (Carroll, 2018). After this program, students reported
changes in their perceptions of people living with mental illness and increased empathy (Carroll, 2018). Mental health education can also be integrated into other aspects of nursing education (such as medical-surgical clinical placements) to reinforce the importance of all aspects of nursing care and a more holistic approach to practice. The Registered Nurses’ Association of Ontario (2017) developed an assessment tool to evaluate the integration of mental health and addiction competencies in undergraduate nursing curriculums with the intent to address gaps in educational content, knowledge, or skills. Assessment tools like this one could highlight areas in need of improvement when developing nursing curriculums, thus enhancing mental health knowledge in nursing students.

Second, the institutional barriers of time constraints and lack of clinical support contributed to nurses’ discrimination towards people with mental illness, thus reinforcing the importance of adequate nurse-to-patient staffing ratios with supportive material and human resources (such as psychiatric mental health consult liaison services and psychiatric mental health nurse specialists). Adequate staffing ratios for hospital nurses in general would allow for more time to provide better mental health support, as specialized training in mental health nursing is only effective if nurses have adequate time to implement them. Additional support could come from interdisciplinary mental health professionals or nurses with specialized psychiatric mental health training to assist and supervise nurses in providing patient care, thus relieving some of the uncertainty of working with patients with mental illness. There is a need for more mental health specialized advanced practice nurses (APNs). Psychiatric Mental Health APNs could exercise leadership by facilitating changes that improve nursing practice, improve the
delivery of care, and influence new policy that benefits the public including anti-
discriminatory policies and practices (CNA, 2008a). APNs could work with professional
and interdisciplinary organizations to minimize discrimination towards people with
mental illness (Tracy & Hanson, 2014). Nurses also reported that workplace time
constraints limited time available for professional mental health training and education.
For nurse managers and hospital administrators, providing nursing staff with adequate
mental health training and designated time to access training could help reduce
discrimination in the workplace and ameliorate the harm caused by discrimination
towards patients with mental illness such as increased costs due to prolonged hospital
stays and higher rates of morbidity (Hanafiah & Van Bortel, 2015; Marchand et al.,
2015).

Finally, the introduction of integrated medical and psychiatric care units, that
specialize in treating patients with physical illness and comorbid psychiatric conditions,
could potentially reduce fragmentation of care and discrimination by health professionals.
A need for such units has been demonstrated, as researchers have found that 43% of
hospital inpatients that were receiving psychiatric care had an indication for admission to
a medical-psychiatric unit (Caarls et al., 2019). Other examples of similar integrated units
have been demonstrated across the world, including the United States and the
Netherlands (Chan et al., 2018; Leue et al., 2010). It has been suggested that inpatient
medical-psychiatric units are financially viable and can reduce the stigma of mental
illness (Coira, Grady, Coira, & Coira, 2019).
Limitations

This review was contingent on the availability of studies as outlined by the search strategy and inclusion/exclusion criteria. As a result, some studies that highlighted discrimination may have been missed. Whittemore & Knafl (2005) indicate a challenge with search strategies is that they may only yield up to 50% of eligible studies. To minimize this limitation, a hand search of reference lists was employed to locate additional literature.

There was little literature that solely focused on nurses’ perceptions of discrimination towards people living with mental illness. Several of the research articles included data from a variety of health care disciplines, including nursing, within the same study. This makes it difficult to discern how big an impact nurses had on discrimination. Despite this, the themes remain consistent between articles that include different health professionals and those that only include nurses.

There is also an issue of publication bias. This integrative review only included published literature; therefore, some research may have been excluded if it was not published in an English language peer reviewed journal. There was an over-representation of studies from Europe and Australia, thus limiting transferability. There may be differences in culture, health care services, or educational requirements that contribute to nurses’ perceptions that differ from nurses across the globe. Further review of research literature from other countries would allow for a broader perspective of different populations and nursing settings.
Conclusion

Discrimination by hospital nurses towards people living with mental illness can lead to harmful consequences for patients. Negative attitudes, prioritizing physical health over mental health, and institutional/workplace barriers are factors that prevent nurses from providing optimal care, contributing to discrimination towards patients with mental illness. There is evidence to show that such discrimination results in negative patient experiences when accessing health services, and increased risk of patient harm. The authors of this review suggest increased education for nurses and nursing students with involvement of specialized mental health nurses and advanced practice nurses (APNs). Psychiatric Clinical Nurse Specialists, Nurse Practitioners, and psychiatric liaison services could provide expert consultation to patients, as they can be helpful in responding to the unique needs that patients with mental illness may have while they are hospitalized for medical conditions (Zolnierek, 2009). APNs can help hospital nurses improve their mental health care skills through coaching and mentorship, provide greater exposure to people living with mental illness, and ultimately improve care that patients receive. Managerial and administrative changes could also be made, as issues of workplace time constraints and lack of staff support were identified as contributors to discrimination. Decreased nurse-patient staff ratios and increased clinical support, psychiatric mental health education and supervision could provide nurses the adequate resources required to effectively address patients’ concerns and improve patient care overall.
References


Tracy, M. F. & Hanson, C. M. (2014). Leadership. In A. B. Hamric, C. M. Hanson, M. F. Tracy, & E. T. O'Grady (Eds.), *Advanced practice nursing: An integrative approach* (5th ed.). (pp. 266-298). St. Louis, MO: Elsevier.


### Search Terms Used

<table>
<thead>
<tr>
<th>Population AND</th>
<th>Intervention AND</th>
<th>Context AND</th>
<th>Outcome</th>
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<tr>
<td>“mental health” OR “mental illness*” OR “psychiatric illness*” OR “mentally ill” OR “patients with mental illness*”</td>
<td>nurs*</td>
<td>“medical surgical” OR “medical-surgical critical care” OR “emergency department***” OR “non-psychiatric hospital***” OR “non-mental health hospital***” OR “general hospital” OR “acute care”</td>
<td>discrimin* OR perception* OR experience*</td>
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</table>
Table 2

*Summary of Reviewed Studies*

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<tr>
<th>Author, Year, and Country</th>
<th>Aim</th>
<th>Study Design</th>
<th>Sampling Method, Inclusion Criteria, and Size</th>
<th>Data Collection and Measurement/Analysis</th>
<th>Limitations</th>
<th>Summary of Key Findings</th>
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<tr>
<td>Arnold &amp; Mitchell (2008), UK</td>
<td>To explore nurses’ perceptions of mental health services for older people in acute care settings.</td>
<td>Qualitative design using grounded theory</td>
<td>Convenience sample. - Inclusion: Qualified nurses employed in the acute care trust on a substantive contract, working in an area where older people might be admitted.</td>
<td>Three focus groups. Thematic analysis and observation of groups.</td>
<td>Small sample size. Self-reported nature of data.</td>
<td>Three key themes: ‘mental health issues’, ‘training and education’, and ‘collaborative working’. Patient’s physical needs took precedent over mental health needs. Participants labeled patient with mental illness, sometimes unknowingly, without considering other</td>
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<td>Author, Year, and Country</td>
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<td>Artis &amp; Smith (2013), UK</td>
<td>To explore: ED staff attitudes to patients who self-harm and the impact of attitudes on behavior.</td>
<td>Qualitative design.</td>
<td>Purposive sample.</td>
<td>Semi structured interviews.</td>
<td>Small sample size, therefore, data saturation may not have been reached.</td>
<td>Participants expressed the need for further education related to mental health. An overarching theme of balancing differences and diversity, where staff felt they were often having to balance competing expectations in relation to possible effects on behavior. Participants expressed a need for increased interdisciplinary help but identified a lack of collaboration as a barrier to care.</td>
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<td>The perceived barriers to and facilitators of effective working with people who self-harm.</td>
<td>contact to treat initial presenting problems. Sample (n=10)</td>
<td>comparisons more difficult. Participants were only from one ED thus limiting transferability.</td>
<td>patients who self-harm. Other themes include beliefs about self-harm, the perceived barriers and facilitators to work effectively with patients who self-harm, and the importance of identity, culture, and roles in the ED.</td>
<td>Pluralistic ignorance, where individuals perceived that others’ negative actions reflect stable negative attitudes, but do not perceive these attitudes and behaviors for themselves.</td>
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<td>Staff perceptions of their team members’ attitudes towards people who self-harm and how these impact others’ behavior.</td>
<td>Who ED staff identify as their team.</td>
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| Brunero et al. (2018), Australia | To describe basic social processes faced by general health professionals involved in the provision of health care for people with mental illness in specific general hospital settings in Australia. To develop a substantive theory that explains the components of these processes. | Qualitative design using grounded theory | Purposive sample Inclusion: Social workers, medical staff, and nurses who did not identify as a mental health professional. 3 participant observations 2 focus groups 21 individual interviews 12 study site hospital policy and protocol documents | Participant observation Focus groups Individual interviews Document review | Sample size for each focus group is not indicated. Self-reported nature of individual interviews may elicit bias. The differences in professions of the participants make comparisons more difficult. | Interactions with patients with mental illness demonstrated conflict between the ideals of patient care and the realities of their work. Distorted clinical pathways, where patients with mental illness were perceived as deviating from the norm. Participants considered patients with mental illness as having their own isolated space. Staff modified their approach to patients and had preconceived
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<td>ideas of how to behave when working with patients with mental illness. Participants felt that patients with mental illness would be better off receiving care in purposefully designed rooms. Participants struggled with being able to see the relevance of their work with patients with mental illness due to the invisibility of mental health work. Participants expressed a lack of clinical confidence when working with</td>
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<td>Brunero, Buus, &amp; West (2017), Australia</td>
<td>To gain insight into medical-surgical nurses’ process of categorizing people living with mental illness in general hospital settings</td>
<td>Qualitative focus groups.</td>
<td>Purposive sample from two separate non-mental health care wards</td>
<td>Two semi-structured focus groups.</td>
<td>What was said in the focus groups may not reflect actual clinical practice.</td>
<td>Nurses categorized patients as: the managed (not problematic), the unpredictable (unable to predict patient behaviors), the emotional (crying behavior), and the dangerous (perceived risk of violence). These categories explained and justified participants’ nursing practice as it relates to the challenges and barriers of providing effective clinical care.</td>
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<td>Inclusion: Nurses who had direct patient exposure who primarily identify as medical-surgical nurses without substantial mental health experience.</td>
<td>Discourse analysis.</td>
<td>The complexities of general hospitals and the assumptions about discourses across nursing specialties may have framed the language used.</td>
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<td>Sample (n=16)</td>
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<td>Limitations in the transcription process due to poor audio quality.</td>
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<td>Doyle, Keogh, &amp; Morrissey (2007), Ireland</td>
<td>To describe the experiences and challenges that nurses encounter when caring for patients who present to the emergency department with suicidal behavior.</td>
<td>Mixed methods.</td>
<td>Purposive sample of ED nurses. Sample (n=42)</td>
<td>Semi-structured questionnaire. Descriptive statistics. Thematic analysis.</td>
<td>Low response rate. No clear inclusion criteria identified. The researchers indicate that the initial intention of this study was to be solely qualitative, but due to circumstances this was not possible. Subjective responses were only limited to open ended questions on the questionnaire, therefore follow up questions and clarification</td>
<td>Participants identified their main role was to undertake assessments and create a safe environment. Care provided mostly focused on physical needs and, overall, participants did not identify psychological wellbeing as part of their role. Participants’ feelings towards patients depended on the circumstances of the patient’s admission. This reflected the care that the patients received. Some participants were...</td>
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<td>Harrison &amp; Zohhadi (2005), UK</td>
<td>To identify factors and issues that nurses consider to be of relevance to meet patient’s mental health needs</td>
<td>Qualitative phenomenology</td>
<td>Convenience sample</td>
<td>Qualitative focus group interviews</td>
<td>Only 1 focus group of staff from a unit specializing in the care of older people. Themes of ‘disruption’, ‘role conflict’, ‘professional resources’, and ‘professional distress’ emerged.</td>
<td>Nurses felt that their role was to be willing to invest more time in the care of patients if their circumstances were perceived to be authentic. Perceived lack of skills and insufficient resources were perceived to be the biggest challenge when working with patients who engage in suicidal behavior.</td>
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<td>Lakeman et al. (2012), Ireland</td>
<td>To explore peoples’ experience, understanding of, and the impact of discrimination as a consequence of being identified with mental health problems</td>
<td>Qualitative.</td>
<td>Convenience sample.</td>
<td>Face to face interviews.</td>
<td>Results cannot be generalized beyond the small cohort of participants who volunteered. Not an exhaustive exploration of all types of discrimination.</td>
<td>Discrimination was reported in relation to employment, personal relationships, business and finance, and health care. Participants reported a sense...</td>
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<td>Inclusion: Over 18 years of age.</td>
<td>Thematic analysis, aided by NVivo software.</td>
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<td>Self-identified as experiencing mental health problems.</td>
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<td>Attend mainly to physical health needs and that mental health needs were not a legitimate area of nursing concern. Nurses described lack of knowledge of mental illness and time constraints to care for people with mental illness.</td>
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<td>Lawn &amp; McMahon</td>
<td>To explore the experiences of people living</td>
<td>Survey</td>
<td>Purposive sample</td>
<td>Online survey</td>
<td>Analysis took place after the interviews; themes were not able to be explored in further detail.</td>
<td>The finite dataset led to an approximation of data saturation; therefore the list of themes may not be exhaustive.</td>
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<td>(2015), Australia</td>
<td>with borderline personality disorder when they access health care services.</td>
<td>Inclusion: Any person identified as having a borderline personality disorder diagnosis.</td>
<td>Perspectives of 153 people were captured.</td>
<td>Results are reliant on self-reported data and on what participants have been told about their diagnoses.</td>
<td>The sample size was too small to analyze the differences in experience of indigenous populations or culturally and linguistically diverse populations. Gender difference in response rates may be reflective when patients with BPD attempted to have their health needs met.</td>
<td>Significant association between receiving a diagnosis and not receiving adequate information about their diagnosis or treatment. Respondents reported waiting more than 4 hours in the ED department when seeking treatment for self-harm, whereas the national average is 19 minutes for medical concerns.</td>
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<td>of more females being diagnosed with borderline personality disorder, or females with borderline personality disorder are more likely to participate in surveys than males.</td>
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<td>Responses to questions vary due to the survey allowing participants to opt out of answering questions.</td>
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<td>Did not examine differences in private and public hospitals.</td>
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<td>Lyons, Hopley, &amp; Horrocks (2009), UK</td>
<td>To explore the current nature and extent of stigma and discrimination in an area north of England and make comparisons to data from 1997.</td>
<td>Descriptive survey.</td>
<td>Purposive sample. Sample (n=210)</td>
<td>Questionnaires via post, telephone, and email. Thematic analysis</td>
<td>The possibility that some accounts may have been distorted by some participants because of their mental health problems. Comparison of data from two studies with different methodologies. Self-reports may elicit bias. No follow up questions or clarification could be sought due to data being collected via questionnaire.</td>
<td>27 participants report discrimination from health and social care staff and staff from other organizations. Reports of having their physical health overlooked. Reports of lack of respect and poor care, which manifested as not being listened to, having questions being directed at the person accompanying the service user, being video recorded without consent, and one</td>
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<td>MacNeela at al. (2012), Ireland</td>
<td>To assess whether nurses working in general hospitals have access to stereotyped perceptions or specialized insights on psychiatric patients.</td>
<td>Multi-methods qualitative design.</td>
<td>Purposive sample.</td>
<td>A think-aloud decision-making task.</td>
<td>No clear inclusion criteria identified.</td>
<td>Participants described attitudes that correspond with the stereotypical depictions of risk and vulnerability.</td>
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<td>Inclusion: Medical-surgical nurses working in two hospitals in Ireland.</td>
<td>A critical incident interviews.</td>
<td>Findings are based on one simulated patient case scenario.</td>
<td>Participants prioritized functional nursing goals to achieve stability in patient behavior and ward environment when describing psychosocial care. This</td>
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<td>Sample (n=13)</td>
<td>Thematic analysis of the think-aloud responses.</td>
<td>Limited transferability.</td>
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<td>Content analysis of the think-aloud responses.</td>
<td>Small sample size.</td>
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<td>Analysis of the thematic analysis in the context of the critical incident interviews.</td>
<td>Some categories of nursing experience were underrepresented.</td>
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<td>Participants had limited exposure to the simulated case. Repeated</td>
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<tr>
<td>McDonald et al. (2003), USA</td>
<td>To examine how patients’ psychiatric diagnoses affect nursing care for medical problems</td>
<td>A post-test experimental design</td>
<td>Sampling strategy not indicated.</td>
<td>The Clinical Decision Making Instrument with three identical vignettes describing a patient being admitted with a possible MI, except for three conditions: 1) a non-psychotic psychiatric condition 2) a psychotic condition, and 3) a control condition.</td>
<td>Behaviors and attitudes in actual clinical situations may be different than those exhibited by a patient vignette.</td>
<td>Participants in the psychotic patient condition were less likely to believe the patient was experiencing an MI and less likely to respond to symptoms.</td>
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<td>Blinded random assignment to groups.</td>
<td>Content analysis of how quickly nurses predicted a mean probability of</td>
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<td>Participants in the psychotic condition predicted a mean probability of</td>
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<tr>
<td>Author, Year, and Country</td>
<td>Aim</td>
<td>Study Design</td>
<td>Sampling Method, Inclusion Criteria, and Size</td>
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<td>Sample (n=60)</td>
<td>planned to respond to the patient’s symptoms.</td>
<td>The inclusion of medication lists in the patient vignettes may have confounded participants’ responses to certain patient symptoms.</td>
<td>Participants were instructed to estimate the time to perform each nursing task to the nearest second. There may be inaccuracies in the time estimates.</td>
<td>35% (SD=18.19) that the patient was having an MI, compared to participants in the non-psychotic condition who predicted 49.5% (SD=19.29) and the control condition, who predicted 50.6% (SD=28.17). Time estimates for carrying out nursing tasks and delegating tasks was not significant between groups. Response to sudden anxiety differed significantly between groups: 45% of</td>
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<td>Author, Year, and Country</td>
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<td>Participants in the psychotic condition indicated the possibility of an MI, 36.8% of participants in the non-psychotic condition indicated the possibility of an MI, and 78.9% of participants in the control condition indicated the possibility of an MI. There was a significant difference between the psychiatric condition and the control condition difference in the likelihood of predicting an MI.</td>
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<td>Author, Year, and Country</td>
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<td>Reed &amp; Fitzgerald (2005), Australia</td>
<td>To explore rural nurses’ attitudes and how they affect care, the problems they associate with providing care, and the impact of education, support, and experience when caring for people with mental illness.</td>
<td>Qualitative descriptive study.</td>
<td>Stratified random sample. Inclusion: Nurses who provided direct patient care. Nurses who did not have specialized mental health training.</td>
<td>Semi-structured interviews. Qualitative content analysis.</td>
<td>A small sample size in one rural hospital limits transferability. Self-reported accounts may be biased.</td>
<td>$x^2(1, N = 41) = 4.81, p &lt; .03$ but no significant difference between the non-psychotic condition and the control condition $x^2(1, N = 41) = 2.93, p &lt; .09$. Nurses felt a dislike for working with people living with mental illness and felt that this was not their role. Nurses identified fear, causing avoidance of patients. Nurses who received specialist support and education felt...</td>
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<td>Van Nieuwenhuizen et al. (2013), UK</td>
<td>To investigate recognition of diagnostic overshadowing (misattributing physical symptoms as mental health concerns) to more comfortable. Nurses prioritized physical care, causing mental health concerns to not be adequately addressed.</td>
<td>Qualitative design.</td>
<td>Purposive sample selected based on diversity in professional background, experience, age, gender, and ethnicity.</td>
<td>Semi-structured interviews.</td>
<td>Unable to determine the extent to which each of the factors contribute to diagnostic overshadowing.</td>
<td>Participants commonly recognized that diagnostic overshadowing was a problem, although some participants did not think it was a key issue.</td>
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<td>Author, Year, and Country</td>
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<td>Zolnierek &amp; Clingerman (2012), USA</td>
<td>To explore a medical-surgical nurse’s perceptions of</td>
<td>Qualitative, descriptive case study.</td>
<td>Convenience, purposive sample from a medical-</td>
<td>Semi-structured interview.</td>
<td>The small sample size limits transferability.</td>
<td>Overall negative experiences.</td>
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<td>identify contributory and mitigating factors.</td>
<td></td>
<td>doctors, nurses, and nurse practitioners who work in an emergency department.</td>
<td>Inductive content analysis.</td>
<td>Findings may not be generalizable to other departments.</td>
<td>Problems obtaining a history, problems with examination, environmental problems, labelling and stigma, fear of violence and avoidance, time pressure, and a lack of implementation of parallel working with psychiatry were all identified as contributors to diagnostic overshadowing.</td>
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<tr>
<td></td>
<td>Inclusion: Any non-mental health</td>
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<td>15 nurses</td>
<td>Self-reported nature of the interviews may elicit social desirability bias.</td>
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<td>doctors, nurses, and nurse practitioners who work in an emergency department.</td>
<td>5 nurse practitioners</td>
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<td>10 doctors</td>
<td>The differences in professions of the participants make comparisons more difficult.</td>
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<td>Author, Year, and Country</td>
<td>Aim</td>
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<td>caring for a person with severe mental illness.</td>
<td>surgical setting.</td>
<td>Inclusion: A registered nurse caring for an adult with severe mental illness.</td>
<td></td>
<td>Causality cannot be determined due to non-experimental design.</td>
<td>The participant felt unprepared and frustrated.</td>
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<td></td>
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<td>Sample (n=1)</td>
<td></td>
<td>Possibility of bias in the analysis of data by the researcher.</td>
<td>Themes of discomfort, frustration, lack of personal satisfaction, and difficulty emerged.</td>
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<td>Leaving the patient until last due to patients with mental illness taking a lot of time and effort.</td>
<td>Aversion to working with patients with mental illness.</td>
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<td>Not addressing patient's mental health needs.</td>
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</table>
Figures

Records identified through database searching, (n = 546)

Records after duplicates removed, (n = 469)

Records screened, (n = 469)

Records excluded (Title review), (n = 432)

Full-text articles assessed for eligibility, (n = 37)

Full-text articles excluded, with reasons (does not meet inclusion criteria, not primary sources), (n = 23)

Studies included in qualitative synthesis, (n = 11 + 1 Mixed Method)

Studies included in quantitative synthesis, (n = 2 + 1 Mixed Method)

14 Studies included in the review

Figure 1 Prisma Diagram
Chapter 3 Methods
Methodological Framework and Philosophical Underpinnings

In this chapter, the theoretical perspectives guiding the study and the research methods are documented. The theoretical framework of interpretive feminist phenomenology was chosen for this research with the aims of (a) understanding non-mental health nurses’ perceptions of working with people living with mental illness and (b) understanding the conditions that contribute towards discrimination by nurses towards people living with mental illness in non-mental health care settings. Given the volume and complexities of the literature on interpretive feminist phenomenology and the scope of a Master of Nursing thesis, in this chapter I have outlined the basic assumptions and concepts for each theory relevant to this study. What follows is a description and discussion of phenomenology, interpretive phenomenology, feminist theory, and interpretive feminist phenomenology, all of which influenced my position as a researcher in conducting the study.

Phenomenology

Phenomenology is not only a philosophy, but a qualitative research method derived from the philosophy that seeks to explore human lived experiences of a phenomenon of interest (Kafle, 2011; Streubert & Carpenter, 2011). A phenomenological approach to research values the perceptions of the individual and how those perceptions are influenced by experience (Streubert & Carpenter, 2011). Phenomenological research aims to describe and to interpret subjective lived experiences and understand how in perceiving, meanings are attributed to experiences (Streubert & Carpenter, 2011). As the main aim of my study was to describe and understand registered nurses’ perceptions of discrimination towards people with mental illness, a phenomenological approach was
selected. Phenomenological researchers seek to understand life experience and look for the essence of a phenomenon experienced subjectively (Polit & Beck, 2017). Little research has been done on nurses’ subjective experiences of discrimination related to patients with mental illness. Most current research focuses on the concept of stigma. There has been even less research that focuses on non-mental health nurses and their perceptions of discrimination towards patients with mental illness. Furthermore, a phenomenological approach to research is most useful when little is known about a phenomenon (Polit & Beck, 2017). Exploring through phenomenological research, nurses’ perceptions of discrimination towards the mentally ill is both relevant and timely with the potential to contribute further knowledge for nursing and health care of people living with mental illness.

Edmond Husserl (1962) is credited as being the founder of early phenomenological philosophy (Polit & Beck, 2017). He argued that philosophy should be a rigorous science (where there is confidence in the findings of a research study and an established consistency in the methods used) in which there is a deep concern for human experience (Streubert & Carpenter, 2011). He believed that consciousness was the medium between the person and the world and that minds and objects both occur within experience (Giorgi, 2012; Laverty, 2003). Husserl also believed that phenomenological inquiry should include questions about lived experience and the meanings of experience brought to consciousness (Giorgi, 2012). According to Husserl (1970), researchers must return to the world of lived experience when undertaking phenomenological research.

According to Laverty (2003), one main assumption of Husserlian phenomenology is the “life-world”, described as the world around us, the cosmos and our experiences of
ourselves and others, including how we perceive the world. He also believed in the importance of intentionality in phenomenological research, in that consciousness is intentional (Husserl, 1970). Without the world, there is no consciousness (Sadala & Adorno, 2002). When we are conscious of an object, it takes on a meaning to the person, therefore the object and the person are inseparable, and this is intentionality (Husserl, 1970). The researcher’s task, when undertaking phenomenological research, is to analyze the experiences of consciousness (i.e., the meaning given towards a phenomenon) to uncover how meaning is given to an object and to understand the essence of a phenomenon (Sadala & Adorno, 2002). For Husserl, phenomenological reduction (i.e., bracketing), which is the process of suspending judgement and personal opinions, is done with the intent of moderating potential influences that a researcher’s beliefs may have on the data analysis and interpretation (Streubert & Carpenter, 2011). Although the aim of this study was to learn about the perceptions of nurses in relation to discrimination through in-depth description of personal experiences and thoughts, pure Husserlian phenomenology seeks to describe a phenomenon rather than explain it, while avoiding preconceived assumptions and ideas about the phenomenon (Giorgi, 2012). In my research the focus of analysis was on the interpretation of nurses’ perceptions, with the assumption that the researcher cannot totally suspend prior belief related to a phenomenon. One approach to phenomenological understanding that appealed to me was interpretive phenomenology, which is discussed below.

**Interpretive Phenomenology**

An alternate phenomenological approach to research is interpretive phenomenology (Streubert & Carpenter, 2011). Martin Heidegger, a German
philosopher, and student of Husserl is often credited as the founder of interpretive phenomenology. Heidegger rejected the idea of suspending judgement and personal opinions (bracketing) and proposed an interpretive narration to understand phenomena (Kafle, 2011; Streubert & Carpenter, 2011). Heidegger argued that phenomenology’s primary concern was the meaning of presence in the world (“being”) and consciousness was not separate from the world of human existence (“being-in-the-world”) (Baird & Mitchell, 2014; Dowling, 2007). Based on this premise, Heideggerian interpretive phenomenology focused on the subject’s (the individual) lived experiences of a phenomenon, accessible through lived stories of being in the world (Kafle, 2011). Interpretations are made by ongoing interpretive analysis that starts with a naïve understanding of a phenomenon, develops into an explicit understanding, then through a rich interpretive description of the phenomenon (Streubert & Carpenter, 2011).

Other philosophers have expanded on Heidegger’s philosophy of phenomenology, including Maurice Merleau-Ponty, a French philosopher who sought to discover participants’ perceptions of lived experiences (Thomas, 2005). Congruency between the selected philosophical framework and the researcher perspectives is important therefore an interpretive phenomenological approach, influenced by Merleau-Ponty (1962) philosophy, guided my study (Baird & Mitchell, 2014). In my research, the focus was on nurses’ perceptions of discrimination, which aligned with the Merleau-Ponty approach. A description of Merleau-Ponty’s philosophical stance to phenomenology is detailed below.

**Merleau-Ponty and the phenomenology of perception.**

Merleau-Ponty (1962) claimed that perception was the basis of embodiment and humans perceived and experienced the world using their bodies. As humans, we interact
with the world through sight, hearing, sexuality, and our bodies, therefore our senses shape our personal existence, our lived experiences (Merleau-Ponty, 1962). Merleau-Ponty rejects dualities, such as thoughts and feeling, self and other, subject and object, and mind and body, thus contesting Cartesian dualism (i.e., the mind as separate from the body), a philosophical understanding that has predominated health research (Morstyn, 2010). He argued that all knowledge, even scientific knowledge was gained from a particular point of view, without which, the symbols of science would not make sense (Merleau-Ponty, 1962). Objective thinking when examining an object blinds us from understanding that the object is inseparable from the person perceiving it therefore, fully suspending judgement about a phenomenon is difficult and the same can be said about our relationships with others (Merleau-Ponty, 1962). He argued that everything that humans live and think about always have several meanings (Merleau-Ponty, 1962). Each individual is only able to perceive the reality of the world from their own perspective therefore the truth of reality is limited by our understanding of it as people (Merleau-Ponty, 1962). According to Thomas (2005), Merleau-Ponty believed that perception is what opens us to reality by providing direct experiences of events, objects, and phenomenon of the world.

In my study, it is the reality of discrimination by nurses towards people living with mental illness that is assumed to be existing in the world. Discrimination is understood as the unfair treatment based on labels or prejudgments toward a group of people (the mentally ill), which I believe can be further understood through the exploration of individuals’ perceptions, therefore Merleau-Ponty’s philosophy aligned with my research aims.
Feminist Theory

Historically, some feminist theorists have argued that Global North societies have been dominated by a patriarchal structure, primarily a construction of (white) men, and for the benefit of (white) men, thus others’ experiences including women were subjugated, considered inferior, dismissed, and/or even silenced (de Beauvoir, 1989; Jebali, 1995). Patriarchal societal structures and processes contribute to the idea that qualities deemed as feminine are less valuable in society (Jebali, 1995). Despite a wide range of feminist theories, there is some congruency, in that feminist researchers examine how assumptions about gender(s) and gender inequality influence knowledge development, social-economic-political justice and inequalities, and what counts as truth to re-evaluate ways of knowing from a feminist lens (Burton, 2016).

Historically, women were not involved in medical and scientific research (and if they were, it often went unacknowledged) and the normative standards of health research were constructed in keeping with a masculine ideal/perspective (Rodgers, 2005). This contributed to the healthy masculine (most often, typified by the white, middle class male) as becoming the generalized model of health, frequently resulting in research being misapplied to others including women, youth, and children (Swartz, 2013). This led feminists to critically re-evaluate scientific research and ask how gender has influenced knowledge development (Gerrard & Javed, 1998). A masculine normative standard can also be relevant for understanding individuals with mental illness. Feminist theorists have argued that the standard of “normalcy,” stereotypical of male development, is used to create diagnostic labels for psychiatric disorders (Goicoechea, 2013). Aspects of gender expression that are frequently attributed to femininity – such as emotionality – have been
frequently labeled as pathological, thus shaping gendered societal and health care professionals’ views of mental illness (Goicoechea, 2013).

Feminist theory claims that gender is important in shaping knowledge and individual experience (Rodgers, 2005). Feminist researchers examined how gender (as an important characteristic) relates to other aspects of society, such as race, class, and power differentials, in the construction of relationships (Eun-Ok, 2010). Zeiler and Folkmarson (2014) argue that feminist theory can be a valuable resource to address issues concerning marginalization, oppression, discrimination, and non-normativity and that feminist theories are important to guide health care research of the human experience. This does not mean that all feminist research focuses on women’s experiences or women’s health (Eun-Ok, 2010). Feminist research that includes all gender identities is essential to understand gender dynamics and gendered differences in health care and medicine (Eun-Ok, 2010). Eun-Ok (2010) states that nurse feminist researchers can challenge oppression of and discrimination towards vulnerable populations, and even empower research participants. This is particularly relevant to my study, as this study explores discrimination towards the mentally ill, who as a group have had a long history of experiencing stigma and discrimination. Findings from this study may bring to light the problem of discrimination, thus challenging previous assumptions about the phenomenon. A feminist approach to research aims to establish a collaborative and non-exploitive relationship with research subjects, thus respecting the participant’s experiences (Eun-Ok, 2010; Polit & Beck, 2017; Simms & Stawarska, 2014).
Interpretive Feminist Phenomenology

Phenomenology, historically, has been overlooked by feminist researchers, as there has been an argument that phenomenology and feminism were incompatible (Fisher, 2000). Feminist researchers have criticized phenomenology, stating that it is abstract, bound in theory, fails to acknowledge gender and sexual difference, and is indifferent to socio-political discourse (Fisher, 2000). It has also been criticized, by some feminist scholars, in that phenomenology was originally developed primarily by men, thus potentially guilty of masculine bias (Fisher, 2000). However, Garko (1999) argues that phenomenological approaches can address feminist issues and that feminism and phenomenology are alike, in that they both commit to describing, understanding, and exploring the experiences of the research subject.

Feminist phenomenology is a relatively new approach in the investigation of matters concerning health care and medicine (Zeiler & Folkmarson, 2014). Traditionally, many topics of concern for feminist researchers were situated in social science and were outside the realm of health science (Zeiler & Folkmarson, 2014). However, feminist phenomenological research is relevant in health care in that the experience of difference and vulnerability (related to preconceptions of normalcy), can be investigated and subsequently challenged (Zeiler & Folkmarson, 2014). As a research method, it can be used to gain a deeper understanding of the participants’ experiences and uncover how differences in perceptions shape these experiences (Baird & Mitchell, 2014; Simms & Stawarska, 2014).

In nursing research, a feminist phenomenological approach can guide understanding of the hierarchies and power differentials that nurses may experience
amongst themselves, other health care providers, and patients as well as within the larger health system (Goldberg, 2006). Since my research is focussed on understanding discrimination, an issue that may have foundations in power differentials and ideas of normativity, an interpretive feminist phenomenological method offered both a rich description and understanding of the phenomenon with a critical lens to examine what conditions are at play in each situation. In my review of the literature, I found no research studies that used a feminist approach to researching nurses’ attitudes towards patients with mental illness, suggesting this study was unique, novel, and could contribute to the growing body of feminist nursing research and knowledge development for nursing.

**Research Design**

An interpretive feminist phenomenological research method was chosen to explore and understand nurses’ perceptions of discrimination toward patients with mental illnesses. In the next section, I outline each step of the research method including the recruitment, sampling, data collection tools and methods, and data analysis.

**Ethical Considerations and Research Data Management**

Approval from the University of Calgary’s Conjoint Health Research Ethics Board was obtained prior to commencement of the research (CHREB ethics ID REB18-0830). There was minimal risk to the participants, in that there was very little expected risk that would not be encountered in everyday life (Polit & Beck, 2017). There was a small risk for psychological distress due to the potentially sensitive nature of this study’s focus. Although no participants disclosed any psychological distress during the research processes, the participants were informed of available mental health services (such as Alberta Health Services psychiatric services or the Calgary Distress Centre) that they could contact if they felt they needed to. Each interview remained confidential, and a
pseudonym was selected by the participant to be used throughout the data transcription, analysis, and any writings related to the study. No identifying information was collected during the interview process. All digitally recorded interviews and transcripts were only accessible on a need-to-know-basis by my supervisor and supervisory committee. All digitally recorded interviews and transcripts will be destroyed five years after completion of this study.

**Recruitment**

Nurses were recruited from one general medical hospital unit in a large urban center in Alberta. Initial contact was made with the unit managers via email to obtain permission to recruit RN participants on the general medical unit. After the unit managers agreed to assist with recruitment, the clinical nurse educator was contacted and provided with a recruitment email to disseminate to RNs on the respective unit. The clinical nurse educator sent the recruitment email to all RNs on the unit. Each potential participant could confidentially contact me via email or phone. All participants contacted me directly and voluntarily agreed to participate in this study. A total of 10 RNs who met the inclusion criteria volunteered to participate. Written informed consent was obtained from all participants (Appendix A).

**Sampling**

Purposive sampling is the most common sampling method in phenomenological studies and therefore it was used in this study to select participants who had a specialized knowledge on the phenomenon under investigation (Streubert & Carpenter, 2011). Purposive sampling allows for the selection of interviewees that will best inform the research (Polit & Beck, 2017).
For this study, a purposive sample of 10 registered nurses was used. For the study, inclusion criteria were RNs who, at the time of the study, currently worked in a non-mental health care setting for at least one year, who had experience caring for patients with mental illness, and who spoke English. Exclusion criteria were RNs who had current or previous experience working primarily in a mental health care setting.

**Participant Demographics.**

All participants had worked as RNs in non-mental health care hospital settings and some, at the time of the interviews, had worked in other nursing roles such as administration, education, community health, and outpatient care. The average age of participants was 31.5 with a standard deviation of 4.9. The average years of RN experience was 4.5 with a standard deviation of 2.7. All the participants were educated to a bachelor’s degree level, with one having graduate level education. None of the participants had additional mental health training outside of undergraduate nursing education. All participants were working as RNs at the time of the study.

**Data Collection and Management**

Data was collect using in-depth, semi-structured interviews, using an interview guide (Appendix B). An interview guide was prepared while still allowing for the flexibility required to allow the participants to freely talk about their experiences (Polit & Beck, 2017). Participants were asked open ended questions, as this allowed the researcher to gain access to the participants’ thoughts and ideas (Fisher, 2000). This question guide allowed for the participants to describe their experiences in their own words and allowed for a rich description of those experiences (Garko, 1999). Each participant was asked their age and to provide a description of their work setting prior to the interviews. Each interview took between 20 to 80 minutes to complete.
Feminist phenomenological researchers attempt to establish rapport with participants, and create collaborative relationships (Eun-Ok, 2010; Polit & Beck, 2017). Each participant was interviewed in an empathetic manner, as it was anticipated that the topic of inquiry may be sensitive to some individuals. This was done by actively listening, refraining from any opinionated comments, and conducting interviews in an environment that was familiar to the participants (such as their own homes or in a private setting outside of the workplace). Each participant was given adequate time to fully voice their experiences and ideas, and in turn provide a detailed description of their perceptions of discrimination (Polit & Beck, 2017). All interviews were audio recorded, with permission from the participants. Pseudonyms were used in the interview recordings, transcription processes, and data analysis and all data were stored on a password protected computer. The audio recordings were listened to several times later and transcribed verbatim. Verbatim transcription was necessary to ensure that the best quality data was collected, and accurately reflected what the participants experienced (Polit & Beck, 2017). This transcription process was undertaken by me.

**Data Analysis**

For this research study, Interpretive Phenomenological Analysis (IPA) according to Smith et al. (2009), was used to guide analysis. IPA is primarily concerned with developing a detailed examination of the subjective lived experience (Polit & Beck, 2017). It uses in-depth interpretation and analysis of subjective experiences to understand the perceptions of the participant (Smith, Flowers, & Larkin, 2009). Smith et al. (2009) argues that by using IPA to investigate lived subjective experiences, analysis inevitably becomes interpretive. IPA assumes that interpretations occur simultaneously with data
collection, as the researcher gains access to the participants’ experiences, and in my study, through the in-depth interviews (Smith et al., 2009). IPA is an appropriate method for data analysis in feminist phenomenological research, in that it assumes the person is embodied within a social context. In this research study, it is assumed the nurse’s perceptions and behaviors towards patients with mental illness are embodied within the social context of a medical unit (Smith et al., 2009).

Smith et al. (2009) outlined a systematic six-step process to help guide researchers in analyzing qualitative data, in the case of my study, analysis of the participant interviews. Step one is reading and re-reading, which requires immersion into the original data (Smith et al., 2009). I did this by reading the transcribed interviews and listening to the audio recording of the interviews while re-reading the transcript (Smith et al., 2009). Smith et al. (2009) stated that the purpose of this is to ensure the participant becomes the focus of analysis and to avoid a premature reduction of the lived experience.

Step two is initial noting, which involves examining the semantic content on an exploratory level (Smith et al., 2009). This step requires the researcher to make notes while reading over the transcripts from the interviews, and this should be done with a clear phenomenological focus (Smith et al., 2009). I did this after an initial reading of a hard copy of the transcripts and I made notes of the language used by the participants, the focus of their conversation, and how they made meaning of the phenomenon (Smith et al., 2009). I also made notes of similarities and differences in transcripts and identified any contradictions in perceptions of discrimination (Smith et al., 2009).

Step three in the IPA process was developing emergent themes (Smith et al., 2009). This step required the researcher to take the new larger data set (i.e., the original
transcript and the provisional notes) and begin to look for emerging themes (Smith et al., 2009). This involved reducing the volume of the data, while still preserving detail and complexity (Smith et al., 2009). The themes reflect the participants’ thoughts and perceptions as well as the researcher’s interpretations (Smith et al., 2009). The following table lists the emergent themes that appeared frequently in the data during the initial stages of analysis:
### List of emergent themes

<table>
<thead>
<tr>
<th>Emergent themes</th>
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<tr>
<td>Patients’ behaviors</td>
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<td>Nurses’ stress</td>
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<td>Lack of resources</td>
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<td>Capacity issues</td>
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<td>Labels</td>
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<td>Shift report</td>
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<td>Building rapport</td>
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<td>Inadequate care</td>
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<td>Neglected care</td>
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<td>Isolation</td>
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<td>(overcapacity beds)</td>
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<td>Invisibility/visibility of illness</td>
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<td>Prioritizing physical tasks</td>
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<td>Difficulty</td>
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<td>Perceived lack of competence</td>
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<td>Workload</td>
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<td>Dichotomizing patients</td>
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<td>Fear</td>
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<td>Positive perceptions</td>
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<td>Vulnerability</td>
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<td>Unpredictability</td>
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<td>Age</td>
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<td>Building trust</td>
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<td>Caution</td>
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<td>Moral conflicts</td>
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<td>Lack of information</td>
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<td>Lack of satisfaction</td>
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<td>Perceptions of normality</td>
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<td>Avoidance</td>
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<td>Documentation</td>
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<td>Distinguishing professional role</td>
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<td>Avoidance</td>
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<td>Not knowing what to say</td>
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<td>Lack of exposure</td>
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<td>Generalizations</td>
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<td>Addictions</td>
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<td>Race</td>
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<td>Perceived severity influencing care</td>
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<td>Risk</td>
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<td>Self-awareness</td>
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<td>Lack of consistency</td>
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<td>Conflict</td>
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<td>Not feeling listened to</td>
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<td>Staff safety</td>
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<td>Feeling pressured</td>
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<td>Self-improvement</td>
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<td>Awareness</td>
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<td>Functional independence</td>
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<td>Assumptions based on appearance</td>
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<td>Compass</td>
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<td>Distancing</td>
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Step four of the IPA process is searching for connections across emergent themes (Smith et al., 2009). This involves the creation of a chart or a map of how the themes fit together, to explore and organize the newly discovered themes (Smith et al., 2009). Themes may be re-evaluated and even discarded, depending on the research question (Smith et al., 2009). At this time during analysis, connections between themes should be made (Smith et al., 2009). During this stage of analysis, I created tables to organize and connect the themes that I had identified. This was done by categorizing the emerging themes into six broad superordinate themes, in which the most frequent emergent themes could be organized. Superordinate themes were developed based on how they encompass the emergent themes and how frequently they emerged. For example, the emergent themes “unpredictability”, “labels”, “age”, “gender”, and “addiction” all related to the superordinate theme of “Perceptions of the Patient”, therefore the emergent themes were categorized into this broader theme. Emergent themes were discarded if they appeared infrequently in the data, did not relate to the research question, and could not be categorized into one of the broad superordinate themes. Details of the superordinate themes that arose from the emergent themes are detailed in the table below:

Table 2. List of superordinate themes

<table>
<thead>
<tr>
<th>Superordinate themes</th>
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<tr>
<td>· Dichotomy of mental health and physical health</td>
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<tr>
<td>· Behaviours towards the patient</td>
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<tr>
<td>· Perceptions of the patient</td>
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<tr>
<td>· Feelings of difficulty</td>
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<tr>
<td>· Feelings of helplessness</td>
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<tr>
<td>· Perceptions of potential solutions</td>
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</tbody>
</table>
Step five is moving to the next case and involves returning to the next participant’s transcript and repeating the process all over again (Smith et al., 2009). Step six in the IPA process, the final step, is looking for patterns across cases which requires the researcher to look at the themes that emerge from all cases and determine what connections can be made (Smith et al., 2009). Smith et al. (2009) state that at this point, themes may have to be relabeled or downgraded to sub themes. At this point in the research, connections were made across all the superordinate themes and further categorized into five broader themes that encompassed and related to the superordinate themes. The following table is a list of the master themes and how they relate to the superordinate themes:

Table 3. Master table of themes

<table>
<thead>
<tr>
<th>Master themes</th>
<th>Relationships to superordinate themes</th>
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<tbody>
<tr>
<td>Dichotomy of the mind and body</td>
<td>· Dichotomy of mental health and physical health</td>
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<td></td>
<td>· Perceptions of the patient</td>
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<tr>
<td>Othering</td>
<td>· Perceptions of the patient</td>
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<tr>
<td>Gendered perceptions</td>
<td>· Perceptions of the patient</td>
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<tr>
<td>Discriminatory nursing practices</td>
<td>· Behaviour towards the patient</td>
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<tr>
<td></td>
<td>· Perceptions of the Patient</td>
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<tr>
<td>Tensions between ideals and realities</td>
<td>· Feelings of difficulty</td>
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<tr>
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<td>· Feelings of helplessness</td>
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<td></td>
<td>· Perceptions of potential solutions</td>
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</table>

Using Smith et al.’s (2009) IPA approach to data analysis, I was able to systematically reduce a large amount of rich data into smaller subthemes. This made it possible to categorize subthemes into master themes, which appeared frequently in the
data. Ultimately, this process allowed for the discovery of five master themes, which include: (a) dichotomy of the mind and body, (b) discriminatory nursing practices, (c) tensions between ideals and realities, (d) othering, and (e) gendered perceptions (Table 3). The IPA process allowed for an in-depth examination of the subjective lived experience of the research participants, which gave rise to detailed descriptions of how nurses perceive discrimination towards people living with mental illness in general hospital settings. The following chapter is a more thorough discussion of the master themes found in this study.
Chapter 4 Findings

Chapter 4 consists of a results manuscript, *Registered Nurses’ Perceptions of Discrimination Towards People Living with Mental Illness: An Interpretive Feminist Phenomenological Study*, to be submitted for publication to a peer-reviewed journal upon supervisory committee approval. Only three of the five major themes were included in the manuscript due to journal word limitations. The themes included in the manuscript are: (a) dichotomy of the mind and body, (b) discriminatory nursing practices, and (c) tensions between ideals and realities. These themes were selected for inclusion in the manuscript due to their prominence in the data compared to the other major themes. The themes not included in the published manuscript are (a) othering and (b) gendered perceptions. Chapter 4 begins with the manuscript and is followed by a discussion of the remaining two themes: othering and gendered perceptions.
Registered Nurses’ Perceptions of Discrimination Towards People Living with Mental Illness:  
An Interpretive Feminist Phenomenological Study  
RUTHERFORD, Alanna, University of Calgary, RN, MN student, LIND, Candace, RN, MN, PhD, DELA CRUZ, Aniela, RN, MSc, PhD, EWASHEN, Carol, University of Calgary, RN, MN, PhD,

Author Note

Author Contributions

AR conducted the study and drafted the manuscript. CE, ADC, and CL assisted with revisions critical to the intellectual content of the manuscript.

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Abstract

Aims: To explore and interpret registered nurses’ perceptions of discrimination towards patients with mental illness. To advance understanding of the conditions that give rise to and sustain discrimination by health professionals towards people with mental illness.

Design: Interpretive feminist phenomenology guided by Merleau-Ponty’s philosophy of perception.

Methods: Ten qualitative interviews conducted in a Canadian city, from December 2017 to March 2019, with registered nurses experienced in caring for people with mental illnesses on a general medical hospital unit. Data were analyzed using Interpretive Phenomenological Analysis.

Results: Three main themes were identified: (a) dichotomy of the mind and body, (b) acknowledgement of discriminatory nursing practices, and (c) tensions between ideals and realities. Discrimination was perceived in situations where nurses struggled with balancing the demands of physical and mental health care, and where nurses perceived a lack of mental health education, professional training, and work time to adequately address mental health concerns. This resulted in nurses prioritizing physical care over mental health care, dismissing, and/or avoiding psychosocial interventions and assessments and feeling professionally incompetent compared to other specialized mental health professionals.

Conclusion: An anti-discriminatory model of healthcare that emphasizes the importance of mind body interconnection could enhance nursing practice by reducing discriminatory attitudes and practices towards people living with mental illness. Furthermore, increased professional development in the workplace with emphasis on anti-discriminatory mental
health knowledge, attitudes, and practices could foster non-discriminatory work environments.

Impact:

- **What problem did the study address?**
  Discrimination towards people with mental illness by nurses working in a non-mental health care setting (hospital medical unit).

- **What were the main findings?**
  Three main themes were identified: 1) dichotomy of the mind and body; 2) acknowledgement of discriminatory nursing practices; and 3) tensions between ideals and realities.

  Physical care was prioritized over psychosocial care with mental health care viewed as a specialty practice, not the responsibility of medical unit nurses.

  Contributors to discriminatory nursing practices included misperceptions of patients’ physical/medical conditions and levels of independence, as well as perceptions of insufficient mental health nursing knowledge and professional training, insufficient work time and resources, and a lack of support from management, the health care organization, and peers.

- **Where and on whom will the research have impact?**
  - Nurses working in general medical hospital environments.
  - Nursing educators and educational institutions in designing nursing curriculums and continuing education for nondiscriminatory work with people living with mental illness.
• Nursing researchers to investigate nurses’ discrimination further to establish preventive and interventional initiatives.

*Keywords:* nursing, discrimination, mental health, mental illness, interpretive phenomenology, feminist phenomenology, general medical unit, prejudice, differential treatment.
INTRODUCTION

Many people around the world face barriers to accessing quality health care and even where these health care services are available, some people are often denied access due to discriminatory practices in health care settings (WHO, 2021). This responsibility to resolve discrimination extends to all health-care professionals and to workplace environments (CNA, 2015). According to Kassam, Williams, & Patten (2012), discrimination is defined as the unfair treatment towards individuals or groups, by another individual or group, based on actual or perceived labels or characteristics and may include segregation and exclusion.

Nurses are not immune from enacting discrimination, nor from being individuals treating other individuals with discrimination. Research indicates that nurses engage in unfair treatment towards people with mental illness (Zolnierek, 2009). Therefore, inquiry into the phenomenon of discrimination from a nursing perspective can provide relevant information for all nurses, contribute to a deeper understanding of discrimination towards people living with mental illness, and provide insights to mitigation of discrimination towards this patient population. It is important that nurses treat all patients equitably for ethical practice, therefore this study seeks to uncover nurses’ perceptions of working with patients with mental illness in general medical hospital settings to explore discriminatory behaviors that nurses may engage in.

Background

According to the World Health Organization (WHO) (2013), mental illness, neurological disorders, and substance use disorders account for 13% of the total global
burden of disease in 2004. People with mental illness have experienced a long history of discrimination due to stigma, ignorance, and prejudice (Thornicroft, 2006). Marchand, Palis, and Oviedo-Joekes (2015) found that 10.9% of Canadians aged 15 years or older had experienced prejudice and discrimination from a health care provider and among these individuals, 62.4% reported having a mental disorder. They found that rates of prejudice and discrimination were significantly higher for respondents with anxiety, concurrent mood or anxiety and substance disorders, and co-occurring mood and anxiety disorders compared to respondents without any mental disorders (Marchand, et al., 2015). Negative attitudes, devaluation of mental illness, and misconceptions related to mental health have been identified as contributing factors to the problem (Hamilton et al., 2014; Howard & Holmshaw, 2010; Ross & Golder, 2009). Given these findings, it can be assumed that most registered nurses (RNs) will have contact with individuals with a mental illness at some point in their professional career, regardless of their work setting.

Potential consequences of healthcare professionals discriminating against people with mental illness are deterioration of preexisting mental illness, misdiagnosis and mistreatment of medical conditions, increased mortality, lowered self-esteem, dissatisfaction and avoidance of health services, diminished therapeutic patient-practitioner relationship, and higher health care costs (Hanafiah & Van Bortel, 2015; Harangozo et al., 2014; Ross & Goldner, 2009; Skosireva et al., 2014, Thornicroft, 2006). Discrimination may be unconscious or subtle, but it may be enough for patients to sense unfair treatment (McAllister, Creedy, Moyle, & Farrugia, 2002). Some of the more overt discriminatory practices towards people with mental illness have been identified by several researchers. People with mental illness are disproportionately more likely to
experience higher rates of disability and mortality due to physical health problems being neglected or mistreated, and people with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, and this is often related to physical health concerns and suicide (WHO, 2013). Further, Mather et al. (2014) found that people with mental illness in non-mental health care settings have lower rates of psychiatric referrals, lower rates of interventions and diagnostic procedures for heart disease and myocardial infarction, lower rates of referrals for costly procedures (such as hip and joint replacement, organ and bone marrow transplants, and pacemaker insertion), lower rates of hospital admissions related to diabetes, higher rates of hospital acquired infections, poorer post-operative outcomes, and increased length of hospital stay.

Healthcare professionals such as nurses without formal mental health training are expected to care for people with mental illness in generalist hospital settings (Brunero, Jeon, & Foster, 2012). Previous researchers have identified that nurses who work in medical-surgical inpatient settings feel they lack the skills and competence to provide adequate care to patients with psychiatric co-morbidities (Atkin, Holmes, & Martin, 2005). Furthermore, people living with mental illness have reported avoiding health services due to the expectation that they will be discriminated against from health care providers (Henderson, Evans-Lacko, & Thornicroft, 2013).

RNs are expected to adopt an evidence-based approach to practice by incorporating the best evidence into clinical decision making (Polit & Beck, 2017). However, much of the current health literature on nurses’ perceptions of mental illness focuses on understanding stigma, whereas there is a paucity of research evidence on the
phenomenon of discrimination as perceived by nurses. The results of this qualitative study could further inform nursing practice, as it relates to caring for people with mental illness in general medical hospital settings. Furthermore, findings from this study can potentially guide future health research into discriminatory practices of health professionals.

THE STUDY

Aim

The primary research question for this study was: What are nurses’ perceptions of discrimination towards people living with mental illness in non-mental health hospital settings and what are the conditions that give rise to discrimination? The research aims were to: (a) understand non-mental health nurses’ perceptions of working with people living with mental illness and (b) understand the conditions that contribute towards discrimination by nurses towards people living with mental illness in non-mental health care settings.

Design

This interpretive feminist phenomenological study incorporated a phenomenological focus on the lived experience of discrimination with feminist thought, which traditionally focuses on women’s experiences including bodily experiences, gendered analyses, and structural power differentials (Fisher, 2000). In keeping with feminist phenomenological thought, an analytical focus was placed on how participants perceive discrimination through their bodily experiences of working on a general medical unit while paying attention to the gendered and structural powers that influence these perceptions and the phenomenon of discrimination.
Understandings of phenomenology were guided by the Merleau-Ponty (1962) philosophy of perception. Merleau-Ponty claims that embodiment is the basis of perception and that all humans experience the world using bodily sensations (i.e., their senses). As embodied human beings, we interact with the world, sensing and forming the meanings and values of our perceived world (Merleau-Ponty, 1962). Merleau-Ponty rejects dualities, such as thoughts and feeling, self and other, subject and object, and mind and body. He argues that all knowledge, even scientific knowledge is gained from a point of view, without which the symbols of science would not make sense. Employing objective thinking when examining an object blinds us from understanding that the object is inseparable from the person perceiving it, and the same can be said about our relationships with others (Merleau-Ponty, 1962). He argues that everything that humans live and think about always have several meanings (Merleau-Ponty, 1962). Individuals are only able to see reality from one perspective, which is their own perspective, therefore the truth of reality is limited by our understanding of it (Merleau-Ponty, 1962). This is congruent with feminist phenomenology, as importance is placed on the context and history that may influence individual perceptions of the phenomenon of interest (Fisher, 2000). Merleau-Ponty’s philosophy resonates with interpretive phenomenological research, as it seeks to conceptualize a reality that is situated in complex and multifaceted experiences and perceptions, therefore Interpretive Phenomenological Analysis was used to highlight and interpret these experiences and perceptions (Benner, 1994).

**Recruitment, Participants, and Sample**
Participants were recruited using purposive sampling, from a medical unit located in an urban hospital in Canada. Inclusion criteria were at least one year of RN experience on a general medical hospital unit, English speaking, and had no previous work experience in a mental health/psychiatric care setting. Exclusion criterion was RNs who previously had experience working in a mental health/psychiatric care setting. The final sample included 10 RNs. Characteristics of the participants are included in Table 1.

Data Collection

In-depth, semi-structured interviews ranging from 20 to 80 minutes were conducted between December 2017 to March 2019 by the primary researcher, using a question guide based on the aim of the study (see Table 2). All interviews were audio recorded, transcribed by the primary researcher, and prepared for analysis.

Ethical Considerations

Ethical approval was obtained from a university research ethics board and informed consents were obtained prior to the interviews. Participation was voluntary and pseudonyms were used to maintain anonymity and confidentiality. Identifying information was excluded from transcripts, as well as all other documents related to analysis and synthesis of data.

Data Analysis

Interpretive Phenomenological Analysis (IPA) allowed for a detailed examination of the participant’s perceptions of discrimination towards patients with mental illness, with a focus on the RN’s perceptions in general medical hospital settings (Smith, Flowers, & Larkin, 2009). The steps of the IPA process are detailed in Table 3. Interpretive analysis focused on the nurses’ lived subjective experiences of discrimination.
towards people with mental illness and the perceived conditions that gave rise to nurses’
discriminatory practices.

Rigor

Smith et al., (2009) refer to Yardley’s (2000) criteria for judging qualities of
qualitative research. These criteria include sensitivity to context, commitment and rigor,
transparency and coherence, and impact and importance (Yardley, 2000). Rigor was
established by in-depth engagement with the topic through personal experience and
background literature reading, methodological competence and skill using a rigorously
systematic process throughout the data collection and analysis stage. Rigor was also
maintained by having a pre-established rapport with the participants built through
previous working relationships and the sharing of quotes and data analysis with a
supervisory committee. All interviews were transcribed verbatim and select quotes were
provided to support the analysis.

FINDINGS

Five major themes emerged: (a) dichotomy of the mind and body, (b)
acknowledgement of discriminatory nursing practices, (c) tensions between ideals and
realities, (d) othering, and (e) gendered perceptions (see Figure 1). For this paper, the first
three themes are presented.

Dichotomy of the Mind and Body

When speaking of providing nursing care, participants dichotomized mental
health and physical health into two separate categories, as if the mind and body were two
distinct entities, prioritizing care of the physical body over the mental illness. This theme
encompassed how perceptions of the mind and body as separate and distinct entities contributed to discrimination.

**Caring for the tangible/intangible.** The physical visibility of an illness impacted nurses’ perceptions of patients and their care. One participant described the difficulty of caring for patients with mental illness compared to patients with observable medical conditions and the intangibility, internality, and subtlety of mental illness:

> I guess it's probably because it's something not necessarily tangible. I guess, usually with a medical patient, you can sort of physically see on the outside what is going on with them. You can see the numbers, you can see the labs, you can see their symptoms in a way. I guess with mental health patients you don't necessarily. I feel like it's ...it's different. It's more subtle. It could be expressions. It could be just how they respond to something. So, it's definitely… it feels like it’s more internal, like internal in a way and with some people [nurses], they are not really into that. (Sara)

This quote highlights how the discomfort of working with patients with mental illness relates to the lack of visibility of the illness with no quantifiable patient data to rely on.

Another participant continued to describe how he would rather care for a medically acute patient than a patient with mental illness because physical illnesses can be treated with observable interventions, such as giving medications:

> I would rather take, um, a the most challenging medical patient who’s complex than having to work with an eating disorder patient… Because as medical nurses we always look for black and white answers and in mental health patients, there are no black and white answers. (Jack)
This suggests the participants perceived a dichotomy of mind and body, where the RN classifies nursing interventions for physical conditions as concrete and preferred, whereas this is not true for patients with mental health conditions. A clear dividing line seemed to be drawn between concrete physical observables and the intangible unknowns of the mind.

**It’s not my job.** Confusion over RN roles and responsibilities in mental health care became apparent. One participant described her RN responsibilities as:

> I ask them [patients] if they have any suicidal ideations and tell them where to go for additional resources. I think that is enough, but that is just me. Maybe someone would want to take on more. I think that either a therapist or a mental health nurse. For me, that’s not really what I signed up for. (Jessica)

The above statement highlights how, as a medical nurse, responsibility for mental health care focused on attending to the immediate psychiatric crises, then referral to a mental health specialist. A boundary in job responsibility for mental health care is established, wherein mental health care becomes the responsibility of more specialized multidisciplinary team members. Furthermore, she indicated that she did not “sign up” for mental health care. Perceived responsibilities of a medical nurse excluded a primary focus on mental health care. By establishing this boundary around responsibility, only the most urgent mental health care is prioritized, and other aspects of mental health care are deferred or referred to specialized mental health care professionals. This boundary in job responsibility became further apparent when another participant expressed a dislike of initiating conversations related to mental health and how they perceived differences between the RN role and that of a clinical psychologist:
I often find that I… I don’t like to quote-unquote dig into people’s brains… I just kind of shy away from things where I am worried that I might open Pandora’s box and don’t have the skill to kind of guide the conversation back to something productive or of clinical value. I don’t see that as my role as an RN. I say that more as someone like a clinical psychologist who can, like, productively help someone work through um, their thoughts and create improved though patterns. (Amy)

Feelings of discomfort and perceptions of lacking nursing skills to provide mental health care that is of clinical value led the nurse to avoid engaging in conversations related to mental health. The use of the term Pandora’s box¹ suggests a fear of prompting patient thoughts and behaviors that could not be contained and possibly even be destructive for the patient. It is as if there is an anxiety about not being able to handle the potential conversations that may be elicited from patient discussions about mental health.

**Discriminatory Nursing Practices**

Another theme that emerged was how discrimination towards patients was present in nursing practice. For example, discrimination was understood as both intentional and conscious, and/or as a more subtle and subconscious direct nursing practice.

**Subconscious discrimination.** Another dichotomy arose in acknowledging the different forms of discriminatory nursing practices. Upon reflection, several of the participants acknowledged that they had subconsciously enacted discrimination towards patients with mental illness, not intentionally discriminating but in retrospect, recognized nursing actions as potentially discriminatory. Most frequently, subconscious discrimination was described as differences in patient care delivered due to perceptions of
functional independence and in the use of overcapacity beds (i.e., beds placed in common areas on the unit to meet capacity demands, often reserved for those deemed more medically stable). One participant stated:

I probably have [discriminated], maybe not in like a direct sort of way. Maybe indirectly. I probably have, like, as an example, I guess, maybe something like if I had a psych patient or two in my load of five [patients], I would probably go to them last because they were usually independent. (Sara)

From the perspective of a medical nurse, functional independence was an indicator of medical stability, therefore as an effect, patients who were medically stable with mental illness were not prioritized. The participant inadvertently discriminated, perceiving the patient with mental illness to be functionally independent and therefore not requiring immediate nursing care. This care differentiation, as a discriminatory practice, was not consciously perceived by the participant until further reflection on their decisions and actions.

Several participants acknowledged the use of overcapacity beds as a form of indirect discriminatory practice. In keeping with institutional policies and procedures, able-bodied patients with mental illness when assessed as physically/medically stable, were placed in an overcapacity bed, despite recognizing that resources such as access to emergency equipment and access to bathrooms were lacking for quality care:

We get lots of homeless people, or people from drop-in centers, and because they are deemed more medically stable, I find lots of times they are put into an overcapacity room where they don’t have a bathroom, there is not oxygen set up,
there’s not, um, a suction tubing in that room… we’re not fully prepared and not fully set up to deal with a code in overcapacity. (Ian)

Several participants perceived the use of overcapacity beds as a form of indirect differential treatment, in that adequate care could not be provided in the case of an emergency but the hospital’s organizational needs to fill hospital beds to meet capacity demands took priority over the equity of care that could be provided by nurses. Another participant described how medical unit procedures were interrelated with practice judgements:

… in the medical unit where the person requires a one-person assistance to get to and from the bathroom, they [patients] would be given priority in a semiprivate room over somebody with a mental health condition, say, who is fully ambulatory, walking and talking … and it would be strictly based on the fact that the person is independent in ambulation rather than a holistic view of this to say ‘You know what? Putting this person in this dark space in the back of the unit, you know, might not be what’s best for them.’… People assume that they do look after themselves or should look after themselves. You know? There’s that kind of judgement piece that comes from this, that when in fact, that… that whole self-care piece may be in fact a symptom of their mental health. (John)

In this situation, the use of overcapacity beds on a medical unit affects the nurse’s ability to provide holistic care. Based on institutional policies and procedures, several patients assessed as functionally independent were isolated in overcapacity beds at the back of a hospital unit. Nurses experienced pressure to conform to the policies and procedures of the organization without questioning, where one RN described how, when working in a
charge nurse role, their clinical judgement and competence were questioned by upper management whenever they voiced concerns about the appropriateness of admitting a patient into an overcapacity bed.

**Conscious discrimination.** Several of the participants appeared reluctant to report accounts where they perceived themselves to discriminate against patients but readily referred to situations where they had witnessed other nurses engaging in discriminatory behaviors. One participant described the use of medication as the first choice of treatment to sedate patients, as opposed to non-pharmacological interventions. This same participant detailed the use of deception to get the patient to comply with their wishes, where they hid medication in a patient’s food to get the patient to take their medication. Another participant described how some nurses answered the call bell of a patient with a physical illness before a patient with a mental illness:

> I have seen in work settings where some patients who have a mental health disorder… she [the patient with mental illness] is calling for help or ringing the bell and there is another patient who is cognitive and there is no mental disorder with that patient, and she [the patient with physical illness] is calling. The nurse will preferably go to the patient who is mentally healthy than go to the patient who is mentally sick because she [the nurse] feels like this patient is always calling because she is demanding, she has this disorder, she is delirious, or dementia is going on, or she is depressed, or attention seeking behaviors [are] there. (Jas)

This participant witnessed patients with physical illnesses being treated more favorably by nurses than patients with mental illnesses, a form of discrimination in discounting the
person with mental illness as being, for example, demanding or attention seeking. In effect, the diagnostic label of mental disorder could result in nursing (mis)judgements, a condition of direct discriminatory nursing practice. The same participant went on to describe another form of direct discrimination in her workplace:

The nurse has this judgement in her head thinking ‘This patient has this depression thing ongoing and she will be depressed anyhow’ and she just explains ‘I’m sorry, I have no time, I will see if anyone else can come and sit with you’ and she leaves, but if there is a medical patient that starts crying or is calling for help, she [the nurse] will calmly give her [the patient] five or ten minutes and thinking there is something new that has happened and maybe ‘I should sit with her [the patient], give her some time’. (Jas)

In this participant’s experience, more nursing time is provided for the patient with a physical illness who is tearful as it is assumed that the tearfulness is legitimate, a sign that something distressing has happened and is worthy of discussion. In contrast, a tearful patient with depression is dismissed, as it is assumed that a depressed patient always cries and discussion would take too much time, more time than the nurse has available. The lack of nursing time appears to be another condition of direct discrimination, as the nurse prioritizes their time for the patient with the most worthwhile, legitimate concern. In this example, there appears to be a resignation, a prognostic pessimism, where the nurse assumes that the depressed patient “will always be depressed” and that they would be unable to adequately help.

Another participant described how physical health assessment of the mentally ill patient is often ignored on a general medical unit by stating:
…a head-to-toe assessment, which in most cases, the person [the nurse] is not
even going to do because the person [the patient] is up and walking around. I
witnessed nurses not doing these things. It’s because observationally, the person
[the patient] looks really good, so it literally becomes vitals, pills, see you later.
Where somebody else who physically might be [in]capable, uh, gets more time.
(John)

Nursing care also appeared to differ, when caring for patients who were perceived as drug
seeking by nurses:

They [nurses] might not investigate fully… for example, if there is somebody that
says… that is possibly labeled as drug seeking… and they [the patient] say that
they have pain, they [the nurse] might ignore it, not document it at all. (Ian)

This highlights how patients’ concerns can be dismissed as illegitimate with a subsequent
lack of thorough nursing investigation and documentation. There is a preconceived
notion, a prejudice toward drug seeking behavior. The socio-cultural stigma and prejudice
towards addiction leads to the labeling of patients as “drug seeking”, thus contributing to
the neglect of the patient’s experience of pain.

**Tensions Between Ideals and Realities**

All but one of participant expressed the desire to provide quality nursing care for
patients with mental illness but perceived a lack of mental health skills and workplace
time; they did not feel it was possible given the current situation. Participants felt
conflicted about the care that they were able to provide, while trying to balance
organizational demands and limited resources. Participants described not knowing what
to do to address patient’s psychosocial needs nor having the organizational support to do
Two subthemes arose: (a) lacking skills to care for patients with mental illness and (b) not having enough time.

**Lacking the skills.** One participant described a situation where she did not feel equipped to talk to patients living with mental illness “… I don’t know if I am saying it the right way, or it’s being digested the same way I am intending it to.” (Amy) This participant further described a situation where she struggled to communicate with a patient with schizophrenia. This could reflect yet another condition of discrimination, the fear of saying the wrong thing, resulting in avoiding conversations with patients. A perceived lack of mental health knowledge and communication skills, especially in conversing with a patient about their mental health condition, resulted in the nurse avoiding conversations about patient’s mental health.

Participants highlighted how their perceived lack of knowledge was a consequence of inadequate workplace training, leaving them feeling ill-equipped to address mental health concerns. For example, participants described how workplace education was mainly focused on medical nursing skills, while little attention was placed on mental health nursing skills:

After nursing school, I don’t know, it becomes much more up to the individual nurse to take an interest in [mental health], to attend courses, and to, sort of, almost self-educate at that point. (Lucy)

Nurses perceived mental health care as very difficult, as the health care organization prioritized education towards physical nursing skills as opposed to mental health nursing skills. One participant described how her undergraduate nursing education better equipped her to work with people living with mental illness, but a lack of workplace
training left her feeling less confident in her skills: “I definitely felt more equipped to deal with it [mental health care] when I was fresh out of university… I sort of had that [mental health] experience really more recently.” (Joy)

Another participant described her perceived lack of mental health skills as a barrier to effective mental health care:

I absolutely have patients sitting across from me all of the time who battle with some mental illness, or addiction, or some other chronic ailment and I am not scared of that or intimidated by that, it’s more I don’t feel like I have the skills to treat that. (Amy)

She did not feel frightened by the patient’s mental illness but considered her lack of mental health nursing skills that contributed to her preference to not work with patients with mental illness. This perceived skill deficit appears to be compounded by a lack of workplace mental health training with the education that is provided prioritizing physical nursing skills. All participants believed that more workplace training with a specific focus on mental health care would reduce some of the difficulties and they all expressed a desire for this training.

**Not enough time.** Participants described patients with mental illness as required more nursing time and that organizational resources were not available, thus resulting in avoidance practices and difficulties in care. Limited staffing, lack of specialized mental health support, and high acuity on the hospital unit left the nurses feeling like they did not have the time nor resources to adequately care for patients with mental illnesses. One participant stated:
It takes time to listen. It takes time to write down conversations and continue with care. Right? Like, I think what happens is we just do what we need to with the time that we have but it could be done better. (Monique)

Participants felt that the care provided to patients with mental illness is inadequate, but due to time constraints, it was not possible to fully address the patient’s concerns. Nurses had a belief that physical care did not take as much time as mental health care (such as, listening to the patient) and they acknowledged that the mental health care provided could have been better.

Another participant was asked if he had ever discriminated against a patient with a mental illness, to which he responded “Well, if you call not spending the time to address their mental health problems as much as we would spend on a medical patient, if that is discrimination, then yeah.” (Jack). Again, not spending enough time with patients with mental illness was identified as a form of discrimination. Time, not having adequate time, appears to be a condition of discrimination, where participants not only perceive mental health care as more time consuming, but they also feel that the work settings do not allow for the nursing time required to adequately address mental health concerns. This sustains tensions between the ideals and the realities of providing mental health nursing care on a medical unit.

DISCUSSION

The results of this study highlight RNs’ perceptions of discrimination towards patients with mental illness, the conditions of this discrimination, and some of the barriers to preventing discrimination. Study results demonstrate the complexities of discrimination towards people with mental illness, as described by medical unit nurses.
Further nurses described how professional, educational, and organizational conditions contribute to discrimination towards people living with mental illness.

Participants viewed mental health and physical health as two dichotomous aspects of patient care and noted mental health care as the less desirable of the two, despite the CNA (2015) indicating that nurses should address both the physical and psychological health of people. Participants described how physical aspects of nursing care were more visible and that they were more easily quantifiable in the form of vital signs and lab values. Due to this visibility, the participants stated that physical aspects of nursing care were easier to manage, as they could be addressed with a specific intervention or medication. De Jonge et al. (2001) found that patients who had high scores for anxiety, depression, and somatization in general hospital settings were rated higher in nursing complexity compared to those who had low scores, despite a review of medical records that could not explain the increased perceived complexity. Overall, nurses perceived patients living with mental illness as having more complex needs, but these needs could not be objectively validated by the researchers (De Jonge et al., 2001). Participants described feeling ill equipped to care for patients with mental illness and voiced a dislike for working with this patient population, favoring patients with observable medical illnesses. When nurses view the mind as separate from the body, the body often becomes the focus of care (Ross & Goldner, 2009). Feminist scholars have critiqued a biomedical view that focuses on the observable aspects of mental illness and ignores the external factors that contribute to mental illness (Goicoechea, 2013). External social, political, historical, environmental, and cultural factors that contribute to mental illness (such as gender, race, and socio-economic status) are overlooked when too much emphasis is
placed on an individualistic approach and a biomedical model of health (Feely & Long, 2007). According to the CNA (2017), it is the RN’s professional and ethical responsibility to provide equitable care regardless of these external factors, although this may be difficult in less than ideal work environments (such as those with inadequate staffing and/or lack of organizational support). Nurses compromise nursing care of patients when mental health is viewed as less important, which can lead to prejudgment, stereotypes, and discrimination (Thornicroft, 2006).

There appears to be a “medical nurse” identity where visible and tangible patient care is not only favored, but also preferred and sought after. Several participants indicated that mental health care was not part of their role, and many felt that this aspect of nursing care would be better addressed by specialized mental health care professionals. This reflects normative ideals of what nursing care is on a medical unit verses that of a psychiatric unit, perhaps reminiscent of the organizational structure that separates those with physical ailments and those with psychiatric ailments into two distinct environments (i.e., the medical unit verses the psychiatric unit). The organizational structure of the hospital reinforces this distinction between inpatient units. This could perpetuate discriminatory behaviors, as the medical RN may limit general mental health care and assessment, as they do not feel nor perhaps does the organization, that it is the primary responsibility.

Participants described forms of discrimination towards patients with mental illness in their nursing practice. Discriminatory practices were identified as conscious, where nurses were aware that they were providing differential treatment, such as using deceit to administer medication or purposely choosing not to answer call bells. This form
of conscious discrimination, based on prejudicial labels, led to less-than-optimal nursing assessment and care. This leads to questions about working conditions, availability of supports in the workplace, and ethical practice for mental health patients in the context of professional responsibilities within contemporary general medical hospital settings. Nurses also described discrimination as being subconscious, where the nurses were unaware that their behaviors were discriminatory at the time but recognized such behaviors as being discriminatory upon further reflection, for example, not spending as much time with patients, attending to patients last, or avoiding conversations about mental health. One participant described a situation where a patient with mental illness voiced concern about how the RN was treating her differently, unbeknownst to the RN. This highlights how subconscious and subtle discrimination can be noticed by patients yet unnoticed by nurses, potentially causing distress to the patient. Perhaps this unconscious discrimination is a result of implicit bias, which is an action taken based on prejudice and stereotypes without intending to do so (Brownstein, 2019). This implicit bias was demonstrated by several participants who stated that people living with mental illness require less nursing time due to the belief that they can and should be able to attend to their own personal health needs. Ross & Goldner (2009) suggests that a health care model that puts more emphasis on physical health than mental health can lead to nursing attitudes such as having “more productive” uses of one’s time and resources, and attending to the observable physical aspects of care, rather than addressing mental health concerns.

One participant detailed an account where they used deception to get a patient to take their medication, feeling it was necessary yet recognizing this did not comply with
the patient’s wishes. This participant used their position as a care provider to administer medication, against the patient’s wishes. This could be suggestive of inherent imbalances in the nurse-client therapeutic relationship, where the client is dependent on the nurse to adhere to their treatment decisions. Although this situation could be interpreted as discriminatory, the nurse’s rationale stemmed from a concern for the patient’s wellbeing. Nurses are required to provide persons in their care with open and accurate information that they need to make informed health care decisions and to respect the decisions a person makes (CNA, 2017). The CNA’s (2017) Code of Ethics states that nurses must be sensitive to the inherent power differentials between care providers and their patients and that nurses must not misuse this power to influence the decision-making of others.

The perception of functional independence, which is an individual’s ability to perform activities of daily living, emerged as a condition of discrimination (Curzel, Forgiarini Junior, & de Mello Rieder, 2013). Levels of patient care provided were conditional on the patients’ physical abilities, and patients deemed more physically able, received less nursing time and care. Normative ideals of what a “medical” patient should look like contributed to how both the organization and the nurse viewed patients with mental illness (Brunero et al., 2018). Nurses’ assumptions that able-bodied patients with mental illness are in less need of nursing care and the institutional assumptions that patients with mental illness are suitable to fill overcapacity beds (temporary hospital beds placed in common areas on the unit and not in a designated hospital room) gave rise to tensions and ethical dilemmas, where RNs were aware that the use of overcapacity spaces was not conducive to the wellbeing of patients with mental illness but felt overruled in addressing this concern. This highlights how assumptions and judgements
about patients who are functionally independent include that they can meet their self-care needs and are therefore in less need of a regular patient bed. The availability of resources in the hospital lead to tensions for the RNs, who were aware that the use of overcapacity beds is a form of indirect discrimination towards people with mental illness, but pressures to fill beds at the organizational level limited the nurses’ ability to provide holistic nursing care to patients in overcapacity spaces. This is reminiscent of a power struggle between the organization and the RNs, where organizational policies and procedures took precedent over the RNs’ desires to provide holistic nursing care, leaving the nurse feeling powerless with clinical judgements overruled (Haque & Waytz, 2012). This suggests a dehumanizing quality of institutionalized care, where the patient and the RNs’ experiences are ignored, and the need to fill hospital beds to meet capacity demands takes priority, regardless of what is best for the patient (Haque & Waytz, 2012). This is suggestive of a form of organizational discrimination due to lack of resources and capacity issues that affects the nursing care provided at the bedside. Nurses described tensions between the care that they would like to provide and the realities of the workplace. Perceptions of organizational barriers to providing adequate mental health care were described. A lack of time was universally perceived by the RNs, who indicated that the medical unit was too busy to provide thorough mental health care. There was an assumption by RNs that physical interventions took less time than mental health interventions, leading to RNs neglecting the psychosocial aspect of patient care. This perception of increased complexity with mental health care is not validated by current research (De Jonge et al., 2001).
Staffing issues, a lack of multidisciplinary support, and acuity on the medical unit were all described as contributing to not having enough time for patients. Maben, Latter, and Macleod Clark (2007) highlight how the ideals and values of nursing, that are instilled during nursing education, cannot be implemented in the work setting without adequate support, staff, and a good skills mix. This ideal-reality conflict can leave nurses dissatisfied with the care that they are able to provide, leading to burnout or high staff turnover (Maben et al., 2007). Sharrock (2006) found that the availability of time and a priority on physical care and task completion in the hospital environment affected nurses’ ability to attend to patients’ mental health needs. Nurses described a need for additional staff to adequately address all patient concerns, but this was rarely ever addressed. This may be related to financial or budgetary constraints of the organization, where they may not have the resources to adequately staff hospital units, or a lack of precedence placed on mental health care. Organizations can adopt an anti-discriminatory approach to the delivery of health care to minimize such discrimination at the organizational level. For example, the Action Framework for Building an Inclusive Health System (Public Health Agency of Canada, 2019) provides a framework for addressing stigma and discrimination at the individual, interpersonal, institutional, and population level.

Nurses also reported that they lacked necessary mental health nursing skills they related to not having adequate mental health training. The RNs described how their continuing education lacked mental health skills training and was predominately focused on hands-on medical skills. All but one of the nurses described a desire for increased mental health education and more exposure to patients living with mental illness, but the responsibility to pursue this was placed on the individual nurse. Brunero et al., (2018)
found that health care professionals working with patients with severe mental illness in
general hospital settings linked their confidence and ability to care for this patient
population to qualification and training. Participants from this study indicated that the
mental health skills that they had learned in the work environment came from peers and
coworkers, rather than training programs, highlighting a need for increased mental health
care training and education (Brunero et al., 2018).

Time constraints interplay with this condition of discrimination, as nurses
reported that there was not enough time on the medical unit to individually seek out
training or gain further experience working with this patient population. This may be
related to the previously mentioned biomedical model that dominates the health care
system. Perhaps, if a more holistic model of health were adopted, where health is not seen
as just an absence of disease, both the mind and the body are seen as interrelated and
equally important, and external factors related to mental health are accounted for, nursing
education would better equip nurses to work with patients with mental illness in all health
care settings (Harrison & Zohhadi, 2005; White, 2002). DeCola and Riggins (2010),
make several suggestions to help improve time constraints that nurses face, including the
retention of nurses through enhanced job satisfaction. Retention of qualified and skilled
nurses not only eases some of the stress of heavy workloads, it also has the potential to
decrease healthcare costs (such cost associated with hiring, training, and decreased
productivity) (DeCola & Riggins, 2010; Maben et al., 2007). Perhaps these cost savings
could be used to hire more staff nurses, which may ultimately lead to decreased work
load and improved job satisfaction. Professional associations have also been found to be
of support to nurses (DeCola & Riggins, 2010). They can continue to support and enable
nurses to address workforce issues (such as staffing and patient safety concerns) and actively engage in professional advocacy with policy makers (DeCola & Riggins, 2010).

**Limitations**

Although this study generated rich data, a limitation of this study was the lack of diversity of nurses interviewed. Further investigation with a larger sample of nurses from a variety of specialties and cultural backgrounds would have to be conducted to allow for more inclusive results.

**CONCLUSION**

The main findings of this study resulted in three main themes: (a) dichotomy of the mind and body, (b) acknowledgement of discriminatory nursing practices, and (c) tensions between ideals and realities. RNs working on a large urban hospital medical unit tended to view the mind and the body as distinct entities, which contributed to their preference to work with patients with visible illness and created a perceived boundary in the level of care that they were responsible for providing. The RNs acknowledged their own and their peers’ discriminatory nursing practices, and these were further classified as direct discrimination and indirect discrimination. Finally, the RNs described several tensions between the care that they desired to provide and the realities of the care that they were able to provide due to a lack of training and organizational demands.

Reinforcement of anti-discriminatory models of healthcare could help address discrimination in the workplace by health professionals. Greater emphasis on professional development in mental health knowledge and practice in the work setting could also help RNs feel more confident and competent when working with people living with mental illness. This includes recognition of the holistic nature of nursing in
biomedical settings, continuing education and other nursing organizational supports such as adequate staffing levels to alleviate time constraints. Furthermore, nursing research with a larger and more diverse sample could further understanding of discrimination by health professionals in the workplace and highlight potential solutions.

**Conflict of Interest Statement**

No conflict of interest has been declared by the authors.
References


Table 1

*Characteristics of participants (N=10) in this study*

<table>
<thead>
<tr>
<th>Nurses (N=10)</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>70</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Age in years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>25-29</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>30-34</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Years of experience</td>
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<td></td>
</tr>
<tr>
<td>1-3</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>4-6</td>
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<td>40</td>
</tr>
<tr>
<td>7-9</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Education level</td>
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<td>90</td>
</tr>
<tr>
<td>Graduate degree</td>
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<td>10</td>
</tr>
</tbody>
</table>
Table 2

*Interview guide*

<table>
<thead>
<tr>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are your perceptions of working with people living with mental illness in your current work setting?</td>
</tr>
<tr>
<td>What do you find most rewarding when working with patients with mental illness?</td>
</tr>
<tr>
<td>What do you find most difficult when working with patients with mental illness?</td>
</tr>
<tr>
<td>Can you describe any experiences that stood out for you when you were working with patients with mental illness?</td>
</tr>
<tr>
<td>Can you describe a situation where you have witnessed or potentially have participated in discrimination towards people living with mental illness in your current work setting?</td>
</tr>
</tbody>
</table>
### Table 3

**Steps in the IPA process (Smith et al., 2009)**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description of analysis during each step</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reading and rereading</td>
<td>• The transcribed interviews were read and reread, and the audio recordings were listened to multiple times.</td>
</tr>
<tr>
<td>2. Initial noting</td>
<td>• The semantic content was analyzed on an exploratory level. Notes were made with attention to language, the focus of conversation, and meaning making of the phenomenon.</td>
</tr>
<tr>
<td>3. Developing emergent themes</td>
<td>• Initial emergent themes were developed from the original transcripts and the provisional notes, which reflect participants’ original thoughts and the researcher’s interpretations, were listed chronologically.</td>
</tr>
<tr>
<td>4. Searching for connections across emergent themes</td>
<td>• The emergent themes were re-evaluated and discarded, depending on their relation to the research question.</td>
</tr>
<tr>
<td>5. Moving to the next case</td>
<td>• Steps 1 through 4 were repeated for the remaining transcripts.</td>
</tr>
<tr>
<td>6. Looking for patterns across cases</td>
<td>• Connections across cases were made and a master table of themes was created.</td>
</tr>
</tbody>
</table>
Figure 1. Themes and Subthemes
Epilogue: Additional Significant Findings

Two additional themes emerged from the data but due to word limitations of the journal, they were not included in the above manuscript. These themes are Othering and Gendered Perceptions (Figure 1). Several participants described ways in which they felt that patients with mental illness did not belong on the medical unit. Other participants discussed how gender impacts how they perceive patients with mental illness. The following is a detailed description of these additional themes.

Othering

Most participants used language that would suggest that patients with mental illness were different from themselves or different from patients with physical health concerns. According to Simone de Beauvoir (1989), othering occurs when a person or a group (such as people with mental illnesses) are deemed outside the norm, outside what is understood as normal and healthy. Othering became apparent in one participant’s description of discrimination:

You have all of these influxes of psychiatric patients, patients with mental illness, you are not equipped to take care of them, because you don’t have the experience, you don’t have the staff, and you don’t have the time. That is why people tend to avoid those. (Jessica)

Active avoidance of patients with mental illness was described as referring to patients with mental illness as “those” patients, implying a difference outside the norm for a medical hospital unit. The participants identified a change in their work environment, where they are increasingly expected to care for people with mental illness, but they
described situations where they perceived themselves as “not equipped” or not supported enough to provide adequate nursing care. Many of the nurses described their lack of knowledge of mental health care as a condition of discrimination, where they avoided having to work with people with mental illness. The expression “not equipped” implied a perceived lack of professional knowledge in nursing a mentally ill person, along with specific organizational barriers (time and human resources) that prevented/obstructed adequate provision of mental health nursing care. The mentally ill patient was perceived to be different, thus requiring a different set of nursing skills and institutional resources than for normal medical patients on the unit. This perception appeared to be a contributing factor to discrimination, which ultimately led to avoidance behaviours.

Othering was also present in the way another participant used language about patients. For example, a participant labelled patients in their hospital unit according to their illness type, differentiating patients with medical illness as people who are sick, from patients with psychiatric illness as people who are depressed:

It’s a medicine unit, it’s not a psych unit. You do have some patients with medical disorders going on. We need to take care of their medical illness and if someone is sick then…. If someone is sick… we’ll definitely take care of that patient than taking care of someone who is depressed. (Jas)

In keeping with the institutional structure of a large urban hospital in Canada, participants made a clear distinction between a medical unit and a psychiatric unit, and between who best fits where. The patient with depression on a medical unit was viewed as someone with less legitimate health concerns than someone with a physical or medical illness - a
patient who was perceived as legitimately “sick”. The implication is that nursing care is prioritized to patients with physical illness.

Another participant elaborated on the normative view of patients on the medical unit:

Um, I think it [care of a patient with mental illness] takes a lot more time than just the, like, a regular medical patient and I think the nurses are strapped for time and I don’t think they uh, are having enough time to actually… like truly help a patient and be there for them. (Monique)

“Regular medical patient”, in this example, seems to signify yet another boundary, between the regular and the irregular, with the perception that the irregular takes more time, time which is not available in the medical unit workplace. There is an assumption of normality, as if there is a prototype of what a “medical” patient looks like, in which a patient with mental illness does not fit. The participant acknowledges the inadequacies of “truly” helping a patient with mental illness on their unit while perceiving patients with mental illness as not only more time consuming, but different from other patients on the unit.

Other participants spoke about the prevalence of patients with mental illness in their work setting, despite perceptions that patients with mental illness were outside the norm for a medical unit. One participant stated: “I feel… even though it’s a medical unit, most of the patients that we get on the medical unit, like 80% of them, come with some kind of mental issue.” (Jas). This participant recognizes that many of the patients admitted to the medical unit have a psychiatric comorbidity yet nurses do not always
have the time to adequately address the mental health aspects of their care. The nurses sometimes viewed these patients as outside of what is considered to be an ideal patient on the unit, while recognizing that inadequacies in care were due to a lack of time available for mental health care on the unit. Participants deemed the patient with a mental illness as not normal for the unit despite the increasing prevalence of this patient population, perhaps reflecting normative ideals of what a medical patient should act and look like.

**Gendered Perceptions**

Gendered differences in patients were also found to influence how the RNs perceived and behaved toward patients with mental illness, as assumptions about the typical expression of mental illness based on the patient’s gender influenced RNs’ perceptions of the patient. One male identifying participant described situations where he did not always feel safe when taking care of female patients with mental illness for fear of allegations being made against him.

I am cautious personally, even to dealing with… with women with mental health…. sometimes trauma exists in these cases as well, previous traumas, especially if they are addicts, you know… Problems with relationships, often with uh, fathers and other male types in a… a male-female relationship that it’s just not safe for me professionally to care for them… I don’t ever want to get involved in some sort of allegation being made that is false and then having to… to have to defend myself as a professional. That’s not something I’m interested in. So, I am aware of that and I might actually be judging somebody based on… on that. Now it’s usually not outright. Like I usually have to meet them and talk to them if I am assigned to them for the day… before… and get a feel for it before I kind of go
‘Maybe this isn’t the best for me here.’…It might be safer to have a woman care for her. (John)

His justification for this stance was based on his perceptions that many female patients with mental illness have a history of trauma or relational issues with men and are more likely to make accusations against a male RN.

When asked about discrimination and gender differences between male and female patients with mental illness, one RN stated:

I’d say that, um, sometimes men [with mental illnesses] can be a little bit more aggressive, um, if it’s a younger male and then if you have an older gentleman, I wouldn’t say the most aggressive, I’d say having depression or something like that and I’d… that’s probably… that’s probably discrimination as well, and if I see a female, it might be based on… I think I link gender and age together almost…. I’ll try to understand more if it’s a female, possible because I am also female or if it’s a male, I think I have a harder time. (Joy).

The patient’s age and gender influenced the RN’s perceptions of the person with a mentally ill illness. A younger male patient is perceived as more aggressive, whereas an older male patient is perceived to be less aggressive. The participant acknowledges her perceptions as probably discriminatory and acknowledges that she tries to better understand female patients based on having a similar gender. A more in-depth discussion on the influence that gender has on nurses’ perceptions of people living with mental illness can be found in the following chapter.
Summary

In this chapter, I presented a manuscript that focused on three of the five themes that emerged from the data. This was followed by a presentation of the two themes not included in the manuscript. The five themes that emerged from this study are: (a) dichotomy of the mind and body, (b) acknowledgment of discriminatory nursing practices, (c) tensions between ideals and realities, (d) othering, and (e) gendered perceptions. The participants tended to view the mind and the body as separate, which contributed to their preference to work with patients with visible illness. By doing so, participants created a perceived boundary in the level of care that they were required to provide to patients with mental illness. The participants acknowledged their own discriminatory nursing practices but tended to describe situations where they had witnessed discriminatory nursing practices more frequently. Participants also described several tensions between the care that they wanted to provide and the realities of the care that they were able to provide, which was most often attributed to a lack of mental health training and organizational demands. Throughout the interviews, most participants used language that suggested that the mentally ill patient was othered. Participants described a distinction between how a medical patient acts and looks like verses how a mentally ill patient acts and looks like, with the latter being considered different to other patients on the unit. Finally, the participants described several gendered aspects of discrimination towards patients with mental illness, where the RNs’ interpretation of gender altered their behavior towards the patient. This was often due to preconceived notions that male and female patients behave differently, therefore influencing participants’ approaches to patient care.
Chapter 5 Discussion

In Chapter 4, I presented findings related to participants’ perceptions of discrimination towards patients with mental illness, the conditions of discrimination, and some of the barriers to prevention explicated through interpretive descriptions and feminist analysis. This feminist phenomenological analysis yielded results that demonstrate the complexities of discrimination towards people living with mental illness in non-mental health care settings as well as the interplay of conditions that give rise to discrimination. Five themes were uncovered, which are: (a) dichotomy of the mind and body, (b) discriminatory nursing practices, (c) tensions between ideals and realities, (d) othering, and (e) gendered perceptions. Within the theme of dichotomy of the mind and body, participants’ perceptions of mental health and physical health as being two distinct entities that require a separate set of nursing skills is discussed. The theme of othering highlighted perceptions of patients with mental illness as being different than the general population of a medical unit, thus being outside the norm and othered. The theme of gendered perceptions encapsulates how perceptions of mental illness and gender influence discriminatory behaviors towards the mentally ill and how gender may play a role in discrimination toward the nurse. The theme of understandings of discrimination highlights how nurses perceive and understand both indirect and direct discrimination towards people living with mental illness. Finally, the theme of tensions between ideals and realities highlights how perceived organizational barriers contribute to discrimination towards people with mental illness and the conflicts between the care that nurses desire to provide and the reality of the care that they are able to provide. The following is a detailed discussion of these themes.
Time Constraints and Discrimination

Time constraints interplay with discrimination, as nurses reported that there was not enough time on the medical unit to individually seek out training or gain further experience working with this patient population. This is consistent with other research, where nurses reported a lack of time to provide adequate nursing care (Arnold & Mitchell, 2008; Brunero, et al., 2017; Doyle et al., 2007; Harrison & Zohhadi, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). Nurses described tensions between the care that they would like to provide and the realities of the workplace. Perceptions of organizational barriers that hindered the RNs’ ability to provide adequate mental health care were described throughout the interviews with the participants. A lack of time was universally perceived by the RNs, who indicated that the medical unit was too busy to provide thorough mental health care. There was an assumption that physical interventions took less time than mental health interventions, leading to RNs neglect the mental health aspect of patient care. Staffing issues, a lack of multidisciplinary support, and high acuity on the medical unit were all described as conditions constraining time for mental health care. Perhaps situations of discrimination reflect a lack of training in effective mental health nursing skills, thus affecting nurses’ ability to efficiently engage in psychiatric interventions, and/or; a lack of resources, such as adequate staffing levels or parallel psychiatric services to assist nurses caring for people with mental illness.

Another factor related to inadequate nursing time that could potentially contribute to discrimination is an institutional culture that prioritizes the speed of assessment, admission, and discharge over the quality of care delivered. Nurses described a need for additional staff to adequately address all patient concerns, but this was rarely ever
addressed by hospital administrative staff. This may be related to financial or budgetary constraints of the organization, where resources for staffing hospital units may be scarce, or a lack of precedence placed on mental health care in a general medical hospital setting (Arnold & Mitchell, 2009). Organizations could adopt an anti-discriminatory approach to the delivery of health care to minimize such discrimination at the organizational level. This may be related to the previously mentioned biomedical model that predominates the health care system. Other researchers found that nurses identified a need for more support, both from management and from specialized mental health services and such support could help alleviate time constraints (Arnold & Mitchell, 2008; Brunero et al., 2017; Harrison & Zohhadi, 2005; 2018; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013).

**Discrimination and Dichotomy of Mind and Body**

In this research, mental health and physical health were perceived to be two distinct aspects of nursing care, with mental health nursing care deemed to be the less desirable of the two, often leading to discriminatory practices such as avoiding patients with mental illness or not spending adequate time with them. Despite the code of ethics that guide Canadian nurses and their practice of holistic care for patients (CNA, 2015) the mind-body separation/dualism persists in practice, particularly in the care of patients living with mental illness. This may be understood as a dichotomy, where the mind is private and intangible, but the body is public, therefore tangible, and quantifiable (Brunero et al., 2018). This dichotomous thinking supports the predominant biomedical view that currently dominates the health care system, where health is viewed as an absence of disease and illness is viewed as the result of biological pathology, with
minimal attention given to the psychosocial factors that may contribute to illness (Goicoechea, 2013). The biomedical model of health influenced the way that the participants view mental illness and its importance to the patient’s wellbeing. According to Thornicroft (2006), healthcare providers risk missing valuable patient assessment information when mental health is viewed as unimportant, which can lead to discrimination and inadequate delivery of care. Harrison and Zohhadi (2005) suggest nurses adopt a more holistic model of health, where all aspects of patient care are valued equally. Holistic nursing care of patients require an approach that cares for the mind-body-spirit (Ross & Goldner, 2009). Perhaps, a dichotomous view of the mind and body and health and illness in hospital settings, influences nurses’ perceptions of mental illness, despite holism being a central concept in nursing theories (Mason, 2014).

Furthermore, when the mind is viewed as separate from the body (such as that of the biomedical view of health), the body often becomes the focus of care and mental health care is often neglected (Ross & Goldner, 2009).

Participants recognized that they would benefit from additional education, perceiving an inadequate knowledge and practice expertise to adequately care for patients with mental illness, which appeared to be a contributing factor to discrimination. This feeling of incompetence lead to RNs avoiding patients with mental illness, as they felt that they did not have the skills to take care of them. From this research, it was apparent that this perceived lack of competence was a result of inadequate training and continuing education of mental health care after undergraduate education. This may highlight a need for more ongoing educational opportunities for all nurses throughout their nursing careers. All but one of the participants in this study voiced an interest in further mental
health training but stated that the opportunities for such training were not readily available to them. One participant even described how nurses had to take the initiative to seek out mental health education on their own, rather than having it provided to them by their employer. Reed and Fitzgerald (2005) interviewed nurses working in a rural general hospital setting and found that half of the nurses demonstrated a strong desire to help patients with mental health care needs but identified a lack of education and support as a barrier to this. Other researchers have found that healthcare workers who work in general hospital settings obtain most of their psychiatric nursing knowledge from personal experience, peers, and co-workers, rather than formal training programs (Brunero et al., 2018; Reed & Fitzgerald, 2005). It has been suggested that increased exposure to people living with mental illness should start during undergraduate education and continual mental health should be offered to general nurses on an ongoing basis to better equip them with the confidence and skills required for caring for people living with mental illness (Brunero et al., 2018; Zolnierek, 2009).

In some situations, a dislike for working with this patient population on a general medical unit was expressed, favoring patients with observable medical illness who were considered legitimately sick, therefore providing less care to those with mental illnesses. Although the prioritization of care is acceptable in some circumstances, many participants prioritized their time based on diagnosis rather than actual patient acuity. This was often due to the RNs’ perceptions of caring for patients with mental illness as difficult and their perceived incapability to adequately do so. This perceived incapability may be attributed to the previously noted lack of mental health training, exposure to people living with mental illness, and confidence in providing mental health care. This
finding is consistent with other studies on health care providers’ discrimination towards the mentally ill, which found that non-mental health nurses valued physical health over mental health, and prioritized care to meet the physical health needs of patients, often neglecting patients’ psychosocial needs (Arnold & Mitchell, 2008; Harrison & Zohhadi, 2005; MacNeela et al., 2012; Reed & Fitzgerald, 2005). Harrison and Zohhadi (2005) found that general hospital nurses caring for people that required mental health care perceived themselves as primarily being responsible for the physical needs of patients. The participants in this same study also felt that their time and energy providing mental health care could be spent more legitimately caring for patients with physical illnesses (Harrison & Zohhadi, 2005). Similarly, Reed and Fitzgerald (2005) found that nurses prioritized physical care (such as attending to hygiene) over psychosocial wellbeing and engaged in avoidance behaviors when psychosocial interventions were required. This avoidance was recognized as negligence in care (Reed & Fitzgerald, 2005).

Some participants in this study perceived a difference between what they believed to be the responsibility of the RN versus that of specialized mental health care professionals. This was described by several participants as the belief that mental health care is not the role of the RN working on a general medical unit and the RNs deferred aspects of mental health care to other health care professionals. Other researchers have found that RNs working in an emergency department described their primary role as attending to the physical aspects of care and then referral of the patient to psychiatric services (Doyle et al., 2007). Doyle et al., (2007) also found that the participants in this same study did not mention caring for patients’ psychological wellbeing as part of their role despite other researchers indicating that psychosocial assessments and brief
psychological interventions by nurses can help reduce suicidal ideation and suicidal behavior (Guthrie et al., 2007). Although referral to specialized psychiatric services may be necessary in many cases and interprofessional collaboration is encouraged in the care of patients with mental illness, this does not mean that general nurses are exempt from providing psychosocial care that may be beneficial to the patient (Arnold & Mitchell, 2009; Brunero et al., 2018). Arnold and Mitchell (2009) suggest that collaboration between general nurses and mental health nurses can help foster a supportive environment where nurses can learn and develop skills necessary for adequate mental health care. It is important to note that collaboration is not the same as referral, in that collaborative care is the process of communication and decision-making that enables the separate and shared knowledge or skills of two or more professionals or disciplines to synergistically influence patient care (Health Canada, 2007). This lack of collaboration could be a result of institutionalized structures that separates patients in the hospital based on their physical and mental ailments, separating the mentally ill and the physically ill onto different hospital units. Such structures reinforce the notion that mental health care is a distinct aspect of care that is better treated in a specialized environment. This may also contribute to a lack of educational and training opportunities for nurses, as mental health care may not be prioritized as a requirement for nurses working in a general medical hospital setting. Educational and training priorities were often focused on hands on medical skills, where mental health training was deemed as less important. This left the nurses feeling that they lacked the skills required to adequately address mental health concerns in a workplace environment that required them to address mental health concerns.
Othering the Patient Living with Mental Illness

Participants described the ways in which they, or their colleagues, viewed the patient living with mental illness as different, thus the “other”. Language used by some participants such as “those patients” and “regular medical patients” suggest that patients with mental illness are viewed as different or abnormal in non-mental health environments. It is as almost as if the patient with mental illness is perceived as flawed or untouchable (Thornicroft, 2006). They are perceived as different from “normal” medical patients, which led to discrimination from the nursing staff. Ross & Goldner (2009) found that nurses working in non-psychiatric environments held stereotyped attitudes towards patients with mental illness such as the belief that all people with mental illness are aggressive, dangerousness and unpredictable, thus leading to discriminatory labels. Other researchers have found that these labels most frequently resulted in limited patient contact and avoidance behaviors towards patients with mental illness (Brunero et al., 2017; Brunero at al., 2018; Harrison & Zohhadi, 2005; Reed & Fitzgerald, 2005; Van Nieuwenhuizen et al., 2013; Zolnierek & Clingerman, 2012). These labels may arise from the belief that mental illness is a sign of weak character and the fault of the patient, thus leading to discriminating behaviors (Hanafiah & Van Bortel, 2015; Ross & Goldner, 2009; Thornicroft, 2006). One nurse even describes a situation where her colleagues indicated that patients with mental illness did not belong on a medical unit, despite the patient having a comorbid medical condition. This suggests that patients with mental illness were perceived to be a minority on the unit although one participant stated that up to 80% of patients on the unit had a mental illness. The patient with observable physical illness is in the preferential group, the mentally ill patient is marginalized. This form of
discrimination could also be a result of institutionalized care that separates patients based on diagnosis, where a distinction is made between what kind of patient is appropriate for the general medical hospital unit, leading to a notion that patients with mental illness do not belong on a general medical hospital unit. Arnold and Mitchell (2008) describe how an organizational change in the United Kingdom’s National Health Service influenced how nurses cared for patients with mental illness in general hospital settings. They indicate that prior to this organizational change, it was common for nurses from mental health units to visit general medical units to offer advice, often relocating patients to a more conducive environment (Arnold & Mitchell, 2009). The same was true for medical/surgical nurses, who would often visit mental health units to assist with patient care (Arnold & Mitchell, 2009). After this organizational change, a boundary was formed between general and mental health services, where each service was provided with individual and unique budgetary constraints (Arnold & Mitchell, 2009). This resulted in a reduction in collaborative working between medical/surgical and mental health services which led to service delays and decreased capacity in treating underlying mental health disorders in general hospital settings (Arnold & Mitchell, 2009). Although these findings are based out of the United Kingdom, where nurses are educated in different specialty streams, this highlights how a reduction in nurse collaboration had an unfavourable impact on service delivery. Other researchers have also suggested that sometimes it is necessary to place patients living with mental illness on general hospital units, such as in rural care settings, where there are limited mental health resources and supports due to geographical distance to more specialized services (Reed & Fitzgerald, 2005). Although this integration of psychiatric patients and general medical patients may be unavoidable
in some circumstances, perhaps there is a need for a more integrative model of health care that emphasizes mental health as a legitimate health concern, along with physical health.

**The Influence of Gender on Discrimination**

One participant described instances where he felt that it was inappropriate for him to care for women with mental illness due to fear of allegation. The participant was not clear on what allegations he was afraid of but acknowledged that this was a prejudicial practice and stated that this was not a typical action taken. Perhaps this perception is rooted in a belief that mentally ill women are unable to accurately differentiate between therapeutic interventions verses an inappropriate encounter, leaving the nurse fearful of interacting with this patient population. It should also be recognized that this participant may also be aware that he may not be the more appropriate caregiver in certain circumstances.. Keogh & Gleeson (2006) found that male nurses experienced feelings of anxiety when working with female patients due to a fear that physical touch (such as that required for hands on interventions) may be misinterpreted as sexually inappropriate. Even though several participants attributed this anxiety to the patients’ psychiatric diagnosis, the researchers found that the patient’s age and gender were the greatest contributors to male nurses’ fears of allegation rather than the patient’s actual illness (Keogh & Gleeson, 2006). Male nurses had developed strategies to cope with these anxieties in the form of having a chaperone during procedures involving physical touch or avoiding care that may be misinterpreted as being sexually inappropriate (Keogh & Gleeson, 2006). Evans (2002) suggests that male nurses face a stereotype that men are sexually aggressive, which may make their interventions open to negative interpretations.
This highlights how gendered stereotypes of male masculinity and preconceptions about women living with mental illness impacts how RNs behave.

Young male patients were perceived, by a couple of nurses, to be more aggressive compared to older male patients or female patients. This could be reflective of stereotypical beliefs about people living with mental illness and this assumption contributes to a fear of young male patients with mental illness. Globally, men have been found to be more aggressive than women, however, women tend to use indirect aggression (i.e., inflicting reputational harm rather than physical or verbal abuse) to an equivalent or greater extent than men (Archer & Coyne, 2005). Despite these gendered differences, women and men have been found to be equally aggressive when faced with physical attack or an unjustified insult in a laboratory setting (Bettencourt & Miller, 1996). Wood and Eagly (2002) suggest that gendered differences in aggressive behaviors are caused by differences in physical attributes that interact with cultural values and customs. Age is also correlated to aggression; as individuals get older, their level of aggression decreases (Tsorbatzoudis, Travlos, & Rodafinos, 2013). Although relationships between age, gender, and aggression have been found in in several studies that would justify participants' fear of aggression from male patients with mental illness, no participants described situations where they were actually assaulted by a patient with mental illness. This fear may be a result of stereotypes based on social gender norms and not actual experience.

**Conscious and Unconscious Discrimination**

The participants described different forms of discrimination towards patients with mental illness in their own nursing practice, as well as discrimination that participants
observed in their workplace environment. Conscious discrimination (where the nurse was aware of their discriminatory behaviors) and unconscious discrimination (where the nurse was not aware that their discriminatory behaviors at the time) were identified in this study, sometimes not recognized as discrimination by the participant until further reflection on their actions (Bertand, Chugh, & Mullainathan, 2005). Participants described not spending as much time as they should have with patients, avoiding conversations about mental health, ignoring call bells, or using medication to sedate patients rather than attending to the patients’ mental health concerns. Other researchers have found that health care professionals purposefully engaged in avoidance behaviors and planned care differently (such as in the case of a myocardial infarction and anxiety) when a diagnosis of a mental disorder was known (Brunero et al., 2018; Lawn & McMahon, 2015; MacNeela et al., 2012). Ross & Goldner (2009) suggested that a health care model that puts more emphasis on physical health can lead to such nursing attitudes as having more productive uses for one’s time and resources rather than addressing mental health concerns.

The perception of functional independence was found to be a condition of discrimination throughout the data. Normative ideals of what a medical patient looks like contributed to how both the organization and the nurse treated patients with mental illness. This assumption that able-bodied patients with mental illness are in less of need of nursing care or that they can be used to address capacity issues by filling beds on any unit in the hospital gave rise to tensions and ethical dilemmas, where the RNs were aware that the use of overcapacity spaces was not conducive to the wellbeing of patients with mental illness but felt powerless in addressing this concern. Typically, these overcapacity
beds were described as temporary hospital beds placed in common areas on the unit, with limited privacy, access to a bathroom, and emergency medical equipment. Nurses experienced workplace pressure to conform to the policies and procedures of the organization without questioning, where one RN described how their clinical competence was questioned whenever they voiced concerns about the appropriateness of placing a patient in an overcapacity space, while working in a charge nurse role. Several participants expressed a desire to provide a therapeutic environment that is more conducive to mental wellbeing but they often felt unsupported in their efforts to advocate for this. This is reminiscent of a struggle between the organization policies and procedures and the RNs desired practices, where organizational needs to meet capacity demands took precedent over the RNs’ desires to provide holistic nursing care. This suggests a quality of care conflict, where the patient and the RNs’ experience are marginalized, and capacity demands take precedent (Haque & Waytz, 2012). Researchers have found that nurses perceive the general medical hospital environment as inadequate to deal with patients with mental illness, as they described how most rooms where isolated from the nursing station, limiting observation and access to assistance, but such concerns were rarely ever addressed (Reed & Fitzgerald, 2005). There was also a concern of unsecured exits and stairs that could lead to patient harm (Reed & Fitzgerald, 2005). Often patients with mental illness were perceived to be a disruption on the unit, while some nurses described noise on the medical unit as being disruptive to patients with mental illness (Arnold & Mitchell, 2009; Zolnierek & Clingerman, 2012). Perhaps this indicates a need for hospital environments that can safely accommodate patients with mental illness who are receiving care for physical ailments. Greater support from the
organization to address these environmental concerns could not only help nurses while caring for patients with mental illness, but also provide an environment that is more comfortable, safe, and therapeutic for the patient.

**Discrimination and Inadequate Education and Training**

Like the theme of dichotomy of the mind and body, nurses reported feelings of incompetence related to not having adequate training and education to provide adequate mental health care, which appeared to be a condition of discrimination. This often resulted in nurses avoiding psychosocial interventions due to perceptions of a lack of competence in mental health care. The heart of discrimination comes from a place of misinformation and a lack of education on the part of the health care provider (Ross & Goldner, 2009; Hamilton et al., 2014; Harangozo et al., 2014; Morgan, Reavley, Jorm, & Beatson, 2016; Thornicroft, 2006). In this study, the RNs describe how their continuing education lacked in experiential mental health nursing and was predominately focused on medical nursing knowledge and practice. This is consistent with findings from other researchers who found that when nurses felt unprepared to work with patients with mental illness due to a lack of confidence in their clinical skills, they tended to avoid patients with mental illness (Arnold & Mitchell, 2008; Brunero, Buus, & West, 2017; Brunero, Ramjan, & Salamonson, 2018; Zolnierek & Clingerman, 2012). Ross & Goldner (2009) found that nurses without specialized knowledge in mental health were more likely to discriminate against patients with mental illness. Other researchers describe how nurses were afraid to say or do the wrong thing and expressed a desire for more mental health training but stated that these opportunities were limited, which is also described in the results of this study (Brunero, et al. 2017; Brunero, et al., 2018; Reed &
Fitzgerald, 2005). All the RNs in this study described a desire for increased mental health education and more exposure to patients living with mental illness, but the responsibility to pursue this was placed on the individual nurse. This highlights a need for ongoing mental health training and education for nurses who work in a general medical hospital environment, not only to potentially reduce discrimination, but to meet the RNs’ desire to address this knowledge gap.

**Limitations**

One limitation of this study is the homogeneity of the nurses interviewed. All participants were relatively close in age with a mean age of 31.5(4.9) years with similar experience 4.5(2.7) years and were living in the same urban setting. Nurses of different ages, years of experience, or living in different settings may have different perceptions and experiences of working with patients with mental illness. Similarly, the sample is not inclusive of all nursing backgrounds and specialties. It is unknown whether differences in work settings, and therefore populations encountered, would have an impact on nurses’ perceptions and attitudes of patients with mental illness. Further investigation with nurses from a variety of specialties would have to be conducted to allow for more inclusive result.

**Implications for Nursing Practice and Education**

Findings from this study highlight that nurses are not immune from discrimination towards patients with mental illness, whether this discrimination is direct or indirect. This study indicates a need for ongoing critical reflection of nurses’ own attitudes and behaviours when interacting with patients living with mental illness. This may allow for nurses to be conscious of behaviors, prevent discrimination, and improve patient care.
Reflective practice is a way in which nurses reflect on an event and consider how things could have been done differently, therefore nurses can continuously assess their behaviors and attitudes when interacting with patients with mental illness (Tracy, 2014).

Many of the RNs in this study described a lack of mental health knowledge and skills. This reveals a knowledge gap in the RNs’ understanding of mental illness and identifies a need for ongoing, more intensive education in mental illness. The CNA (2017) asserts that nurses have a responsibility to engage in ongoing learning to practice safely and ethically. One potential implication for nursing practice is the need for ongoing mental health and anti-stigma education (Morgan, Reavley, Jorm, & Beatson, 2016). It has been suggested that anti-stigma education can aid in the reduction of discrimination, as discrimination is the behaviour that results from stigmatizing attitudes (CMHA, 2018). The focus of educational initiatives on stigma has been shown to improve attitudes towards people with mental illness, decreases self-stigma, and reduces avoidance behaviours of this population (National Academies of Sciences, Engineering, and Medicine, 2016). Morgan et al. (2016) suggests that anti-stigma education can help improve the knowledge and attitudes that health care providers have towards people with mental illness and can include teachings about positive behaviors health care providers can practice when interacting with this patient population, and also debunk gendered based stereotypes related to mental illness. Other researchers have highlighted the need for effective anti-stigma training in healthcare and state that skills-based training models have shown promise in improving confidence, comfort, and understanding of mental illness (Knaak, Modgill, & Patten, 2014).

As RNs commonly reported not feeling prepared to work with patients with
mental illness (Arnold & Mitchell, 2008), this could inform changes in undergraduate curriculum and continuing education. The RNs described a desire to help people living with mental illness, but just did not have the experience or skills to confidently do so. This education could take the form of longer mental health clinical rotations to allow for more exposure to people living with mental illness or perhaps mandatory mental health educational days for all registered nurses. Also, a curriculum that provides education on mental health skills may increase confidence in nursing students who would then be better prepared to work with this patient population. Carroll (2018) described an innovative undergraduate nursing curriculum change that involved a contact-based, recovery focused approach, along with reflective activities. Nursing students were given the opportunity to speak with people living with various mental illnesses to reinforce the content of each lecture, coupled with reflective activities that focused on stigma, personal biases, and changes in their perceptions (Carroll, 2018). After this program, students reported changes in their perceptions of people living with mental illness and increased empathy (Carroll, 2018).

Mental health education can also be integrated into other aspects of nursing education (such as medical-surgical clinical placements) to reinforce the importance of all aspects of nursing care and a more holistic approach to practice. The Registered Nurses’ Association of Ontario (2017) developed an assessment tool to evaluate the integration of mental health and addiction competencies in undergraduate nursing curriculums with the intent to address gaps in educational content, knowledge, or skills. Assessment tools like this could highlight areas in need of improvement when developing nursing curriculums, thus enhancing mental health knowledge in nursing students.
Increasing nurses’ awareness that this is a problem that can have a negative impact on patient care may make nurses more conscious of the problem and their own behaviors when in the clinical setting. Education that emphasizes the importance of mental health care can hopefully diminish negative attitudes towards mental health work and the duality of mind and body, thus shifting the perspective away from physical care being the only priority. The Canadian Association of Schools of Nursing (CASN) (2015) published entry to practice mental health and addiction competencies for undergraduate nursing education in Canada, which outlines that nurses must provide care in accordance with provincial and regulatory standards when promoting mental health and preventing or managing health conditions or addictions. Included in this entry to practice competency is the expectation that nurses recognize stigmatization and discriminatory attitudes regarding mental health conditions in health care professionals and themselves (CASN, 2015). Thornicroft et al. (2016) found that education, in combination with contact with individuals living with mental illness was effective in reducing stigma towards this population. Not only would this allow for a more holistic model of nursing care, but this may also improve the patient’s health and satisfaction while in hospital.

This study highlights a discrepancy between the CNA’s position statement definition of the RN role and what the participants believed the RN role to be in practice. The CNA (2015) states that RNs’ role includes a focus on wholeness, which includes consideration of the biophysical, psychological, emotional, social, cultural, and spiritual dimensions of the patient and their care. The nurses in this study indicated that attention to physical health was prioritized over mental health, which suggests a policy-practice gap. This may indicate a need for further clarification and reinforcement of all aspects of
nursing care and scope of the RN role in relation to nurses who work in a general medical hospital setting. Perhaps this could be achieved by addressing the previously mentioned need for a more integrative undergraduate nurse education or the need for ongoing continuing education on mental health care for all nurses.

Findings from this study could guide nurses, despite level of education or professional designation, who work with people living with mental illness to help reduce the problem of discrimination. An example of an approach to health care that attempts to address the problems of stigma and discrimination towards the mentally ill is the Action Framework for Building an Inclusive Health System (Public Health Agency of Canada, 2019), which provides a framework for addressing stigma and discrimination at the individual, interpersonal, institutional, and population level. With their clinical expertise, all nurses are in a position work with individuals and the larger health care system to address the problem of discrimination, though education and anti-discriminatory initiatives. Nurses can work with the patient at an individual level to help reduce discrimination towards them (Thornicroft, 2006). All nurses can provide education to patients about mental illness to give patients more insight about the causes and treatment options for their conditions (Thornicroft, 2006). This can empower patients to make their own decision regarding their care and assert their own power against discrimination (Thornicroft, 2006; Tracy & Hanson, 2014). Nurses can also work with patients to teach them about their rights and inform them that discrimination should not be tolerated. This can encourage patients to speak out when they are mistreated by health care providers, therefore giving patients a voice against discrimination (Thornicroft, 2006).
Nurses of all designations (e.g., RNs, CNSs, NPs) can contribute to change by working with the larger health care system. Nurses can offer clinical support and arrange educational activities that can address the knowledge gaps that contribute to discrimination towards patients with mental illness (Tracy & Hanson, 2014). Thornicroft (2006) suggests that anti-discrimination education should begin early in a healthcare provider’s career, to effectively establish more positive attitudes towards patients with mental illness and see long term effects throughout their practice. Hanson (2015), states that the clinical nurse specialist is adept at performing systems-level assessments, identifying needs for improving practice and outcomes, and implementing interventions that change clinician and team behaviors. These interventions could be the adoption and implementation of policies that foster a non-discriminatory approach to the care of patients with mental illness (such as mandating that all health care providers take mental health first aid training or the establishment of an anonymous system to report discrimination). Nurses can position themselves strategically with policy makers, advocate for fair treatment of patients with mental illness, and influence policy development (Tracy & Hanson, 2014). Advocacy for fair treatment towards patients with mental illness can also include media campaigns (O’Grady & Johnson, 2014). Thornicroft (2006) states that media portrays mental illness in a negative way that can illicit fear and negative attitudes and suggests that health care providers work with media to reduce this. Opening Minds is an example of a campaign that works with health care professionals to help reduce stigma and discrimination in mental illness (Mental Health Commission of Canada, 2012). This campaign has organized conferences with health care providers, journalists, students, and researchers to addresses the negative portrayal of
people with mental illness in media (Mental Health Commission of Canada, 2012).
Nurses can get involved with similar media campaigns to provide education about mental illness and encourage more favorable attitudes toward this patient population.

The institutional structures that act as barriers to holistic nursing care include time constraints and lack of clinical support. These barriers contribute to nurses’ discrimination towards people living with mental illness, thus reinforcing the importance for adequate staffing levels and supportive resources to support all nurses. As nurses commonly reported time constraints and lack of adequate staffing as a justification for limiting time with patients living with mental illness, this problem could be minimized with additional staff support. Findings from this study suggest that limited staffing, and the time constraints that result, are barriers to providing adequate mental health care on the medical unit, thus indicating a need for more frontline nurses with varied skills, experience, and education levels (CNA, 2015). Organizational policies and procedures that foster supportive and safe working environments could also help foster could also contribute to adequate staffing and time constraints (CNA, 2015). Further support could also come from interdisciplinary health professionals or nurses with specialized training to assist nurses in providing patient care, thus relieving some of the uncertainty of working with patients with mental illness. There is a need for more specialized mental health APNs. APNs exercise leadership by facilitating changes that improve nursing practice, improve the delivery of care, and influence new policy that benefits the public (CNA, 2008). APNs can work with professional and interdisciplinary organizations to minimize discrimination towards people living with mental illness (Tracy & Hanson, 2014). Nurses also reported that time constraints limited time available for additional
training and education, thus compounding the problem of lack of education. This is of concern to nurse managers and hospital administrators, as harm caused by discrimination towards patients with mental illness can contribute to increased costs (i.e., prolonged hospital stays and higher rates of morbidity), therefore providing nursing staff with adequate training and designated time to access training would help reduce these problems (Hanafiah & Van Bortel, 2015; Marchand et al., 2015). Perhaps adequate staffing to minimize time constraints and increased clinical support could also contribute to nurses’ job satisfaction and confidence (DeCola & Riggins, 2010).

Knowledge Translation

Knowledge translation is often associated with efforts to enhance systematic change in clinical practice, therefore it is important that the findings of this research reach a broader audience that could potentially use these findings to help implement changes related to discrimination towards patients with mental illness (Polit & Beck, 2017). As this is a manuscript-based thesis, both previously presented manuscripts are intended for publication in peer reviewed journals. The intent of publication is to allow the findings from this research to be available to Canadian and international readers. At a local level, findings from this study will also be disseminated to healthcare staff at a large hospital via a staff newsletter and educational presentations, which have been arranged in collaboration with a Clinical Nurse Educator.

Areas for Further Research

As this study had a small sample size, further investigation involving more nurses from a variety of different demographic and professional backgrounds could add a more inclusive and diverse contribution to the current research on health care providers’
discrimination towards people living with mental illness. From this research, it is unknown how experience, age, work settings, and geographic location impact perceptions and experiences of working with patients with mental illness. I suggest that further research examine the experience of nurses of varying ages, years of experience, work environments, and geographic locations. Not only would this allow for a more all-encompassing voice but would also allow for greater transferability of the results (Polit & Beck, 2017). I also suggest further research that include the perceptions of patients with mental illness who have experience of being treated in a general medical hospital setting to obtain an insight into the patient’s perspective and what can be done to address this problem.

Although I interviewed both female and male identifying participants for this study, further research to investigate the nonbinary or queer identifying RN’s experience could provide a valuable insight into the problem of nurses’ discrimination towards patient with mental illness, as no participants identified their gender as nonbinary or queer. Feminist research is not limited to the female experience, nor does it exclude other gender identities from being the subject of inquiry (Eun-Ok, 2010). Male and nonbinary/queer nurses, being a minority in themselves, can provide a unique perspective to the topic. This may uncover gendered differences in the way that nurses view and interact with patients with mental illness and can provide further insight into the problem.

Further research that is specific to nursing is required. In the reviewed literature, most studies included a variety of health care professionals, with minimal research found that solely studied nurses and discrimination in relation to patients with mental illness in general hospital settings. More nursing-focused research can give nurses a greater voice
in the discussion about discrimination and help shape the future of nursing. More nursing research specific to nurses' discrimination towards people living with mental illness will also add clarity to the concept of discrimination, from a nurse’s perspective. Another area for further research may be in intervention studies to help establish what kinds of interventions, at the systemic and/or individual level, could help address the problem of discrimination. Once discrimination is better understood, antidiscrimination nursing initiatives can be developed that ultimately lead to better patient outcomes.
Chapter 6 Conclusion

As nurses’ discrimination towards people living with mental illness is a problem that can lead to harmful consequences to health services users, it is important to explore nurses’ experiences to gain further insight into this issue. In this study, I interviewed registered nurses (RNs) to learn about their perceptions of working with people living with mental illness in non-mental health care hospital settings, and in doing so, I uncovered assumptions and conditions that contribute to discrimination and I learned more about discriminatory behaviors.

Nurses have the ethical responsibility to promote justice (CNA, 2017). The CNA (2008) position statement indicates that, when providing care, nurses must not discriminate against patients based on health status and this includes patients with mental illness. To do so is an ethical violation and is harmful to patients (CNA, 2017). As such nurses are ethically responsible for being aware of their discriminatory attitudes and practices when providing care for patients to provide the best possible service. Discriminatory practices violate several of the CNA (2017) code of ethics values and responsibilities, including: (a) providing safe, compassionate, competent, and ethical care; (b) promoting health and well-being; (c) promoting and respecting informed decision-making; (d) honoring dignity; and (e) promoting justice. Findings from this study indicate a need for greater mental health education and training for RNs who work in general medical hospital settings, increased supports in the form of increased staffing and parallel psychiatric services, anti-discriminatory initiatives at the front line and organizational levels, and a greater emphasis on holistic nursing practice. As RNs are in a
position to address the problem of discrimination towards people living with mental illness, they should use their position to promote just and equitable nursing care.
References


Tracy, M. F. & Hanson, C. M. (2014). Leadership. In A. B. Hamric, C. M. Hanson, M. F. Tracy, & E. T. O'Grady (Eds.), *Advanced practice nursing: An integrative approach* (5th ed.). (pp. 266-298). St. Louis, MO: Elsevier.


APPENDIX A: CONSENT FORM

STANDARD CONSENT FORM

TITLE

Discrimination Towards People Living with Mental Illness: Nurses’ Perceptions

INVESTIGATORS

Principal Investigator/Supervisor: Dr. Carol J. Ewashen
1-(403)-220-6259

MN Student: Alanna Rutherford
1-(403)-483-4488

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form for your records.

BACKGROUND

Mental illness affects many Canadians in their lifetime and it is estimated that almost 15% of acute care medical inpatients, in Canada, have a diagnosis of a mental disorder (Statistics Canada, 2011). People living with mental illness have a long history of experiencing discrimination. Discrimination is unfair treatment based on actual or perceived labels and can include segregation, exclusion, avoidance, coercion, and denial of rights (Kassam, Williams, & Patten, 2012). People living with mental illness have reported feeling discriminated against by health care providers, such as nurses (Ross & Goldner, 2009). This discrimination can lead to harmful consequences such as worsening of illnesses and increased mortality (Mather, Roche, & Duffield, 2014).

There is little research that studies discrimination towards people living with mental illness from nurses’ perspectives. In this study, approximately 10 nurses will be interviewed to learn about their perspectives of this problem and to learn about how and why nurses discriminate against people living with mental illness.
WHAT IS THE PURPOSE OF THE STUDY?

This research is being conducted as a Master of Nursing thesis project. This is a study where nurses who work in non-mental health hospital settings will be interviewed. The purpose is to learn about nurses’ perceptions of discrimination towards people living with mental illness.

WHAT WOULD I HAVE TO DO?

You will be invited to volunteer to participate in an interview that will last around 60 minutes. You will be asked some demographic questions and questions about your nursing experience, work setting, and your perceptions and experiences of working with people living with mental illness. You do not have to answer any questions you do not wish to answer, and you may terminate the interview at any time. The interviews will be audiotaped to ensure accurate recording of what you say during the interview. Interviews will take place in a private room at the University of Calgary’s Health Sciences Library and will be on your own time. You will not have to leave work to participate and no one from your work will know if you agree to participate.

WHAT ARE THE RISKS?

There are no foreseeable risks to you that you would not encounter in your everyday life because of your participation in this Master of Nursing research study. If you do experience any psychological stress, you can call the Calgary Distress Centre at 403-266-4357 for 24-hour support.

WILL I BENEFIT IF I TAKE PART?

There are no direct benefits to you as part of this study. You may be eligible to identify your participation in a research study as a learning activity for renewal of your RN registration with CARNA. Your participation in the study will potentially benefit patients living with mental illness as discriminatory practices in health care can lead to poorer patient outcomes.

DO I HAVE TO PARTICIPATE?

Participation in this study is voluntary and you may stop participating in this study at any time. Please let the researchers know in person or by phone or email. If you wish to withdraw from the study before analysis of data begins, all identifiable information including consent and interview conversations will be destroyed and not used in the study. Only interview data that is anonymized and aggregated will be used for the research study.
WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid for your participation and there will be no costs to you for participating.

WILL MY RECORDS BE KEPT PRIVATE?

Any identifying information such as your name and age will be changed to protect your privacy. Other identifying characteristics such as the name of the city or agency will also be made anonymous.

All interview and consent information collected from you will be locked in a secure filing cabinet in a locked research office. Electronic files, edited for anonymity (names and identification removed), will be stored on a password-protected computer, updated with current software and virus protection, and available only to the researchers. As well, all electronic files will be password protected. Interview recordings will be deleted once anonymized interview transcripts are completed. Backup data files will be kept on an external hard drive, password protected, and locked in a secure filing cabinet in a locked research office.

All interviews will be arranged to be held in a private space and audio recorded. A transcript will be made of your interview. This transcript will not contain any information that links the interview with you. Your name and the names of any people or organizations you mention will be replaced with fake names in the transcript. All copies of the transcripts and audio recordings will be stored in a locked research office in a locked cabinet.

Only the student, the student’s supervisor, and the student’s supervisory committee will have access to the interview recording and the transcript made of the interview. After the study is over, the interview recording will be deleted [or erased] after five years.

Quotes from your interview transcript will be used in the writing that the student does based on this project. The student will make every effort to present the data in a way that conceals your identity. If you decide to terminate the interview, the information you have provided will be not be used for thesis purposes.

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by the University of Calgary, Alberta Health Services or the researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.
SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your employment. If you have further questions concerning matters related to this research, please contact:

Dr. Carol J. Ewashen (403) 220-6259
Or
Alanna P. Rutherford (403) 483-4488

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

Participant’s Name ___________________________ Signature and Date ___________________________

Investigator/Delegate’s Name ___________________________ Signature and Date ___________________________

Witness’ Name ___________________________ Signature and Date ___________________________

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.
Appendix B: Interview Guide

Questions

- What are your perceptions of working with people living with mental illness in your current work setting?
- What do you find most rewarding when working with patients with mental illness?
- What do you find most difficult when working with patients with mental illness?
- Can you describe any experiences that stood out for you when you were working with patients with mental illness?
- Can you describe a situation where you have witnessed or potentially have participated in discrimination towards people living with mental illness in your current work setting?