# Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature

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**Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature**

The aim of this paper was to review the existing literature pertaining to stigma, negative attitudes and discrimination towards mental illness, specifically as viewed through the lens of the nursing profession. The results of the literature review were synthesized and analysed, and the major themes drawn from this were found to correspond with Schulze's model identifying three positions that healthcare workers may assume in relation to stigma of mental illness: 'stigmatizers', 'stigmatized' and 'de-stigmatizers'. In this paper, the nursing profession is examined from the perspectives of the first two major themes: the 'stigmatizers' and 'stigmatized'. Their primary sub-themes are identified and discussed: (1) Nurses as 'the stigmatizers': (a) nurses' attitudes in general medical settings towards patients with psychiatric illness and (b) psychiatric nurses; (2) Nurses as 'the stigmatized': (a) nurses who have mental illness and (b) stigma within the profession against psychiatric nurses and/or psychiatry in general. The secondary and tertiary sub-themes are also identified and reviewed.

*Keywords*: discrimination, mental illness, negative attitudes, nursing, psychiatric nursing, stigma

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## Introduction

At first, when I was waiting to hear whether my cancer was in remission, doctors and nurses in A&E were highly supportive. Later, as soon as they knew that I was known to the mental health services, their attitude changed. It was as if they could relate to someone who had cancer, but not to someone with mental health problems.

'Nadia' (Thornicroft 2007, p. 98)

Mental illness is a major contributor to the global disease burden. Its significant impact on disability, co-morbidity and mortality are experienced at the international, national and regional levels (SSCSAST 2006b, CAMIMH 2007, Lauber & Sartorius 2007).

Despite the prevalence and serious consequences of mental illnesses, low levels of treatment-seeking and follow-through often complicate and sabotage mental health/psychiatry (MH/P) care providers' efforts to remedy the problem (CAMIMH 2007, Lauber & Sartorius 2007, Thornicroft 2007).

One chief reason identified by consumers of MH/P care for not seeking or continuing with treatment is the

**Table 1**
Primary literature search results

| | Search keywords/topics | Sources found | Outside paper scope/not relevant | Reviewed | Not available | Repeats of papers in previous searches |
|---|---|---|---|---|---|---|
| #1 | (Mental illness OR psychiatry) and attitudes and nurses) and DE Nurse Attitudes' and MM 'Attitude to Mental Illness' | 32 | 15 | 13 | 4 | 0 |
| #2 | Mental illness OR psychiatry AND negative attitudes AND nurses | 29 | 20 | 4 | 0 | 5 |
| #3 | (Attitude to mental illness and nurs*) and DE 'Attitude to Mental Illness' and MM 'Nurse Attitudes' | 37 | 9 | 6 | 0 | 22 |
| #4 | Discrimination and mental illness and nurs* | 23 | 18 | 5 | 0 | 0 |

DE, search term denoting 'Descriptor'; MM, search term denoting 'Exact Major Subject Heading'; nurs*, search term denoting truncation of root word.

stigma that they encounter. Healthcare personnel, including nurses, are considered by consumers to be primary contributors to stigma and discrimination against those with mental illness (Sartorius 2007). In Canada, initiatives are underway at the provincial (BCMOHACOMH 2002) and national levels (SSCSAST 2006b) to address this stigma among healthcare providers.

Schulze (2007) identifies three positions that healthcare workers have been seen to assume in this challenge: (1) as 'stigmatizers' of those with mental illness; (2) as 'stigmatized' by their own association with mental illness; and (3) as advocates, or 'de-stigmatizers'.

The purpose of this paper is to undertake a systematic, targeted search and review of the existing body of literature pertaining to stigma, negative attitudes and discrimination towards mental illness, specifically as viewed through the lens of the nursing profession. From this, a synthesis and analysis of the major themes and findings is drawn.

The scope of this paper is limited to an exploration of the literature on MH/P stigma within the nursing profession from the perspectives of Schulze's (2007) roles of nurses as 'stigmatizers' and the 'stigmatized'. Although we have not addressed the topic of how nurses might act in the role of 'de-stigmatizers' in the current review, we consider it to be an important issue and intend to make it the focus of a subsequent paper.

## Methodology

A primary literature search was undertaken to obtain relevant literature. Databases searched were: CINAHL with Full Text, Academic Search Premier, Alt Health Watch, Biomedical Reference Collection: Comprehensive, Child Development & Adolescent Studies, EJS E-Journals, ERIC, Health Source: Nursing/Academic Edition, MAS Ultra – School Edition, MEDLINE, Primary Search, PsychARTICLES and SocINDEX.

Searches of these databases were performed using the search keywords/topics specified in Table 1.

Sources that were not themselves identified in the primary search, but were referenced within the primary search papers, were also retrieved and researched as secondary sources. Additionally, seminal works on the topic were included in this review.

Papers that did not have a primary focus on the specific topic of the paper, were outside the scope of the paper or did not meet criteria for methodological/academic rigor, were excluded.

Once the search was completed, results were analysed and synthesized, and emerging themes identified and discussed.

## Results

The results of the primary literature searches are shown in Table 1.

From this analysis and synthesis of all the reviewed literature (primary and secondary sources and selected seminal works), three themes emerged that corresponded with Schulze's (2007) identified roles. Within the first two themes, further sub-themes became apparent, and these are summarized in Table 2. The first two themes and their sub-themes are discussed within this paper. The third theme, literature related to nurses as 'de-stigmatizers' of mental illness, is intended to be the subject of a subsequent paper.

## Discussion

The themes and sub-themes identified in Table 2 are discussed as follows:

### Theme I: Nurses as 'the stigmatizers'

*A. Nurses' attitudes in general medical settings towards patients with psychiatric illness*
Stereotype-based negative attitudes and prejudices towards mental illness develop early in life, originating from cul-

**Table 2**
Identified emergent themes and sub-themes

| Theme I: Nurses as 'the stigmatizers' | | |
| --- | --- | --- |
| Primary sub-theme A: Nurses' attitudes in general medical settings towards patients with psychiatric illness | | |
| Secondary sub-themes | Tertiary sub-themes | |
| 1. Negative attitudes | i. Fear | ii. Blame/hostility |
| 2. Fragmentation of client care and devaluation of MH/P | | |
| 3. Lack of skills and educational base to meet the needs of MH/P clients | | |
| 4. Lack of resources/infrastructure to support the provision of safe, competent MH/P care | | |
| Primary sub-theme B: Psychiatric nurses' attitudes | | |
| Secondary sub-themes | | |
| 1. Negative attitudes and discriminatory treatment of patients with BPD | | |
| 2. Pessimistic attitudes towards client prognoses and outcomes | | |
| **Theme II: Nurses as 'the stigmatized'** | | |
| Primary sub-theme C: Nurses who have mental illness | | |
| Primary sub-theme D: Stigma within the profession against psychiatric nurses and/or psychiatry in general | | |

BPD, borderline personality disorder; MH/P, mental health/psychiatry.

tural, historical and media depictions (Sartorius & Schulze 2005). But, it is believed that 'greater familiarity with people who have been or are mentally ill leads to more positive attitudes towards them' (Allport 1954, cited in Rogers & Kashima 1998, p. 196). If this were so, it would follow that groups such as nurses would likely to develop beyond these early stereotypical attitudes, given their extensive working contact with people with mental illness. Yet, it appears that the relationship between early socially learned stereotypes and practicing nurses' subsequent beliefs about mental illness is far more complex than Allport's theory describes.

A large volume of material exists within the body of nursing literature, originating from a variety of countries (Australia, England, South Africa, Sweden, USA and Wales) regarding nurses' attitudes towards clients with mental illnesses in general medical settings. All of the sources' observations and conclusions are consistent that there is vast room for improvement in the provision of empathetic and competent nursing care for this population.

Surveys consistently found that patients presenting with mental illnesses and their families felt they had been treated with a lack of dignity and caring, if not outright contempt by staff in general medical settings (Bailey 1994, 1998, Anderson 1997, Scott 2001, BCMOHACOMH 2002, Summers & Happell 2003, SSCSAST 2006b, Anderson & Standen 2007, Patterson *et al.* 2007, Thornicroft 2007).

Stigma also seems to be a barrier to obtaining caring treatment even when the clients' primary reasons for admission are not related to their pre-existing psychiatric disorders. Those with a major mental illness have significantly higher rates of mortality and morbidity from concurrent medical illnesses than the general population (Hardcastle & Hardcastle 2003, Kongable & Tarko 2006), with some estimates as high as 80% (BCMOHACOMH 2002). Yet, their legitimate health complaints are often

assigned little credibility, with assumptions frequently made by healthcare staff that 'any complaint of distress from this group must be a symptom of his or her mental condition' (BCMOHACOMH 2002, p. 6).

1. Negative attitudes
Despite nurses espousing beliefs that MH/P care was an integral component of holistic patient care, negative attitudes were nevertheless found to exist towards these clients and to psychiatry in general (Bailey 1994, 1998, Brinn 2000, Hardcastle & Hardcastle 2003, SSCSAST 2006b, Haddad *et al.* 2007, Thornicroft 2007, Björkman *et al.* 2008). In particular, the primary negative attitudes identified were fear and blame/hostility.

i. Fear A large number of nurses appear to share with the general population some commonly held stereotypical beliefs of mental illness that have been based on media-generated and historical misrepresentations. Those with mental illness are often seen to be dangerous, unpredictable, violent and bizarre, and these conceptualizations understandably give rise to fearful attitudes. Nurses in the studies were often found to endorse beliefs that one might inadvertently say or do 'the wrong thing' and 'set them off' into some explosion of uncontrollable behaviour (Bailey 1994, BCMOHACOMH 2002, Hardcastle & Hardcastle 2003, Sartorius & Schulze 2005, SSCSAST 2006b, CAMIMH 2007, Thornicroft 2007).

In many of the reviewed studies, nurses self-identified that they lacked the skills to confidently and competently manage MH/P clients' behavioural symptoms, and they linked this knowledge gap to their fear of the patients (Bailey 1994, Mavundla 2000, Hardcastle & Hardcastle 2003, Reed & Fitzgerald 2005, Lethoba *et al.* 2006, CAMIMH 2007). As such, conclusions and recommendations in the literature were unanimous – that considerable

additional education regarding mental illness and mental health care was required both for entry-level nurses and for practicing nurses to upgrade their MH/P knowledge bases.

ii. Blame/hostility  Many general nurses hold beliefs that mental illness is caused by factors such as weakness of morals, character or will; laziness; malingering; and the lack of discipline or self-control. Coupled with these misunderstandings is the difficulty in distinguishing psychiatric behavioural symptoms from ill-mannered or uncouth behaviour (Smith & Hukill 1996, Thornicroft 2007, Halter 2008).

Thornicroft (2007, p. 4) refers to an 'attribution theory', whereby the meaning constructed for the condition, and consequently the judgements made of the person with it, are determined by the presumed cause attributed to the affliction. If the MH/P conditions are presumed to be due to experiences or factors beyond one's control, such as heredity or biology, then more compassion tends to be extended to the sufferer, as this is considered to be 'not their fault', thereby meriting more understanding. Conversely, negative attitudes and stigma resulted from beliefs that mental illness is caused by character weakness or behavioural choices believed to be under the person's volition (Thornicroft 2007).

Such negative attribution appears to be particularly evident in nurses' in general medical settings attitudes towards patients who engage in acts of self-harm. Several studies showed that general nurses feel hostility arising from the perception that precious healthcare resources intended to preserve life were being 'squandered' on those who 'wish to die'(Bailey 1994, 1998, Patterson *et al.* 2007). These negative attitudes were found to stem from general nurses' misunderstanding of the psychopathology of psychiatric symptoms that result in self-harm, and their subsequent attribution of negative character traits or motives to them. As Scott (2001) explains, these 'patients . . . are not stubborn and controlling. They may be dying' (p. 5).

Nursing staff in emergency departments (when patients were suicidal or in psychiatric crises), and intensive care units (for care post-suicide attempt) in particular, were found to hold blaming/hostile attitudes, and were often reported to have treated this client population in a demeaning manner for these reasons (Bailey 1994, 1998, Scott 2001, BCMOHACOMH 2002, SSCSAST 2006b, Anderson & Standen 2007, Patterson *et al.* 2007, Thornicroft 2007).

An implicit assumption is often made that the person who has enacted self-harming behaviours did so from a specific *volition to die*. There seems to be little appreciation for the level of pain a person might be under to take such desperate action, the meaning of self-harm symptoms, the

absence of control a seriously psychiatrically ill person might have over such impulses, and the context of these actions as symptoms within an illness.

Serious specific gaps in general nurses' clinical knowledge about suicide were also identified. In one study (Anderson & Standen 2007, p. 473), only 10% of the nurses agreed with the statement 'people who commit suicide are usually mentally ill', and in another (Anderson 1997) a majority of nurses also disagreed with that statement. Furthermore, a significant proportion of respondents in Anderson & Standen's (2007) study saw some degree of normalcy in young people committing suicide, attributing it to likely being 'lonely and depressed' (p. 473).

In all nurse–client situations, the therapeutic relationship is paramount. This is especially so in psychiatric care, where the therapeutic relationship is considered to be the foundation of client care and healing (Beckett *et al.* 2007). Although it would not be reasonable to expect general medical nurses to have the preparation to undertake advanced psychiatric interventions, *all nurses are* nevertheless expected to engage in compassionate, supportive relationships with their patients (Bailey 1994, Forchuk 2006).

Bailey (1994, p. 12) described general nurses' attitudinal posture towards self-harming clients as 'sitting in judgement, probing motives, assessing worthiness, and allocating sympathy from an "Olympian" seat of judgement'. It seems self-evident that holding such attitudes would preclude nurses from establishing any type of therapeutic relationships with these clients.

Although attribution of control of the symptoms/illness directly to the clients' will and/or character was predominantly supported in the literature as a chief contributor to stigma and negative attitudes, it is important to note here that there was also some support found for the converse conceptualization to be true – that beliefs about mental illness resulting from biological or genetically determined factors could lead to a different kind of stigma (CAMIMH 2007, Munro & Baker 2007, Thornicroft 2007). Some sources took the position that attributing mental illness solely to biological or inherited determinants 'appears to increase stigma and social distance, perhaps because the illness is perceived as fixed and chronic' (CAMIMH 2007, p.12).

2. Fragmentation of client care and devaluation of mental health/psychiatry
Recurrent themes were noted in the literature which demonstrated that general medical nurses' attitudes reflected a conceptual fragmentation of clients and their care into 'physical' and 'psychiatric', with a clear devaluing of the MH/P component, and a belief that this aspect of care was 'not their job'.

Today's nursing profession champions caring values, holistic care, health promotion and advocacy, while decrying task-orientation and overemphasis on the medical model (Bailey 1998, Mavundla 2000, Scott 2001). However, the evident prizing of technologically complex task-focused care situations as more 'interesting', 'challenging' or 'worthy', while assigning a lesser value to the caring relationship, could be seen as 'a violation of the heart and spirit of nursing practice' (Scott 2001, p. 2).

Explicit statements were made by nurses and clients in several studies, revealing that general medical nurses did not treat MH/P client needs as a priority, giving clear messages that they had 'better' or 'more constructive' things to do with the scarce healthcare resources of time and money, such as looking after someone who is 'really sick', 'more deserving', who has not 'brought it on themselves', and that the MH/P client is merely 'blocking a bed' (Bailey 1994, Mavundla 2000, Happell 2005, Lethoba *et al.* 2006, SSCSAST 2006b, Thornicroft 2007, Picard 2008).

Established ward policies, routine tasks and hygiene schedules are seen to take much higher precedence than attending to clients' mental health needs (Mavundla 2000, Reed & Fitzgerald 2005, Lethoba *et al.* 2006). The general findings of the studies reviewed can be summarized by Reed & Fitzgerald's (2005, p. 254) observations that 'mental health care may often be left till last, only carried out if there is still time, and only by those who feel able'. This prioritization can be seen implicitly in nurses' behavioural choices, but in some areas it is also made explicit in policies. Summers & Happell (2003) found that emergency triage departments' formal, written guidelines often reflected low prioritization for psychiatric emergencies.

In addition to minimizing the needs of MH/P clients, this view of a mind/body treatment division neither augurs well for clients who initially present with medical illnesses. Nurses who hold such attitudes fail to grasp that this artificial division is perilous to overall client care, as those with major medical illnesses have commensurately higher rates of co-morbid mental illness (Kongable & Tarko 2006). General medical nurses who are unaware that their clients with cardiac events are at high risk for prognosis-worsening mood disorders, that sepsis may be heralded by confusion in the elderly, or that their clients with HIV or Parkinson's disease have the possibility of related Dementias, cannot be providing competent, holistic care. Such inability to meet clients' MH/P needs was linked with consequences of worsening initial medical and psychiatric symptoms, development of complications and prolonged length of hospital stays (Hardcastle & Hardcastle 2003, Happell & Platania-Phung 2005, Kongable & Tarko 2006).

### 3. Lack of skills and educational base to meet the needs of MH/P clients

As discussed previously, general nurses' lack of knowledge of MH/P was itself directly predictive of the identified negative attitudes and stigma towards mental illness.

However, the review of the literature overwhelmingly asserted that even those general medical nurses who did not hold negative attitudes, and who were sensitive to the needs of this patient population had strong reservations about their abilities to effectively provide them with appropriate care, because of insufficient basic education and/or current clinical support. There were unanimous findings that general medical nurses lacked MH/P competencies. Recommendations were consistently made in the literature to close this gap by improving basic nursing education so that it includes psychiatric competencies at entry to practice, and to provide supplementary clinical education for working nurses (Blair & Ramones 1996, Bailey 1998, Crossland & Kai 1998, Mavundla 2000, Hardcastle & Hardcastle 2003, Haddad *et al.* 2005, 2007, Lauber *et al.* 2005, Lethoba *et al.* 2006, Anderson & Standen 2007, Thornicroft 2007).

There were also consistent recommendations in the literature for nurses with advanced education and clinical expertise in psychiatry to be available to act as resource for general nursing staff. Suggestions were made that this resource could take the form of having MH/P nurses available, either in formalized assigned staff positions within the department, as 'on-call' consultants, or informally by promoting more collegial and actively collaborative relationships between the psychiatric and medical units within the agency (Bailey 1998, Brinn 2000, Mavundla 2000, Haddad *et al.* 2005, Reed & Fitzgerald 2005, Lethoba *et al.* 2006).

### 4. Lack of resources/infrastructure to support the provision of safe, competent MH/P care

Another theme noted in the literature was an attitude of fear, not based on stereotypes, but upon what could be considered realistic apprehensions because of the lack of appropriate resources and infrastructure to provide for workplace safety. Institutional-based resources and supports, such as trained security ('Code White') teams who assist with management of aggressive behaviour, are not consistently available (or available at all) in many care settings. Nurses often felt 'on their own' when presented with a client whose condition posed a safety threat to themselves, other patients, or the staff (Bailey 1998, Mavundla 2000, Haddad *et al.* 2005, 2007, Reed & Fitzgerald 2005, Lethoba *et al.* 2006).

## B. Psychiatric nurses' attitudes

Although the literature showed that nurses who worked in psychiatric settings held more positive attitudes overall towards mental illness than did the general public and general medical nurses (Herron *et al.* 2001, Munro & Baker 2007), the data nonetheless revealed some other notable negative attitudinal characteristics within this group.

### 1. Negative attitudes and discriminatory treatment of patients with borderline personality disorder

A number of studies found that those diagnosed with borderline personality disorder (BPD) were perceived negatively by mental health nurses. Some common attitudes identified were that these clients were seen as difficult, annoying, manipulative, seeking of attention, and were labelled with such offensive terms as 'nuisances', and 'time-wasters' (much like MH/P patients were found to be perceived by general nurses). The conclusions drawn in these studies were that psychiatric nurses perceived those with BPD as 'bad', and other patients as 'ill' (Gallop *et al.* 1989, Fraser & Gallop 1993, Deans & Meocevic 2006, Thornicroft 2007). It is believed by many theorists that the diagnosis of BPD itself has become a pejorative 'label' ascribed to those patients (generally female) who the clinician does not particularly like, and that the use of the term itself needs to be seriously questioned (Fraser & Gallop 1993, Warne & McAndrew 2007). These attitudes can even be taken to the point of explicit segregation, where diagnoses of BPD have become exclusion criteria for some agencies' or programmes' provision of care services (Thornicroft 2007). Studies also found that mental health nurses' communications with these patients could often be considered disparaging and unempathetic (Gallop *et al.* 1989, Fraser & Gallop 1993), and that the nurses showed more 'disconfirm(ing) . . . indifferent and impervious responses' with them than with other patient groups (Fraser & Gallop 1993, p. 340).

However, arguments could be made that some of these studies' findings might not be attributable to stigma or discrimination; they may be more reflective of the substantial and ongoing disputes that exist between the multiple and disparate theoretical models within the psychiatric profession. There is considerable debate within psychiatry regarding accurate diagnoses, causative factors, appropriate treatment modalities, optimal service provision and realistic expected outcomes for mental illnesses in general, and for BPD in particular (Deans & Meocevic 2006, Schulze 2007). What might be part of one model's treatment plan could possibly be seen as negative behaviour if one is viewing the interaction through a different therapeutic lens. Nurses' behaviours interpreted as being 'impervious' or 'lacking in emotion'

could conceivably have been examples of the strategic use of distraction, limit-setting and/or containment methods to defuse behavioural escalation, and to assist the patients' regaining control of intense, emotionally dysregulated states (which are symptoms of the psychopathology of BPD).

The main corrective action recommended in the literature to address this sub-theme was to provide psychiatric nurses with more education about BPD. Yet, there appears to be no clear consensus, and much division in the literature and in clinical practice about what constitutes best practices for BPD. Deans' & Meocevic's (2006, p. 48) statement is illustrative of this dilemma (and noted with some irony), that care of clients with BPD should be 'based upon agreed clinical frameworks that guide psychiatric nursing practice *for this difficult group of clients*' (italics mine).

### 2. Pessimistic attitudes towards client prognoses and outcomes

Many of the studies found that MH/P nurses generally held more pessimistic attitudes towards client prognoses and positive outcomes than did the general public (Caldwell & Jorm 2001, Hugo 2001, CAMIMH 2007, Munro & Baker 2007, Schulze 2007, Thornicroft 2007).

The studies generally took the position that the likely contributory factor towards their pessimism was that mental health nurses derive their attitudes from their professional experiences (Caldwell & Jorm 2001, Hugo 2001, CAMIMH 2007, Munro & Baker 2007, Thornicroft 2007). As their experiences predominantly consist of contact with those MH/P clients who are acutely ill, in a period of relapse, or the most poorly functioning and chronically ill members of that population, this narrowed scope of experience was believed to result in a skewing of their perspectives.

Other studies found that MH/P nurses as a group had notable reservations about the overall benefits and safety of the traditional medical model of psychiatric treatment, and held more positive attitudes than other healthcare professionals towards alternative and non-traditional approaches (Caldwell & Jorm 2000, Lauber *et al.* 2005). These reservations might provide an alternate explanation for psychiatric nurses' more negative attitudes regarding client outcomes – they may reflect valid inquiry and challenging of the benefit, effectiveness and safety of existing treatment approaches, rather than pessimistic beliefs of MH/P clients' intrinsic abilities to become well.

The considerable disagreement and lack of clarity existing within the profession as to causes, courses and outcomes of mental illnesses can lead to inconsistent and

discouraging information and a sense of hopelessness being conveyed to clients and families. It was noted that psychiatric nurses need to be aware of this possibility, and exercise caution in their communication with patients and families, ensuring that consistent information and feelings of hope and encouragement are imparted (Caldwell & Jorm 2001, CAMIMH 2007, Munro & Baker 2007, Thornicroft 2007).

## Theme II: Nurses as 'the stigmatized'
### C. Nurses who have mental illness

It would be reasonable to assume that the prevalence of mental illnesses among nurses parallels that of the general population. It could even be speculated that the realities of nurses' challenging workplaces, including understaffing and working in intense interpersonal circumstances, might well increase their incidence of stress-related conditions. However, there was a startling paucity of literature found on this subject. It has been included as a sub-theme here, as the few existing references strongly indicated that this issue was most salient to this paper's topic.

In their 1996 study, Smith and Hukill noted that, although a significant body of literature existed regarding nurses impaired by substance use, to the date of that study there was *no* literature available studying nurses who were impaired by emotional or psychological factors (Smith & Hukill 1996). And, more remarkably, the author of this paper has found scarce mention of the issue in the literature, even to this date.

This almost complete lack of acknowledgement or investigation of the issue may in itself lend support to the contentions in the existing literature – that nurses are most judgemental and stigmatizing of their own when it comes to mental illness, and 'turn a blind eye'.

Nurses' negative judgements towards nurses with mental illness appear to be not only directed towards their colleagues, but self-directed as well. Smith & Hukill's (1996, p. 198) data revealed that 21% of the nurses affected by mental illness in the study themselves attributed their own psychiatric illness to 'a personality weakness or character defect'.

One prominent sentiment was identified in the few literature sources, that nurses who suffered from mental illness often felt that they were targets for 'horizontal violence', or, demeaning, contemptuous and shunning reactions from supervisors and colleagues (Farrell 2001). This ranged from feeling 'drummed out', or, in some cases, to actual expulsion from their workplaces. In stark contrast to the reported strong support received by colleagues during occasions of physical illnesses, nurses voiced feelings of needing to keep their mental illness a secret, rather than

risk being ostracized by their peers (Anonymous 1993, Kotin 1993, Smith & Hukill 1996, SSCSAST 2006a, Joyce *et al*. 2007, Thornicroft 2007).

The 'don't ask – don't tell' attitude towards nurses with mental illness was found in some cases to be based on realistic fears of systematic discrimination and persecution. Several papers from the UK (Carlowe 1997, Brewer & Cox 1998, Hardcastle & Hardcastle 2003) cited overzealous and indiscriminate application of an inquest's recommendations following a sensational case of a nurse involved in patient homicides. The authors stated that the questionable reactions to this inquiry reinforced stigma and entrenched explicit and outright discriminatory hiring guidelines against nurses with a history of mental illness, creating very real barriers to their employment.

### D. Stigma within the profession against psychiatric nurses and/or psychiatry in general

There is considerable evidence that the subspecialty of psychiatry is devalued within the profession of nursing. As noted previously, part of this trend may be due to the devaluation of relational practice, and the prizing of technological skills. It was also thought to be perpetuated by the segregation of MH/P client populations from general medical settings, thereby segregating the staff as well (Lauber & Sartorius 2007).

Furthermore, it was postulated that this lower status and prestige within the profession has been conferred in a type of 'stigma by association' or 'courtesy stigma' (Hinshaw 2007, Thornicroft 2007, Halter 2008), whereby those who are associated with the mentally ill are also judged by the same stigmatizing stereotypes.

Such 'stigma by association' also appears to exist in the form of attributing negative characteristics to MH/P nurses. In comparison to nurses in a number of other specialty areas, MH/P nurses were seen as the least liable 'to be described as skilled, logical, dynamic and respected' (Halter 2008, p. 20).

Given these depictions, it should not be surprising that MH/P nursing was found to be among the least favoured of the specialty areas, with relatively few nurses interested in making a career in this area of practice (Rushworth & Happell 1998, Ghebrehiwet & Barrett 2007, Hinshaw 2007, Horton 2007).

## Conclusions

In this paper, a review of the literature on stigma was undertaken, exploring negative attitudes and discrimination towards mental illness, as it pertained to the nursing profession. The results of this paper have supported the contention that nurses do play the regrettable roles of the perpetuators and the recipients of stigma towards mental illness.

In particular, it was found that nurses in general medical settings often held negative attitudes of fear, blame and hostility towards patients with psychiatric illness, having a detrimental impact on their client care.

An attitudinal division between mental and physical health issues was identified and found to lead to fragmentation of client care and nurses' devaluation of their clients' MH/P needs.

Mental health/psychiatry knowledge and skill deficits were found to arise from gaps in nurses' basic entry to practice preparation and lack of ongoing clinical educational opportunities.

A paucity of institutional resources and supports to address client MH/P needs and staff safety factors were also identified as contributing factors to negative attitudes.

Nurses who choose to work in psychiatry were themselves found to have negative attitudes and discriminatory behaviour towards segments of the MH/P population (specifically BPD), and to be more pessimistic about positive outcomes of psychiatric illnesses than were general nurses and the lay public.

Stigma was also found to be turned inwards, and directed towards others within the nursing profession. This took the form of ostracizing and even shunning of nurses who have mental illness. As well, associative stigma was seen in the devaluing of psychiatric/mental health nurses' status within the profession.

As a detailed review of literature that examines how nurses might better adopt the position of 'de-stigmatizers' of mental illness was outside the scope of this review, such recommendations have not been made here and are intended to be addressed in a subsequent paper.

It is clear from the findings in this paper that honest reflection and assertive action must be taken by the nursing profession to minimize stigma and discrimination of people with mental illness, including stigma directed towards patients seeking care and stigma towards nurses who experience mental health problems. In addition, action will be needed to ensure that nurses who provide MH/P care do not experience negative stereotyping, stigma and discrimination from within the nursing profession. These issues will need to receive attention by leaders in nursing, including administrators and educators, and the latter group will need to include candid discussion of the issue in curricula, both during initial nursing training and in continuing education. In addition, individual nurses will need to be prepared to reflect thoughtfully on this topic, despite it being an uncomfortable and disconcerting one. Although it may be upsetting to discover that stigma and discrimination towards mental illness is a significant problem within nursing, it is understandable that nurses

are prone to the same deep-seated psychological vulnerabilities that lead all human beings to be prone to such defensive behaviour. The nursing profession has been successful in rising to meet many other challenges throughout its long history and, as a consequence, has made immeasurable contributions to ease the suffering of humanity and provide care and compassion. It is now time for nurses to rise to the challenge of eliminating stigma and discrimination in its care of people with mental illness.

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