

Provider Lived Experience and Stigma

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Despite professional values about advocacy for people managing mental health challenges, research on mental health providers indicates that this group expresses as much or more stigma than laypeople. This article reports on a continuing education needs assessment of 101 mental health providers, including evaluation of (a) knowledge about recovery-oriented care, (b) work engagement, (c) provider lived experience with mental health challenges, and (d) stigma, measured as disidentification. In this group of providers, recovery knowledge, lived experience, and work engagement were associated with less stigma toward clients. Recovery knowledge and work engagement were associated with less stigma toward other providers with lived experience, but having lived experience was not associated with stigma toward other providers with lived experience. Findings suggest that the professional culture of nondisclosure may be a factor that increases provider stigma and should be a topic for further research.

Rationale

Common wisdom would suggest that mental health providers, as active advocates for their clientele, would not perpetuate the negative stigma about mental health challenges. Such stigma is widespread in U.S. culture (Corrigan, 2005). Although the empirical literature on this matter is mixed, it appears that mental health providers maintain levels of stigma comparable to that of the general public (Peris, Teachman, & Nosek, 2008; Schulze, 2007; Wahl & Aroesty-Cohen, 2010). Most clinical psychologists rate people with schizophrenia or borderline personality traits as “undesirable” and want high levels of social distance with these groups (Servais & Saunders, 2007). Clearly, mental health providers are not immune to the ubiquitous public messages stigmatizing individuals who manage mental health challenges (Wahl & Aroesty-Cohen, 2010).

Perpetuation of stigma among mental health providers is a serious concern. Stigma affects many domains of life independently of symptoms, including housing, education, employment, social support, and health care (Corrigan, 2012; Kosyluk, Corrigan, & Landis, 2014; Mittal et al., 2014; Rotenberg, 2010; Rotenberg, Bharathi, Davies, & Finch, 2013; Sartorius, 2002). In the hands of mental health providers, stigma is an even greater con-

cern, leading to overdiagnoses and negative labeling, more negative prognoses, and more limited treatment choices (Peris et al., 2008; Sartorius, 2002). Perhaps the greatest concern about stigma is that individuals perceiving stigma are less likely to seek treatment for mental health concerns (Greene-Shortridge, Britt, & Castro, 2007).

Overcoming significant societal stigma is difficult. Among adolescents, education about mental health can reduce stigma, but among adults, the most effective means of reducing stigma is continuous contact with an individual in a similar social role who acknowledges experience with a mental health challenge (Corrigan, 2011, 2012; Corrigan & Fong, 2014; Corrigan & Kosyluk, 2013; Corrigan, Morris, Michaels, Rafacz, & Rüsich, 2012). Mental health providers receive more education than any other segment of the population on this issue, and practicing clinicians have high levels of ongoing contact with individuals who acknowledge mental health challenges, yet do not experience the reduction in stigma that adolescents and other adults experience (Bike, Norcross, & Schatz, 2009; Cohen & Cohen, 1984; Deutsch, 1985; Nachshoni et al., 2008).

Several circumstances make mental health providers resistant to stigma reduction. One of these is the “clinician’s illusion” (Cohen & Cohen, 1984); new clinicians typically work with a caseload of people managing both acute and chronic concerns, but over time, those who do not recover well enough to leave therapy accrue on the caseload, and very experienced therapists are likely to have large caseloads of chronically challenged clientele. This phenomenon skews experienced clinicians’ perceptions and expectations of recovery, causing increased stigma and negative evaluations of clients (Cohen & Cohen, 1984).

Another factor that likely increases resistance to stigma reduction is a professional culture that discourages clinicians from disclosing mental health concerns (Boyd, Zeiss, Skinner, & Reddy, 2016). Ethical requirements for disclosure when a provider is impaired, in combination with a culture of nondisclosure, may create the illusion that any mental health provider

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who discloses a mental health concern is impaired. Nondisclosure may also create the illusion that few mental health providers have faced mental health challenges, despite the fact that studies show that 50%–85% of mental health providers have lived experience with mental health concerns (Bike et al., 2009; Deutsch, 1985; Nachshoni et al., 2008). In some cases, state licensing rules may enforce a culture of nondisclosure by eliminating diagnostic groups from licensure regardless of level of functioning (Boyd et al., 2016).

Furthermore, the culture of nondisclosure robs mental health providers of one of the key facilitators for identification as a means of reducing stigma; providers rarely see people in their same social role as managing a mental health concern, because other providers participate in the culture of nondisclosure. Perhaps as a result of all of these factors, there is evidence that mental health providers engage in a process of “disidentification” with clients; they view clients as being categorically unlike themselves, further nullifying the effects of contact with the outgroup (Servais & Saunders, 2007). For example, note that on semantic differential scales, psychologists rate individuals managing schizophrenia or borderline traits as being very different from themselves (Servais & Saunders, 2007).

New developments in mental health care may be key to addressing the problem of provider stigma. The emergence of recovery model care, which focuses on empowering clients to direct their own care with a focus on their individual goals, was developed in part to mitigate stigma and enhance social justice by recognizing the oppression faced by this group (Carr, Bhagwat, Miller, & Ponce, 2014). This model of care also recognizes lived experience of a mental health challenge as a potential asset and frames recovery as an achievement and source of pride, to the extent that the model advocates professional peer support from individuals with lived experience of a mental health challenge as essential in recovery (Carr et al., 2014). There is evidence that this approach is successful in reducing stigma; empirical evidence shows that clients who are provided with higher levels of recovery model treatment resources report lower levels of internalized stigma (Wciórka, Switaj, & Anczewska, 2015). Based on this, one would expect that mental health providers well trained in recovery model care would describe lower levels of stigma or disidentification with clients.

Based on the clinician’s illusion literature, it appears that clinicians who feel ineffective as they work with clients likely experience burnout or disengagement in their provider role, increasing their perceptions of stigma over the course of their careers (Cohen & Cohen, 1984). Providers experiencing working conditions that minimize stress and burnout and enhance work engagement may be less susceptible to the clinician’s illusion and report lower levels of stigma.

Given existing literature indicating that recovery model training, a value on lived experience, and work engagement (as opposed to work stress/burnout) are factors that may address provider stigma, the following hypotheses were formulated:

Hypothesis 1: Lived experience, recovery knowledge, and work engagement will be associated with lower levels of disidentification with clients (i.e., less stigma).

Hypothesis 2: Lived experience, recovery knowledge, and work engagement will be associated with lower levels of disidentification with providers who have lived experience.

Method

Participants

Participants were 101 providers of clinical mental health services in a large, Midwestern Veterans Affairs (VA) medical center. Of those who reported their discipline, there were 8 psychiatrists, 41 psychologists, 16 social workers, 23 nurses, and 6 respondents from other disciplines. Of those who reported their gender, there were 26 men and 64 women. Respondents had worked at the VA an average of 3.11 ($SD = 1.58$) years and had an average of 4.00 ($SD = 1.07$) years of experience in their discipline.

Procedures

These data were collected in the context of a needs assessment to plan for continuing education in recovery-oriented care and mental health stigma reduction. Surveys, including a measure of work engagement, knowledge of recovery-oriented care, and demographic questions (discipline, years of practice, lived experience of mental health challenges, types of mental health services used, degree of disclosure of lived experience, gender), were sent to 328 mental health providers. The procedure was reviewed by the institutional review board (IRB), which determined that the needs assessment was not research and did not require consent or IRB oversight, as the data were anonymous and intended for educational planning. Labor unions representing employees surveyed also reviewed and approved the survey. Respondents were instructed to skip any items that might compromise their anonymity and were informed that participation was voluntary. The individual receiving the data was not in a supervisory or leadership role, adding another layer of protection from any potential adverse consequences of participation. In total, 101 surveys were returned for a 31% return rate.

Measures

A demographic questionnaire asked about the participant’s discipline (psychiatry, psychology, social work, nursing, or other), gender, years of service at the facility and years in their discipline, types of mental health services they had used, the types of challenges for which they had sought help, and history of sharing mental health concerns with colleagues and supervisors. Because data were collected in an employment setting, every effort was made to reduce participants’ perceived threat, so questions regarding lived experience were designed to capture a wide variety of concerns that may precipitate help seeking, including V-codes such as partner relational concerns and vocational concerns. Items asked about types of challenges, rather than diagnoses, both to demonstrate recovery values about labeling and to protect employees from the risks associated with acknowledging a specific diagnosis. A respondent was classified as having lived experience if he or she reported a history of using mental health services.

The nine-item Utrecht Work Engagement Scale (Schaufeli, Salanova, Gonzalez-Roma, & Bakker, 2002) was part of the needs assessment. The instrument is designed to assess occupational well-being, a construct that is essentially the inverse of burnout. Responses are on a 7-point Likert scale with anchor points ranging from *never* to *always*. Higher scores indicate better work engagement. Validity is supported based on high correlations and similar factor structure to the parent measure, the 17-item Utrecht Work Engagement Scale (Schaufeli et al., 2002; Seppälä et al., 2008). Cronbach's alpha in this sample was .87. Sample items include, "At my work, I feel that I am bursting with energy," and "I am proud of the work that I do."

The Recovery Knowledge Inventory (Bedregal, O'Connell, & Davidson, 2006) is a 20-item, 5-point Likert response scale instrument designed to assess knowledge and attitudes toward recovery-oriented care. Items were developed by a panel of experts in recovery-oriented care and further assessed through factor and reliability analysis to yield the current instrument, which is widely used in VA settings to assess clinicians' knowledge of recovery-oriented mental health care (Bedregal et al., 2006). Higher scores indicate better knowledge of the recovery model and more recovery-oriented attitudes toward clients. Cronbach's alpha in this sample was .73. Sample items include, "All professionals should encourage clients to take risks in pursuit of recovery," and "Defining who one is, apart from his/her illness/condition, is an essential component of recovery."

The semantic differential scale used in Servais and Saunders (2007) was used to assess levels of disidentification with clients (i.e., stigma). Respondents were asked to rate several targets on a 7-point scale between opposing descriptors, "effective–ineffective," "understandable–incomprehensible," "safe–dangerous," "worthy–unworthy," "desirable to be with–undesirable to be with," and "similar to me–dissimilar to me." Targets used in Servais and Saunders (2007) included "myself," "a person with depression," "a person with borderline traits," and "a person with schizophrenia." To further assess disidentification in a professional context, additional targets were added: "a person with PTSD [posttraumatic stress disorder]," "a mental health provider with PTSD," and "a mental health provider with schizophrenia." Higher scores indicate higher levels of disidentification. In this sample, Cronbach's alpha for all items assessing disidentification with client targets was .95, and Cronbach's alpha for all items assessing mental health provider targets was .94.

Results

Seventy-five percent of the sample reported lived experience with mental health challenges, including addiction (12), adjust-

ment concerns (28), anxiety/stress/panic (43), depression (45), domestic violence (7), emotional regulation (6), grief and loss (20), interpersonal challenges (22), marital or family distress (27), nightmares (4), parenting challenges (9), psychosis (1), sexual assault or harassment (4), substance use (8), trauma (11), and vocational concerns (9). Types of services used included individual therapy (70), group therapy (26), psychiatric medications (41), inpatient care (1), partial hospitalization or day treatment care (7), coaching (7), peer support (13), support groups (17), 12-step or other recovery groups (14), and substance use disorder treatment (4). Of the 67 respondents who had disclosed information about mental health to colleagues, they had told an average of 4.2 ($SD = 3.6$) colleagues. Thirty-eight percent of the respondents had shared information about their mental health with their supervisors. Compared to the sample of psychologists in Servais and Saunders (2007), this group of providers described lower levels of disidentification with clients managing schizophrenia but higher levels of disidentification toward clients managing depression or borderline traits. Score distributions on the semantic differential scale were normally distributed.

Student's t tests indicated that those with lived experience did not differ from those without in work engagement or disidentification with other providers with lived experience. Individuals with lived experience evidenced less disidentification with clients ($t = 2.02, p = .048$) and lower scores on the Recovery Knowledge Inventory ($t = 2.56, p = .02$). Means, standard deviations, and intercorrelations are documented in Table 1. Those with high work engagement ($r = -.25, p = .02$) and high levels of recovery knowledge ($r = -.36, p = .001$) described lower levels of disidentification with clients. Those with high levels of recovery knowledge described lower levels of disidentification with providers who have lived experience ($r = -.34, p = .002$). Disidentification with clients and with providers who have lived experience were highly correlated ($r = .77, p < .001$).

Alpha was set at .025 to mitigate the risk of Type I error. Hypothesis 1 was tested using a simultaneous multiple regression analysis; lived experience, work engagement, and recovery knowledge were independent variables, and disidentification with clients was the dependent variable. The model accounted for 31% of the variance in disidentification with clients ($F = 12.15, p < .001$); all three independent variables emerged as significant (see Table 2).

Hypothesis 2 was tested using a simultaneous multiple regression analysis with the same independent variables and disidentification with other providers with lived experience as the dependent variable. The model accounted for 17% of the variance in disidentification with providers with lived experience ($F = 6.16, p = .001$). In this model, lived experience did not emerge as statisti-

Table 1. Means, Standard Deviations, and Intercorrelations

| Variable | <i>M</i> | <i>SD</i> | Work engagement | Recovery Knowledge Inventory | Disidentification with clients |
|----------------------------------|----------|-----------|-----------------|------------------------------|--------------------------------|
| Work engagement | 39.02 | 8.42 | — | | |
| Recovery Knowledge Inventory | 55.02 | 7.81 | -.25* | — | |
| Disidentification with clients | 86.42 | 22.28 | -.23* | -.36** | — |
| Disidentification with providers | 34.72 | 12.73 | -.15 | -.34** | .77** |

* $p < .05$. ** $p < .01$.

Table 2. Regression for Disidentification With Clients

| Predictor | B | SEB | β | <i>p</i> |
|------------------------------|--------|------|---------|----------|
| Lived experience | -15.33 | 5.61 | -.27 | .008 |
| Recovery Knowledge Inventory | -1.56 | .29 | -.54 | <.001 |
| Work engagement | -1.10 | .29 | -.38 | <.001 |

Note. Adjusted $R^2 = .31$, B = coefficient for the variable, SEB = standard error of B, and β = standardized coefficient for the variable.

cally significant, but both work engagement and recovery knowledge were associated with lower levels of disidentification with providers with lived experience (see Table 3).

Hypothesis 1 was fully supported; lived experience, knowledge of the recovery model, and work engagement were all associated with lower levels of disidentification with clients. Hypothesis 2 was partially supported; knowledge of the recovery model and work engagement were associated with lower levels of disidentification with providers who have lived experience, but disidentification with other providers did not vary based on lived experience.

Discussion

It was interesting that providers with lived experience did not differ from those without in work engagement, suggesting that these are not struggling, impaired employees. Note that 75% of the sample identified as having lived experience; no major medical center could function if 75% of the mental health providers on their staff were impaired employees. Those with lived experience stigmatized clients less than their peers without such experience but also scored lower in knowledge of the recovery model than those without lived experience. It is possible that those with lived experience viewed themselves as already practicing recovery model care and may have been less engaged in education about this model. It is also possible that providers' own internalized stigma affects their views of peers managing mental health challenges. Item-level *t* tests of the Recovery Knowledge Inventory identified five items for which providers with lived experience gave responses that differed from those without such experiences; a theme emerging from these items was the idea that recovery-oriented care was most relevant for higher functioning clients, for example, "Recovery is not as relevant for those who are actively psychotic or abusing substances," and "The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment." This pattern suggests this sample of providers with lived experience thinks of themselves as potentially higher functioning and other than representative of people with lived experience as a group; again, the culture of nondisclosure may facilitate provider perceptions that they are alone, or nearly alone, in their level of recovery and cause them to think of themselves as exceptional, facilitating disidentification with clients.

These findings suggest that continuing education interventions targeting stigma reduction among providers may be more effective if they emphasize recovery model care and interventions to increase work engagement (e.g., by reducing work stress and burn-out). Note that of all variables examined in this study, recovery

knowledge had the highest beta values, so there is evidence that education is potentially effective in reducing stigma. However, given the variance in disidentification associated with lived experience and work engagement, factors beyond education are relevant and should also be further studied as keys to reduction in provider stigma. Emphasizing recovery model values on lived experience as an asset, expressing value, and maintaining high visibility of professional peer support should be further studied as well. Given the high correlation between stigma directed at providers with lived experience and stigma directed at clients, longitudinal study of potential causal relationships between these two variables should be subjected to study, as this may be a dynamic that could be used to better address stigma.

Note that although lived experience appears to be associated with less stigma directed toward clients, mental health providers in this sample who had lived experience themselves did not appear to be less judgmental of other providers who had lived experience. Based on these findings, it appears likely that the culture of nondisclosure among providers may be relevant to provider stigma. Given the cultural norm that only providers who are impaired disclose, it is likely that even providers with lived experience perceive those who disclose as impaired or maintaining poor boundaries. It is possible that closeted providers with lived experience may perceive those who disclose as risking increased scrutiny, judgment, and stigma around providers with lived experience, thus further stigmatizing these peers as a potential source of threat.

Although there are limitations to cross-sectional data such as these, these findings suggest fruitful areas for research in reducing provider stigma. The sample for this needs assessment was from a very limited geographical range, was drawn only from VA practitioners, and consisted primarily of providers who had been practicing for under 10 years. These aspects of the sample limit generalizability, and it would be especially important to study providers with longer careers to more fully assess the effects of the clinician's illusion (Cohen & Cohen, 1984). Also, note that although lived experience among respondents was defined very broadly, including histories of help seeking for V-code concerns, targets on the measure of stigma toward other providers were limited to mental health providers with either PTSD or schizophrenia. The range of targets was limited to reduce participant burden and secure a reasonable response rate, since this was a non-incentive, voluntary needs assessment. Further research considering disidentification among similar providers would be useful to better understand these findings. Note as well that most respondents were comparatively early in their careers; literature on the clinician's illusion (Cohen & Cohen, 1984) indicates that mental health providers learn increasingly stigmatizing attitudes over the course of their careers; this sample, therefore, may underestimate the degree of stigma.

Table 3. Regression for Disidentification With Providers With Lived Experience

| Predictor | B | SEB | β | <i>p</i> |
|------------------------------|-------|------|---------|----------|
| Lived experience | -3.14 | 3.32 | -.10 | .35 |
| Recovery Knowledge Inventory | -.68 | .17 | -.44 | <.001 |
| Work engagement | -.42 | .17 | -.26 | .018 |

Note. Adjusted $R^2 = .17$, B = coefficient for the variable, SEB = standard error of B, and β = standardized coefficient for the variable.

It is important to note that these findings are correlational and cannot be construed to represent cause-and-effect relationships; longitudinal studies are necessary to address causal relationships. Institutional history may also be involved in findings; in the 8 years preceding this study, both the facility studied and the VA at the national level had participated in widespread education in and adoption of recovery model care, which included several national VA leaders acknowledging lived experience with a mental health challenge. It is possible that these types of organizational interventions could have altered the degree of variance in disidentification or knowledge of recovery model care. Also, at the time the survey was administered, VA providers were enduring significant negative media attention to the VA, which may have affected work engagement.

The culture of nondisclosure may be a value to be reconsidered among mental health providers. There are many good reasons for nondisclosure, including prioritizing the client's needs in therapeutic interactions (Zur, 2007). However, the cultural value of nondisclosure among mental health providers is not relevant to meeting clients' needs. On one level, nondisclosure and disidentification protect individual providers from the consequences of stigma (Servais & Saunders, 2007), but on a cultural level, nondisclosure among providers likely perpetuates stigma that may negatively affect services to clients (Mittal et al., 2014; Rotenberg, 2010; Rotenberg et al., 2013). Further study is necessary to assess the extent to which stigma directed to providers may be etiologic in stigma directed toward clients.

Some of these findings are intuitive, for example, the indications that providers with lived experience describe less stigma toward clients. This finding may be a foundation for further research identifying means of using lived experience as an asset to reduce stigma among providers. The finding that providers with lived experience did not describe less stigma toward other providers with lived experience was counterintuitive and has implications for the professional culture of nondisclosure that should become a target for future research.

Keywords: stigma; lived experience; recovery; providers

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