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# Stigma: A Barrier in Supporting Nurse Well-Being During the Pandemic



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Public media and the nursing literature are replete with data and anecdotal stories evidencing the overwhelming impact to nurses' well-being during the COVID-19 pandemic. Although many organizations have rallied and are providing robust services to support nurses through the pandemic, stigma (negative perceptions, attitudes, and discrimination) about mental health support is contributing to nurses' reluctance to use the many resources available to them. This article outlines strategies for reducing the stigma and eliminating the barriers associated with obtaining the mental and emotional well-being support and services that nurses need and deserve.

**T**he COVID-19 pandemic exacerbated already existing stressors and burnout in nurses. Fortunately, employers of nurses, professional associations, and other nonprofits rallied by providing a diverse set of robust and free resources to support nurses' well-being. Unfortunately, these resources have been underutilized.

For example, in the midst of the pandemic, even as 51% of nurses reported feeling exhausted and 43% reported being overwhelmed, many nurses did not avail themselves of the resources provided to support them. Twenty-four percent (24%) of nurses reported seeking professional mental health support. However, of the 76% who did not seek mental health support, only 51% reported not needing it. A full 36% of nurses not seeking mental health reported feeling that they should be able to manage their stress and mental well-being on their own.<sup>1</sup>

Younger nurses—those under the age of 34—are not faring as well as their older counterparts, with 81% reported being exhausted and 71% reported being overwhelmed. Although 36% of younger nurses have sought professional mental health support, those who did not were slightly more likely to report concerns around stigma from colleagues (5% versus 3%), stigma from family (6% versus 3%), concerns around licensure (5% versus 3%), and fear of retribution by their employer (4% versus 3%).<sup>1</sup>

Nurse leaders themselves are feeling the pressure of the pandemic. In a longitudinal survey conducted by the American Organization of Nursing Leadership released in August 2021, 36% of nurse leaders indicated they were “not or not at all emotionally healthy”, a 50% increase since February 2021.<sup>2</sup>

In addition, despite all the efforts put forth by employers, just 42% of nurses agreed or strongly agreed with the statement “My employer values my mental health.” In addition, when asked, “What has been most helpful in strengthening your well-being?” 5% of respondents said Employee Assistance Programs (EAP) or counseling services, whereas 4% of nurses not seeking mental health support expressed concerns with EAP confidentiality.<sup>1</sup>

## KEY POINTS

- Resources to support nurses' mental health and well-being during the COVID-19 pandemic are abundant, but widely underutilized.
- Stigma embedded in the culture of nursing and licensure reporting requirements are likely a contributing cause of reluctance to use well-being and mental health services.
- Stigma can be reduced through role modeling, testimonials, education, and American Disability Act (ADA) compliant licensure reporting requirements.

## ISSUE OF STIGMA IN NURSING

Stigma around mental health care has likely caused nurses to be hesitant or even decline to use available resources to support their well-being. Stigma has been defined as a social process characterized by exclusion, rejection, blame, or devaluation that results from anticipation of an adverse social judgment.<sup>3</sup> The cultural assumption is that nurses need to just “deal with” the

difficulties of the job and that if they need help, they potentially are not “cut out for nursing” is a form of stigma.<sup>4</sup> Further, there is anecdotal evidence that nurses fear that if they seek out support services, their employers will question their stability and question their ability to care for patients. Reluctance on the part of physicians to seek help for burnout or other emotional or mental health challenges is well documented, for fear that they will be perceived as weak or unfit to practice medicine by their colleagues or employers, or because they assume that seeking such care may have a detrimental effect on their ability to renew or retain their license.<sup>5,6</sup> The messages to nurses that they have been “heroes” in the pandemic and need to “be resilient” also reinforce the unspoken message that they should not need help to manage their stress, and mental and emotional well-being.

Stigma also becomes embedded in structures. For example, in both nursing and medicine, questions related to mental health care, asked as a prerequisite to licensure or renewal, become a barrier to accessing needed support. Nearly 40% of physicians said they’d be reluctant to get mental health care out of concern over receiving or renewing their license.<sup>6</sup> More than half of nursing state licensing boards ask questions about mental illness on pre-licensure applications. Of the 30 boards that ask questions about mental illness, 8 focus on current disability, whereas the remaining 22 boards ask non-ADA-compliant questions by targeting specific diagnoses, focusing on historical data in the absence of current impairment, and/or requiring a prediction of future impairment.<sup>7</sup>

Prior to the onset of the COVID-19 pandemic, the National Academies of Science, Engineering and Medicine (NAM) published *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*.<sup>8</sup> One of the 6 recommended approaches was to provide support to clinicians and learners by reducing the stigma and eliminating the barriers associated with obtaining the support and services needed to prevent and alleviate burnout symptoms, facilitate recovery from burnout, and foster professional well-being among learners and practicing clinicians. Specifically, the report recommended the following:

1. State licensing boards, health system credentialing bodies, disability insurance carriers, and malpractice insurance carriers should either not ask about clinicians’ personal health information or else inquire only about clinicians’ current impairments due to any health condition rather than including past or current diagnosis or treatment for a mental health condition. They should be transparent about how they use clinicians’ health data and supportive of clinicians in seeking help.
2. State legislative bodies should create legal protections that allow clinicians to seek and receive help for mental health conditions as well as to deal with

the unique emotional and professional demands of their work through employee assistance programs, peer support programs, and mental health providers without the information being admissible in malpractice litigation.

3. Health professions educational institutions, health care organizations, and affiliated training sites should identify and address those aspects of the learning environment, institutional culture, infrastructure and resources, and policies that prevent or discourage access to professional and personal support programs for individual learners and clinicians.<sup>8(p.17-18)</sup>

The American Nurses Association (ANA) also has recognized the need to address stigma and regulatory issues that can become barriers to nurses’ addressing their mental health needs. A position statement adopted by the ANA Board of Directors in the midst of the pandemic articulates that:

ANA believes that policymakers as well as health care leaders and institutions should recognize and address nurses’ unique mental health needs and implement strategies to ensure these needs are met under all conditions, including during disasters and public health emergencies. Access to affordable mental health screenings and confidential mental health assistance and treatment is vital, and the use of these resources must not threaten nurses’ licensure or employment. The profession must put an end to the stigma that is still attached to mental health issues so that all nurses feel able to get the help they need.<sup>9</sup>

Similarly, medicine has begun to address the issue. In 2018, the Federation of State Medical Boards (FSMB) in their Report and Recommendations of the Workgroup on Physician Wellness and Burnout<sup>10</sup> released recommendations for updating licensing applications, advising that questions focus only on current impairment or issues that undermine a physician’s ability to practice. State medical boards were also encouraged to offer “safe haven” nonreporting to physicians who are under treatment and in good standing. State medical boards were also encouraged to work with their state legislatures to ensure that the personal health information of licensees related to an illness or diagnosis is not publicly disclosed as part of a board’s processes. Additional recommendations advised credentialing bodies to avoid asking questions that would discourage physicians from seeking needed treatment and encouraged employers of physicians to offer programming to support the unique emotional and mental challenges that physicians face.<sup>10</sup>

Most recently, the NAM Report on the Future of Nursing reiterated the importance of addressing the stigma of mental health care for nurses with the

recommendation that nurse leaders “evaluate and strengthen policies, programs, and structures within employing organizations and licensing boards to reduce stigma associated with mental and behavioral health treatment for nurses.”<sup>11</sup>(p.363)

## EXISTING EVIDENCE RELATED TO ADDRESSING STIGMA

Very little research has been conducted on reducing stigma for accessing emotional or mental health support in nurses. The issue itself is quite complex in that nurses can be “stigmatized” for seeking mental health care, nurses can be the “stigmatizers” of their colleagues seeking mental health care, and nurses can be “de-stigmatizers.”<sup>12</sup>

One component of addressing stigma is likely addressing nurse’s perceptions of self-care. In ANA’s Health Risk Appraisal conducted between 2013 and 2016, 68% of nurses reported putting their patients’ health, safety, and wellness before their own.<sup>13</sup> A grounded theory study on nurses’ experience of self-care and self-compassion identified nurses needing permission from others and from themselves to be self-caring and self-compassionate.<sup>14</sup>

Research in addressing stigma in nurses is limited; however, evidence from military service members may indicate viable approaches for replication within the nursing profession. Many nurses, like military service members, practice in environments with high and, particularly in the case of the pandemic, long-lasting stress. Similarly, the unusual nature of the experience causes nurses, like members of the military, to heavily rely on comradery with colleagues. During the pandemic, 47% of nurses credited talking with colleagues an activity that has strengthened their well-being.<sup>1</sup>

The US Air Force found that both stigma and fear of adverse impact on their careers influenced the decisions to seek mental health treatment in officer and enlisted nursing personnel (n = 211). Significantly, the officers and nursing personnel agreed with statements like “members of my unit might have less confidence in me” (54%) and “my unit leadership might treat me differently” (58%). Many also had concerns that it would harm their career (47%), they would be seen as weak (47%), or there would be difficulty getting time off work for treatment (45%). Officer nursing personnel were significantly more likely than enlisted to agree that accessing mental health services would be embarrassing, harm their career, or cause leaders to blame them for the problem (p ≤ 0.03 for each comparison).<sup>15</sup>

Research on the underutilization of mental health services by military service members has reported similar insights into the issue of underutilization of emotional and mental support services. A systematic review of the use of mental health services by military personnel that included 111 peer-reviewed articles

identified common barriers to care that included concerns regarding stigma and career impact, and facilitators to care including positive attitudes toward treatment, family/friend support, and military leadership support.<sup>16</sup> These results have implications for the nursing profession as a whole for understanding how stigma and fear may be barriers for utilizing well-being resources and creating cultures of well-being.

A comprehensive review of existing programs within the military identified the most-promising programmatic and policy approaches to reducing stigma. These involved changing policy to reduce discriminatory behavior and educating military leaders, who often set the climate within units and the military institution as a whole. Contact-based programs (i.e., exposing service members to a fellow service member in recovery from a mental health disorder); education programs for both service members and military leaders to improve mental health literacy, and efforts to make the act of seeking care less stigmatizing (e.g., by embedding behavioral health providers in brigade combat teams) were effective in reducing stigma.<sup>17</sup>

Some work has been done in Canada to diminish stigmatization by health care providers for people with mental illnesses. As part of this work, the Mental Health Commission of Canada conducted a multi-phased, mixed-methods study to identify elements of programs designed to combat stigma against mental illness among health care providers most strongly associated with favorable outcomes. The final qualitative analysis identified 6 ingredients of programs that performed significantly better than others in reducing mental health stigma in health care providers.<sup>18</sup> The 6 intervention elements were:

1. Social contact in the form of a personal testimony from trained speaker with the lived experience of mental illness
2. Use of multiple forms or points of social contact such as a presentation from a live speaker with a video presentation, multiple first voice speakers, multiple points of social contact between program participants
3. Teaching behaviors that help health care providers know what to say and do
4. Engage in myth-busting
5. Use of an enthusiastic facilitator or instructor who models a person-centered person-first perspective as opposed to a pathology-first perspective
6. Emphasize and demonstrate recovery as a key part of messaging

## RECOMMENDATIONS

To effectively support nurse well-being during and following the pandemic, nurse leaders must address and eliminate the systemic issues associated with nurse

well-being and mental health support. Although other issues such as staffing must be considered and addressed to bring about more systemic changes, a focus on creating a culture shift to normalize self-care and fully utilizing available resources is also necessary. Messaging should emphasize that the pandemic caused inordinate stress on the health system and individual nurses and reaching out for help is both normal and necessary. Nurse leaders can normalize self-care both by role modeling caring for their own well-being and by sharing their experiences with accessing support for their emotional and mental health. Nurse leaders should be explicit about the importance of self-care and the wisdom of accessing available resources to support well-being.

Leaders who received training have been shown to share more information about mental health and mental health resources, be more supportive of employees' mental health issues, and actively encourage employees to use available resources.<sup>19</sup> Nurse leaders should be educated in the skills and behaviors necessary to promote mental health behaviors, how to recognize and support a struggling colleague, how to encourage the use of available resources, and how to create an environment in which mental health stigma is low. Specifically, teaching nurses and nurse leaders how to have conversations and how to effectively guide colleagues to access EAP and mental health professionals will increase their comfort and effectiveness, and contribute to a culture of well-being.

Sharing examples of, or even testimonials by, nurses who did utilize available resources, are powerful tools for their colleagues. Hearing a first-person account of the value of availing themselves of existing resources normalizes the experience of accessing care. A main mantra should emphasize that patient care is complex and demanding work and, particularly as a result of the pandemic, nurses all need support and resources to help process the experiences of delivering that care. Nurses should err on the side of talking to colleagues and reaching out for support sooner rather than later. Nurse leaders need to emphasize that the experiences of the pandemic have relentlessly demanded a great deal from all caregivers, and all nurses need to utilize a more robust set of well-being and mental health resources than they would in less demanding times.

Addressing the stigma of accessing emotional and mental health care and support by nurses without simultaneously tackling the structural barrier of regulatory reporting may not create a change in nurse utilization of mental well-being resources. The Federation of State Medical Boards Report and Recommendations of the Workgroup on Physician Wellness and Burnout<sup>10</sup> offers a template for nursing to consider, adopt (as appropriately modified), and

implement. Nurse leaders working in partnership with the National Council of State Boards of Nursing and local state boards of nursing can and should advocate for updating licensing and renewal applications to concentrate questions to focus only on current impairment or issues that undermine a nurse's ability to practice, to offer "safe haven" nonreporting to nurses who are under treatment and in good standing, and ensure that the personal health information of licensees related to an illness or diagnosis is not publicly disclosed as part of a board's processes.

In addition, credentialing programs should review applications and renewals for certifying individual nurses to ensure that questions that go beyond the applicant's current impairment or issues or that undermine a nurse's current ability to practice or in any way discourage nurses from seeking needed treatment are not included. There is an opportunity, as well, to examine standards for organizational credentialing to embed the requirement for programming to support nurse's health and well-being and reduce the stigma associated with seeking help. Individual organizations should examine their hiring and credentialing program requirements to ensure that reporting on mental health for new employees is ADA compliant.

## CONCLUSION

Eliminating or reducing stigma to accessing emotional and mental health support services is essential to ensure nurses are robustly supported during and following the pandemic. Transforming nurses' perceptions and the cultural context that serves as a barrier to nurse caring for their well-being and accessing mental health care is needed. Investing in addressing stigma could also have a secondary benefit of improving nurses' perceptions about mental health needs and care in their patient population.

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