

Qualitative synthesis

A framework for identifying stigmatisation patterns in patients with mental health conditions in the acute healthcare setting

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Commentary on: Perry A, Lawrence V, Henderson C. Stigmatisation of those with mental health conditions in the acute general hospital setting. A qualitative framework synthesis. *Soc Sci Med* 2020; 255:112974. doi: 10.1016/j.socscimed.2020.112974.

Implications for practice and research

- ▶ The framework for categorising stigmatisation patterns in patients with mental health conditions may be useful in practice to facilitate stigma reduction in acute care settings.
- ▶ There is a need for high quality review, including quantitative and qualitative observational and interventional studies, to further explore stigmatisation patterns and reduction interventions.

Context

Stigmatisation is the action of devaluing individuals due to some factor identified as a mark of shame or 'stigma'. Stigma has been associated with ethnic features and certain health conditions such as HIV and mental illness¹; in particular, many patients with mental illness are stigmatised and treated unfairly, which can lead them to refrain from seeking help for their illnesses.²

Stigmatisation is generally not fully understood in patients with mental illness in acute-care settings.² The authors of this review thus aimed to address this by synthesising the available qualitative literature where a framework for identifying stigmatisation patterns was offered.

Methods

The study applied a 'best fit' framework approach, using stigma theory to expand on a priori conceptual stigma model³ in order to construct a framework for stigmatisation phenomena in acute-care settings. An initial literature search using broad terms on 22 databases for the period 1996–2019 was carried out, only qualitative primary studies published in English featuring health professionals and patients with mental health conditions in acute care settings were included. A snowballing method was then applied to identify further relevant literature by backward and forward chaining. Searching and screening were conducted by a single author, and no structure appraisal tools were applied. The qualitative synthesis was then performed for the included studies.

Findings

Fifty-one studies were included based on the identification of 26 relevant papers that contained relevant studies used for framework development; these included interview/focus group work and ethnographies. A further 25 studies were less relevant to the review inclusion criteria due to their nature as quantitative work or grey literature.

Five patterns of mental health stigma were identified in the attitudes of health professionals and in the organisation of acute-care settings: devaluation, social control, avoidance, rejection and failing to act. Patients with mental health conditions in acute-care settings may be stigmatised in terms of access, assessment and/or care in terms of environmental structure and professional knowledge. Positive behaviours were, however, also identified, which in some cases operated to counteract these patterns of stigmatisation.

Commentary

This review might provide an initial useful framework for identifying and addressing stigmatisation towards patients with mental illness in both acute-care settings and future research. However, there are essential issues that must be considered when examining the results of this review.

The first issue concerns the systematic search approach. The initial set of papers to use for a snowballing approach was missed, and the papers that retrieved in the backwards and forwards steps were not specified. In addition, as the screening was conducted by one author, this review may easily have omitted relevant studies, increasing the risk of bias in a manner that endangers the validity of the conclusions drawn. The second issue is related to omissions in the inclusion criteria and thus in the selected studies. For example, only primary qualitative studies of patients with mental health conditions in critical settings met inclusion criteria; however, quantitative studies or those in medical surgical settings and studies of patients living with HIV were nevertheless included.

Due to the limitations of this review, further high-quality research is required. Such future research should collect data from both quantitative and qualitative observational or interventional studies to further develop an understanding of stigmatisation patterns in different cultures and to capture all intervention approaches and methods applied to patients with mental illness in acute-care settings. Future research on stigma categorisation and reduction should focus on rigorous evaluation and on addressing stigma at multiple ecological levels within critical care in order to develop a sustainable response. Standardising measures to facilitate comparisons between intervention approaches and methods is an important step towards this.

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Competing interests None declared.

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