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Barriers, Challenges &Successes Among Human Service Professionals Stigma Reduction Treatment Among People With Mental Illness

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MSW, Widener University, 2018

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Dissertation Submitted in Partial Fulfillment

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Abstract

According to the National Alliance on Mental Illness, over 9 million people in the United States suffer from a mental illness (MI). Although human service professionals seek the best practices to treat people with MI, people with MI sometimes struggle to seek treatment because of stigma. The purpose of this generic qualitative study was to explore the barriers and challenges of human service professionals who experienced using a stigma reduction treatment on a person with MI. The mental illness stigma framework and Goffman's stigma theory provided the conceptual framework for the study. Data were collected through semistructured interviews with eight human service professionals who worked in an outpatient treatment setting. Findings indicated that participants experienced challenges using a stigma reduction intervention due to lack of staffing, which led to improper use of a stigma reduction intervention, and lack of education in which some staff lacked the ability to properly communicate with patients. The barriers experienced were due to poor communication with families and the use of medical interventions in which patients were unable to fully participate with the stigma reduction intervention. Meeting patients where they were seemed to be successful with the use of a stigma reduction intervention. Findings may inform the best practices for positive social change with stigma reduction treatments used on people with MI.

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Dedication

I dedicate this dissertation first to God for providing me with the wisdom to accomplish something that is dear to my heart. Second, my husband who patiently stood by me and supported me through this endeavor, and my father who is gone physically but present in the spirit. I love you, Dad, and I made it to the end.

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Chapter 1

Human service professionals are faced with the challenge of helping people with mental illness (Mental Illness obtain consistent treatment for their mental health due to stigma. However, stigma has many different functions, and it often leads to the isolation of stigmatized individuals due to their undesirable characteristics (Roscoe, 2021). Being stigmatized creates challenges for people with MI. These challenges range from seeking treatment for mental health to locating social services needed (Smith & Applegate, 2018). Stigmas also create barriers for people with MI to access treatment, jobs, housing, and relationships; this lack of access compromises their ability to attend to their physical health (Smith & Applegate, 2018). Goffman's stigma theory defines stigma as an "attribute that is deeply discrediting" and that reduces the target "from a whole and usual person to a tainted discounted one" (Sapag et al., 2018, p. 1469). Stigma exists when elements of labeling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold (Sapag et al., 2018).

Being stigmatized in an acute treatment setting has caused people with MI to be viewed as challenging, difficult, and problematic groups to treat (Perry et al., 2020). When this type of stigma has been perceived for a long time, the resulting experience is loss of self-esteem and dignity and/or fear, shame, hopelessness, and guilt in which a person may consciously or unconsciously accept diminished expectations about themselves and start behaving the way people expect them to behave (Mental Health Innovation Network, 2016). This type of stigma leads to self-stigma in which people with MI can start to experience diminished self-esteem and self-efficacy (Schauman et al., 2019). Experiencing these two elements can cause a person to become demoralized and opt out of pursuing important life goals, which translates to the “why try” effect (Schauman et al., 2019).

In the current study, I explored human service professionals’ experiences supporting clients with mental health concerns as they cope with potential stigma. In this Chapter, I review the background and problems regarding stigma and mental health. I also establish a rationale for this study and present social and research implications. In addition, this chapter includes an overview of the details of my study including the research question, design, framework, and significance.

Background

Stigma has been suggested as a contributing factor to the underutilization of mental health treatment among older individuals. This is a common problem that often interferes with recovery efforts (Sarkin et al., 2014). According to Young et al. (2019), some researchers have focused on the understanding of implicit MI stigma and how to reduce it, and other researchers found that ableist beliefs are associated with an indirect and subtle stigma that hurts people with MI. The fear of people with mental illness and the perception that people with mental illness are burdens were two cultural determinants that contribute to the stigma of people with MI (Gregory et al., 2020).

Other studies relating to stigma suggested that different family cultural values and beliefs can impact the understanding of MI stigma among people with MI. Schomerus and Angermeyer (2021) suggested that traditional and conservative family values are associated with MI stigma through negative stereotypes, stronger negative emotions, and discrimination toward people with MI. Xiong et al. (2021) noted that the stigmatization of people with MI is complicated by the fact that stigma and discrimination often vary by nation, culture, and demographic group, and are constantly changing over time with changing sociocultural norms. Researchers have also recognized the impact of stigma through stories of family members who care for people with MI. When caregivers hide their family member’s diagnosis and treatment from neighbors and friends to avoid stigma and protect the family’s reputation, this can impact the self-stigma already perceived (Banerjee & Dixit, 2021). Understanding how the stigmatizing attitudes of psychiatry can change the behaviors of people with MI and impact the quality of care is important for the implementation of stigma treatments (Fino et al., 2019).

Although researchers have made multiple contributions regarding stigma and some challenges human service professionals encounter, more research is needed. The experiences of human service professionals and their use of tailored treatments focused on MI and stigma have not been explored (Schibalski et al. 2017). Understanding how public stigma and family cultural beliefs can affect not only the patient but also the quality of care, relationships, and patient’s mindset can help human service providers implement stigma-free treatment processes for family and friends so that treatment is not interrupted for people with MI.

Problem Statement

One in 25 adults in the United States, which translates to 9.8 million or 4.0%, experience MI that interferes with or limits one major activity in the life of a person with MI (National Alliance on Mental Illness Shares Mental Health Numbers - CICS, 2019).

Half of the people with MI delay seeking treatment due to concerns about being treated differently or stigmatized (Borenstein, 2020). The stigma of MI, according to the American Psychiatric Association, affects social relationships and lowers self-esteem and hopes for recovery (Borenstein, 2020). Public stigma has been identified as a barrier to recovery for people with MI (Knaak et al., 2017). Public stigma has impacted treatment outcomes in relation to a better quality of life, stable work, and school environment as well as positive relationships with providers and family. Public stereotype labels such as dangerous, unpredictable, and unlikely have cause a person with MI to isolate from family, treatment, and participation in activities that increase stimulation (Cassidy & Erdal, 2020).

It is crucial for human service professionals to use of tailored treatments focused on MI and stigma that take into account demographic characteristics, levels or types of self-stigma, diagnosis, recovery orientation, setting, or other factors (Sara et al., 2020). It can be beneficial to understand how stigma is experienced by people with MI, and how this can affect the successes and challenges with treatment and engagement with providers. The treatment itself was not addressed in the current study. What was needed was a better understanding of the barriers to using these types of treatments that address stigma. It was important to understand stigma and stigma experiences and to explore the barriers human service professionals encounter when implementing a treatment program that is aimed at addressing stigma.

Purpose of the Study

The purpose of this generic qualitative study was to explore human service professionals' challenges, barriers, and successes in addressing stigma among clients with MI in a treatment program that involves using a stigma reduction treatment. The stigma associated with MI has been defined as a negative attitude based on prejudice and misinformation that is triggered by a marker of illness (Sartorius, 2007), and stigma continues to be a global public health challenge (Ye et al., 2016). MI is one of the most widely stigmatized conditions, and the stigma associated with MI is so pervasive that people with MI often direct society's negative attitudes about MI toward themselves (Eno Louden et al., 2022). Self-stigma is internalized and has numerous negative effects on people with MI, including lowered self-esteem, lowered self-efficacy, and reluctance to seek mental health treatment (Eno Louden et al., 2022). Understanding the challenges that are experienced by human service professionals may assist with finding best practices. The current study focused on understanding the challenges and barriers of human service professionals who use stigma reduction treatments on people with MI.

Research Question

What are human service professionals' perceptions of challenges, barriers, and successes in addressing stigma among clients with a mental illness in a treatment program that involves using a stigma reduction treatment?

Conceptual Framework

The conceptual framework involved two elements: the mental illness stigma framework and Goffman's stigma theory. The mental illness stigma framework provided terminology for understanding mechanisms of MI stigma that were relevant to the study of the stigmatized and the stigmatizer (see Fox et al., 2018). This framework provided terminology I used to explore the challenges, barriers, and successes of human service professionals.

Goffman’s stigma theory was used to explain the challenges, barriers, and successes of human service professionals who had treated people with MI using a treatment program that included a stigma reduction treatment. Goffman’s stigma theory was used to link the behavioral changes in people with MI because of rejection from society to the challenges, barriers, and successes experienced by human service professionals. This theory also supported the purpose of my study that focused on the individual behaviors of people with MI along with understanding the best practices that can be used to reduce stigma, including a tailored stigma reduction treatment in an outpatient treatment setting.

Nature of the Study

I used a generic qualitative design to combine theories and frameworks to answer my research question. Using a generic qualitative design meant that I was not committed to using an established methodology to answer my research question (see Denzin & Lincoln, 2017). The use of a generic qualitative design meant that my study could stand alone and would not be guided by philosophical assumptions (see Renate et al., 2014). The generic qualitative design best fit my study because I sought to understand the perceptions of participants (see Denzin & Lincoln, 2017). The generic qualitative was used to address my purpose focused on human service professionals’ challenges, barriers, and successes addressing stigma among clients with MI in a treatment program that involves using a stigma reduction treatment. Merriam and Grenier (2019) “has suggested that qualitative research generic studies seek to understand how people interpret, construct, or make meaning from their world and their experiences” (p. 39). This design did not require me as the researcher to be committed to a specific theory but did allow me to consider a theory that aligned with my phenomenon and research question (see Kennedy, 2016).

When conducting a qualitative study, the researcher should ensure that the design aligns with the research question. For the current study, ethnography, grounded theory, and phenomenology did not align with my research question as well as the generic qualitative design. Ethnography is used to understand how the culture of a group explains their perspectives and behaviors; the focus is on the culture itself (Muller, 2020). Grounded theory is a design in which the researcher develops a theory by collecting data, and the goal is generating theory (Glaser & Strauss, 2017). Phenomenology is used to understand the lived experiences of a phenomenon (Moustakas, 1994). The purpose of my study did not focused on generating theory, understanding the cultural norms of the group, or understanding the lived experiences of my participants. A generic qualitative design was best suited to answer my research question.

Definitions

Human service professionals: A generic term for people who hold professional and paraprofessional jobs in diverse settings such as group homes and halfway houses; correctional, intellectual disability, and community mental health centers; family, child, and youth service agencies; and programs concerned with alcoholism, drug abuse, family violence, and aging (Wood, 2019).

Internalized stigma: How a person living with a mental disorder absorbs public stigma into their identity (Szcześniak et al., 2018).

Mental disorder: Any condition characterized by cognitive and emotional disturbances, abnormal behaviors, impaired functioning, or any combination of these. Such disorders cannot be accounted for solely by environmental circumstances and may involve physiological, genetic, chemical, social, and other factors (also called MI; APA Dictionary of Psychology, n.d.).

MI stigma: The societal devaluation of individuals with MI that includes unfavorable stereotypes and perceptions, negative emotional and behavioral responses, status loss, and discrimination (Abdullah & Brown, 2020).

Public stigma: A pervasive barrier that prevents individuals from engaging in mental health care (Parcesepe & Cabassa, 2013).

Stigma: An undesirable attribute that differentiates an individual in such a way that they are discredited and viewed as tainted, handicapped, and less than fully human (Roscoe, 2021).

Assumptions

This study included three assumptions. First, I assumed that participants would be truthful and provide answers that accurately described their experiences. Perkins and Berkowitz (1986) suggested that human behavior is influenced by the misconceptions of how peers think and act, which explains how a person with MI behavior can create challenges as well as barriers in treatment. I assumed that participants' responses would be truthful based on their perceptions and professional interactions with people with MI. Human service professionals are held to an ethical standard that states that they conduct research that adhere to all ethical principles, institutional standards, and scientific rigor.

I also assumed that the behavior of a person with MI will change in a setting of their peers in which stigma is perceived. There are successes and challenges to be understood in this setting. This behavioral change can create challenges and barriers for human service professionals trying to reduce stigma. This is what I sought to understand. Such research takes into consideration cross-cultural bias and is reported in a manner that addresses any limitations (Ethical Standards for HS Professionals, n.d.). Finally, I assumed that the mental illness stigma framework would provide a detail explanation of how stigma is perceived and help human service professionals reduce some of the challenges and barriers that are perceived when working with people with MI.

Scope and Delimitations

This scope of this study included human service professionals' experiences using a stigma reduction treatment when addressing stigma among people with MI. Professionals who were excluded from the study included medical doctors, primary care nurses, and therapists who do not address stigma using a stigma reduction treatment. Professionals included in the study were therapists who used stigma reduction treatments to treat people with MI, licensed social workers who used stigma reduction treatments to treat people with MI, and medical doctors who prescribe stigma reduction treatments.

Limitations

There were several potential limitations that could have affected the results of my study. These limitations included bias due to the specific geographic area selected, purposeful sampling due to specific criteria set, and participants dropping out of the study at the last minute, which could have affected my results. Purposeful sampling is widely used because it helps researchers find participants who can provide rich information related to the phenomenon of interest (Palinkas, 2015). Biased opinions of successful treatments that were previously used could also have created a potential challenge. It is important to be aware of all biased opinions that could impact the validity and reliability of the study's findings (Bruce, 2018; Pannucci & Wilkins, 2010). The misinterpretation of data can have important consequences for future practice, so minimizing bias is a key consideration when designing and undertaking research (Bruce, 2018; Pannucci & Wilkins, 2010).

Significance

This study may be significant in improving the understanding of barriers, challenges, and successes of stigma reduction treatments that are tailored to a person with MI disorder and stigma experienced. This may improve the quality of inpatient and outpatient treatment outcomes for this population. Stakeholders such as mental health providers, psychiatrists, and licensed social workers may be able to use many of these findings related to stigma reduction treatments in assisting people with MI. Obtaining knowledge on implementing the best practices regarding stigma reduction treatments may assist human service professionals in inpatient and outpatient treatment settings.

Understanding the best practices to reduce stigma in this population may create better outcomes in hospital settings and other social settings in which physical care is required for people with MI.

There are also broader social change implications. Results may lead professionals to implement best practices and better understand stigma reduction treatments that are tailored to a person’s disorder and the stigma experienced. If this is the case, there is also a potential for better stigma-related treatment outcomes and successes.

Summary

MI-related stigma, including that which exists in the health care system and among health care providers, creates serious barriers to access and quality care. MI-related stigma is also a major concern for health care practitioners, both as a workplace culture issue and as a barrier for help seeking (Knaak et al., 2017). There is evidence of negative impacts of stigma across multiple domains of life; for example, stigma has been associated with reduced employment opportunities and corresponding poverty, relationship difficulties, reduced help-seeking behavior, and poorer quality health care (Clay et al., 2020). These issues create barriers through such pathways as delays in help seeking, discontinuation of treatment, suboptimal therapeutic relationships, patient safety concerns, and poorer quality mental and physical care (Knaak et al., 2017).

Understanding the importance of approaches to stigma reduction must be multifaceted to address the many mechanisms that can lead to disadvantaged outcomes, and multileveled to address stigma perpetuated at the individual and social-structural levels (Stuart, 2016).

In the current study, I explored the challenges and barriers that prevent people with MI from seeking treatment as well as the challenges and barriers that are perceived by human service professionals that interfere with reducing stigma for people with MI. In Chapter 2, I provide a synthesis of the literature that supported the relevance of the problem and my theory. Chapter 3 addresses my role as the researcher, the methodology used, and how I demonstrated trustworthiness of my study.

Chapter 2: Literature Review

MI stigma is a global issue that has many effects on people with mental illness. These effects cause social issues that create challenges and barriers for human service professionals to effectively provide the services needed to people with MI. Some of the effects that MI stigma can cause are a gap in physical and mental care, isolation from family and friends, and loss of employment. Although these issues are a concern for people with MI, it is also important for human service professionals to use best practices to reduce stigma and overcome challenges that interfere with future treatment successes.

The purpose of this qualitative study was to explore human service professionals' challenges, barriers, and successes regarding addressing and dealing with stigma among clients with MI in a treatment program that involves using a stigma reduction treatment in an outpatient setting. The stigma associated with MI has been defined as a negative attitude based on prejudice and misinformation that is triggered by a marker of illness (Sartorius, 2007). MI stigma continues to be a global public health challenge (Ye et al., 2016).

The current study focused on reducing the challenges and barriers of human service professionals who use a stigma reduction treatment for people with MI. Further research is warranted to examine public stigma reduction treatments designed to a person's mental health disorder and stigma experienced to address the documented problem in which public stigma forces a person to feel fearful, lonely, and rejected, which creates challenges and barriers to obtaining treatment (Ministry & Windhani, 2020). I explored how implementing a stigma reduction treatment catered to a person's disorder and stigma experience could mitigate fear, loneliness, and rejection and reduce the challenges and barriers to treatment outcomes.

MI stigma continues to be a global concern for people with MI. One in 25 adults in the United States, which translates to 9.8 million or 4.0%, experience MI that interferes with or limits one major activity in the life of a person with MI (National Alliance on Mental Illness Shares Mental Health Numbers - CICS, 2019). Half of the people with MI delay seeking treatment due to concerns about being treated differently. The stigma of MI, according to the American Psychiatric Association, affects social relationships and lower self-esteem and hopes for recovery (Borenstein, 2020). Previous research indicated the effects that MI stigma can have on people with MI(Borenstein,2020). Despite the many barriers and challenges that people with MI face, some people with MI successfully engage in treatment and overcome the stigma attached to MI.

I explored the challenges, barriers, and successes of human service professionals who experienced using a stigma reduction treatment. To ground the study, I conducted a review of the literature. Chapter 2 begins with identifying the search strategies used to identify relevant literature. I also describe the conceptual framework used in the study and present a comprehensive review of the relevant literature.

Literature Search Strategies

To identify peer-reviewed articles, I used the following electronic databases through the Walden University Library: Academic Search, APA PsycArticles, Thoreau, Sage journals, APA PsycInfo, Google Scholar, and ProQuest Central. The following keywords were used: *mental illness*, *stigma*, *stigma reduction treatments*, *discrimination*, *mental health*, *mental health services*, *public stigma*, *internalized stigma*, *mental illness stigma*, and *human service professionals*. Most peer-reviewed articles and publications that were used to obtain information were published within the last 5 years. Theories and frameworks used in this study to support the research question were more than 5 years old. Using seminal sources such as the Goffman (1963) stigma theory assisted me in answering my research question. Other sources cited in this study that were more than 5 years old helped to establish credibility of the information presented.

Conceptual Framework

There were two theories or concepts that I combined for a conceptual framework in this study. Goffman's (1963, as cited in Pescosolido, 2015) stigma theory was used to explain potential reasons behind the behaviors of people with MI in conjunction with the stigma experienced by people with MI. The mental illness stigma framework provided a detailed explanation of MI stigma and terminology used in this study.

Goffman's Stigma Theory

In 1959, Goffman laid out his thesis about individual action, public reaction, and identity(Goffman,1963). It was not until Goffman's wife was diagnosed with a serious MI and committed to a mental institution did Goffman realize that public reaction and identity were an issue (Pescosolidio, 2015). However, Goffman did not limit observations to MI or illness; instead, Goffman's theoretical insights on identity were sharpened by employing the common sociological concept of deviance, a concept central to the labeling theory of MI that was to come later (Pescosolidio, 2015). After carefully observing patients in a mental hospital in Washington D.C., Goffman began the development of basic concepts about how culturally and socially defined difference shapes the status, roles, rewards, and penalties of MI (Pescosolidio, 2015).

Goffman explained that an individual becomes discredited by other people and society through various stigmas because of the differences they possess or unwanted behavior that they exhibit in their everyday life. Goffman (1963date, as cited in Atmaca, 2020) used the example of organizations that expect their members to follow specific, codified, and acceptable institutional norms and behavioral patterns and when the organization identifies unwanted behaviors, these differences are considered a type of deviance and can even stigmatize people with various labels. . Goffman (1963, as cited in Atmaca, 2020) then defined *stigmatization* as the “process in which people attempt to discredit, label, and ‘spoil’ the appearance and/or behavior of individuals who, according to the norms of a society, possess an unusual or unconventional appearance or who exhibit peculiar behavior” (p. 2).

Goffman noted that schools that have low academic achieving students who are forced to continue their academic education and do not fear public authority figures react strongly and reflexively against those authority figures. Goffman (1963date, as cited in Atmaca, 2020) noted that this type of behavior conflicts with the behavior of students when they are outside of the school and have control over their freedom. Goffman (1963, as cited in Atmaca, 2020) introduced the stigma theory in which he stated that “student behaviors which do not conform to the accepted behavioral patterns that square with school roles and duties are categorized and often stigmatized by the school administrators and teachers who represent authority” (p. 3). This type of stigmatization can trigger abnormal behaviors in which an individual’s process of creating abnormal identities speeds up (Atmaca, 2020).

Becker (2017, as cited in Atmaca, 2020) indicated that constantly reiterating stigma will eventually turn it into a self-fulfill prophecy. In other words, if a person is constantly subjected to any labeling that is a form of stigma, this person will eventually identify with the label. Goffman (1963date, as cited in Atmaca, 2020) concluded by stating that the “stigmatized person often begins to think that the behavior and attitudes that he or she has been exposed to are the result of intrinsic attributes that he or she possesses” (p. 122).

MI and Mental Illness Stigma Theory

MI is a medical condition that affects multiple people all over the world and has many diagnoses and symptoms that can cause unusual behaviors. MIs are health conditions involving changes in emotion, thinking, or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work, or family activities (Parekh, 2018). In the United States 19 percents of adults experience some type of MI, and 4.1% develop a serious MI (Parekh, 2018). Some of the diagnoses that are considered MI are depression, anxiety, bipolar disorder, dissociative disorder, and schizophrenia (National Alliance on Mental Illness, 2021). Symptoms that are common with most of these diagnoses that can change a person’s behavior are

- excessive worrying or fear
- feeling excessively sad or low
- confused thinking or problems concentrating and learning

- extreme mood changes, including uncontrollable “highs” or feelings of euphoria
- prolonged or strong feelings of irritability or anger
- avoiding friends and social activities
- difficulties understanding or relating to other people
- changes in sleeping habits or feeling tired and low energy
- changes in eating habits such as increased hunger or lack of appetite

Many people do not seek treatment or are unaware that these symptoms are connected to MI and experience a change in their daily functions of life (National Alliance on Mental Illness, 2021). MI is an illness that changes an individual’s behavior, and when MI stigma is involved, it also affects the daily living of people diagnosed with MI. According to Elbulok-Charcape et al. (2021) mental health stigma contributes to lower quality of life, social support, important relationships, education, income, and health care. Misconceptions, challenges, and labels continue to affect people with MI because they are expected to look different from other human beings (National Alliance on Mental Illness, 2021).

The MI stigma framework provided clarity on terminology used in the current study to provide an understanding of the stigma perceived and stigmatizer perception of MI. The mental illness stigma framework provides a common framework and terminology for understanding mechanisms of MI stigma that are relevant to the study of the stigmatized and the stigmatizer (Fox et al., 2018). The mental illness stigma framework was developed from a few MI stigma theories, conceptualizations, and definitions as well as modified labeling theories that address anticipated and experienced discrimination (Fox et al., 2018). A key benefit of using this framework in conjunction with other theories is that it ties together the immense and varied body of MI stigma research, which is important in delineated the types of stigmas that are most important to outcomes for people with MI regardless of the diagnosis (Fox et al., 2018). This framework represents MI from a culturally and socially devalued identity in which people with MI respond and experience MI stigma (Fox et al., 2018).

Using this framework with Goffman's stigma theory provided a basic understanding of the perception of the stigmatized individual and the different types of stigmas experienced that can lead to the challenges and barriers experienced by human service professionals who used a stigma reduction treatment on people with MI. The stigma of MI is the primary cause of multiple barriers to positive treatment outcomes. MI stigma is a major obstacle to the well-being among people with MI (Fox et al., 2018). The effects of MI stigma are harmful and pervasive. These effects can have a negative impact on help-seeking behaviors and initial access to mental health care. Some of these effects include poor treatment engagement, poor attendance with treatment, and poorer treatment outcomes (Hack et al., 2020). MI stigma also hinders people with MI from finding housing, employment, and purposeful relationships that provide a meaningful quality of life. In contrast to the effects of mental illness stigma, people with MI lack social support (Kondrat et al., 2018). MI stigma is a process that starts with labeling and ends with some type of discrimination that affects not only individuals with MI but also the family members who support them (Borenstein, 2020).

Although it is understood how MI stigma can affect family members of those with MI, it is also important to understand stigma around MI in diverse racial and ethnic communities. MI stigma can be a major barrier to people from different cultures trying to access mental health services (Borenstein, 2020). Understanding stigma associated with MI is not only a concern for urban communities but also a concern for increasing use of mental health services in rural and economically deprived communities. A survey that was conducted in 2016 that compared the concerns of MI in an urban area to those in a rural area found that 18.7% of residents (approximately 6.5 million citizens) in nonmetropolitan counties had a mental health concern, and 3.9% (approximately 1.3 million) experienced thoughts of suicide (Crumb et al., 2019; Substance Abuse and Mental Health Administration Center for Behavior health Statistic and Quality, 2017). Help seeking for mental health treatment for children and adults in rural low-income communities in the United States is crucial (Crumb et al., 2019). It is also crucial to have knowledge not only on stigma but also on the many different types of stigmas that impact positive treatment outcomes.

Types of Stigmas

Public Stigma

Public stigma involves the negative or discriminatory attitudes that others have about MI (Borenstein, 2020). Public stigma is also viewed as stigma from the public representing stereotypes, prejudices, and discrimination related to mental illness (Crumb et al., 2019). When public stigma is focused on a specific group such as people with MI, it becomes public MI stigma.

Public MI stigma is composed of multifaceted labels such as negative attitudes, attributions, and stereotypes from the public's point of view toward people with MI; these labels can become internalized and affect the behaviors of people with MI (Johnson-Kwochka et al., 2021). To better understand the effects of these attributions from the public, it is important to understand how public stigma is internalized and can cause self-beliefs (Johnson-Kwochka et al., 2021). Stigma that is internalized leads to self-stigma.

Internalized Stigma

Internalized stigma is described as the stigma a person internalizes after experiencing public stigma. This type of stigma experienced has adverse effects which include eroding an individual's social standing, social networks, and contributing to diminished self-esteem and slower recovery (Tanabe et al., 2016). Persons with mental illness who experience internalized stigma also suffer from economic, social, and cultural violations of discrimination which often leads to isolation and eventually becomes a barrier to healthcare (World Health Organization (Who), 2015; Del Rosal et al.,2021). However, internalized stigma reduces the chances of a person with mental illness to seek psychological help because of the negative attitudes that relate to negative intentions of seeking psychological help (Zia & Mackenzie 2021). Psychological and behavioral health behaviors are often elevated by internalized stigma and because of socially devalued attributes, and acceptance of this devaluation treatment is not sought by persons with mental illness (Brown & Batty,2021). The high degree of comorbidity amongst physical, psychological, and behavioral conditions experienced by persons with MI causes an inability to treat physical health conditions due to stigma which may represent a miss opportunity for clinical treatments aim at improving the psychological and behavioral well-being of mental illness (Brown & Batty, 2021). According to Maslow's Hierarchy of Needs (1943) if some of the most important needs are not met, we may be unable to progress to meet our other needs (Bowen,2020).

Self-Stigma

Self-Stigma is a bit different. Self-stigma refers to the negative attitudes, including internalized shame, that people with mental illness have about their own condition (Borenstein, 2020). This type of stigma can be viewed as the notion that a person who internalizes the negative attitudes about mental health issues, results in lowered self-esteem and self-worth (Crumb et al., 2019). It is important to note that self-stigma is a form of internalizing societal thoughts and negative self-thoughts that over time diminish self-efficacy, self-esteem, and psychological well-being of a person with MI (Chan & Lam, 2018). The self-stigma of seeking help refers to an individual's internalization of public stigma, in which people with mental illness see their own treatment seeking in a negative light (Zia & Mackenzie, 2021). Self-stigma can have a negative impact on the physical and mental well-being of a person with MI if not treated.

Individuals sometimes tend to avoid seeking help because of stigma. It is noted that 18% of adults who are 18 years of age with a mental illness in the United States avoid seeking psychological help or prematurely drop out of treatment due to the stigma of mental illness (Keum et al., 2018). Reducing self-stigma may improve the attitudes of persons with mental illness to seek out help for the purposes of improving their psychological and emotional well-being (Keum et al., 2018). Improving the psychological and emotional well- being of a person with mental illness are essential to reducing self-stigma (Keum et as.,2018).

Effects of Stigma on People With MI

Poor Engagement With Providers

Poor engagement with providers may be one stigma-related issue. Effects of mental health stigma are pervasive and harmful unfortunately persons with mental illness may not actively engage in treatment and often stop attending mental health services all together (Hack et al., 2020). When persons with MI experience stigma, discrimination, or disrespect during treatment these experiences become barriers to treatment and prevent active engagement with providers (Hack et al., 2020). Engagement with providers is a form of communication that is needed for successful outcomes within treatment.

Loss of Employment

Employers who hire people with mental health disorders can create barriers for the gain of successful employment. One of the major concerns for persons with mental health disorders is prejudgment from employers' attitudes about the negative stereotypes that have been established from public stigma. Some of the concerns that create stigma and loss of employment are that persons with MI are not competent to meet the demands of the company, constant supervision is needed, and working is not healthy for persons with MI (Brouwers, 2020). Such labeling in the workplace can decrease engagement with the public and cause further isolation from seeking treatment.

Lack of Physical and Mental Care

One of the major concerns that human service professionals are up against when treating persons with mental illness is the gap in physical and mental care. Any type of stigma perceived by persons with MI creates a barrier for this population to seek any type of physical and mental care. Researchers suggest that the fear of being subjected to public stigma can hinder a person with MI from seeking help and change the attitude of the persons realization of accepting their disorder (Horsfield et al., 2020). Reducing the stigma experience of a person with MI is crucial to overcoming barriers to treatment.

Although it is important that human service professionals are prepared to treat all persons with MI especially those who experience severe behavioral interruptions. Only a small percentage of persons with mental illness experience psychomotor agitation. Agitation and bizarre behavior are stereotypes created about people with mental illness, and these intensify when a patient has a crisis and prevents persons with mental illness from seeking care (da Silva et al.,2020). Understanding the impact of stigma on mental and physical care can prevent isolation of urgent and non-urgent matters.

Cultural Beliefs and Values That Impact Stigma

Many families of different cultural backgrounds are challenge with taking care of members in their family who have a mental illness. However, mental illness can affect any human being at any given time without warning. One of the challenges experienced by persons with mental illness that impacts stigma is a family’s cultural belief or value. For instance, in India 5.8% to 7.3% of the total population, which translate to around 150 million people in India are affected by mental illness.

Positive outcomes are generally scarce, even with treatment. It is suggested that the lack of positive outcomes with treatment is created by barriers such as insufficient funding from the government and stigma perceived by persons with mental illness and their caregivers (Boge et al., 2018). However, when looking at countries that are of Asian descent it is suggested that stigma is perceived greater because of stereotypes such as dangerous and aggressive. The factors that result in such stereotypes are linked to religion and low education (Boge et al., 2018). In India is suggested that cultural norms impact the perception of stigma and stigma perceived both by the patient and caregiver.

This cultural impact does make the experience different. This suggested perception of how stigma is perceived in India with women caregivers is because women caregivers feel burdened and incapable of coping with stigma attached to mental illness (Boge et al., 2018). When looking at the United States and Western Countries cultural influences on mental illness stigma, it is suggested that the attitudes toward mental illness are based on family’s beliefs, religion, and public reactions toward MI (Taghva et al., 2017). In Iran fear and shame are barriers that keep persons with mental illness from seeking treatment it is suggested that families and friends should abandon treatment to avoid the repercussions of stigma. Family members who care for those with mental illness are forbidden to talk about the illness due to cultural beliefs (Taghva et al., 2017). In Iran it is a cultural value to be a perfectionist and to have a mental illness is consider a defect which in this culture increases mental illness stigma (Taghva et al. ,2017). Obtaining an understanding of cultural views on stigma may assist with how stigma is viewed globally and impacts care.

Even within countries, like the United States, culture can make a difference. When looking at the opposite end of the globe in the United States, the African American culture is more likely to distance themselves from persons with mental illness because of labels that suggest MI persons are dangerous (Abdullah & Brown, 2020). It was also suggested from prior studies that studied the cultural beliefs and impacts of stigma amongst African Americans that not every disorder was considered dangerous. African Americans believe that the only dangerous disorder was a person suffering from schizophrenia (Abdullah & Brown, 2020). This cultural belief is consistent with Goffman's stigma theory (1963) in which the definition of the stigmatizer and it process is explained.

Goffman's stigma theory (1963) states that stigmatization is the" process in which people attempt to discredit, label, and 'spoil' the appearance and/or behavior of individuals. These individuals, according to the norms of a society, possess an unusual or unconventional appearance or who exhibit peculiar behavior" (Goffman, 2014; ATMACA,2020, p.2). Nonetheless, it is important to understand how cultural beliefs can impact the decision of a person with a mental illness to seek treatment because of stigma. Almost one-quarter (1.8 billion people) of the world's population identify as Muslim (Lipka & Hackett, 2017). In Australia 2.6 percent of the population identifies as a Muslim which translates into 50 percent of the population identify as a Muslim (2006-to-2016; Australian Bureau of Statistics, 2017a). The Muslim culture in Australia strongly practices cultural, religious, and spiritual attributions to explain the etiology of mental illness. However, this can lead to isolation, physical and mental health disparities between persons with mental illness and persons without.

For those persons with mental illness who follow the CALD Muslim culture in Australia the outcome of seeking assistance will be less than non-CALD Muslims (Bairami et al., 2021). One of main barriers reported within this culture was societal stigma along with the fear of confidentiality. It was noted that historically and cross-culturally that mental illness was seen as having a demon and being treated with religious practices (Bairami et al., 2021). Because religion and culture often merge within the Muslim culture and the Islamic way of life guidance is sought from researchers (see Bairami et al., 2021) that suggests that cultural attributions are define as prevalent mental illness attributions in Islamic culture, underpinned by Islamic theology.

Here is a case where religion and culture overlap, and that is critical. Because Muslims comprise the majority religious identity in countries as diverse as Indonesia (88.2%), Pakistan (96.3%), Turkey (98.0%), and Albania, clinicians should be made aware of the cultural beliefs of Muslims. Having knowledge of providing safe practices when treatments are used with the hope to reduce stigma and increase positive outcomes, clinicians who treat persons with mental illness that practice the Muslim beliefs should be made aware of their cultural beliefs to provide successful treatments (Pew Research Center, 2017; Bairami et al., 2021). This information could reduce one of the barriers to challenges within treatment due to cultural beliefs.

Stakeholders' Challenges and Barriers With Treating Stigma

Reducing stigma and finding the best practices for persons with mental illness can sometimes present multiple challenges for human service professionals. Some of these challenges are because stigma must first be understood from multiple perspectives. The reduction of stigma towards people with a mental diagnosis is one of the great challenges of public health at global (World Health Organization [WHO], 2016). There are two perspectives that are suggested by researchers for stigma to be understood and how challenges with stigma treatments can be overcome. The first perspective looks at an experiential perspective in which stigma is perceived and most consider it a belief (Gronholm et al.,2017). The second viewpoint under experiential can be viewed as endorsed stigma in which means persons with mental illness can perceived this to be a label or stereotype. The third viewpoint under experiential is received stigma in which a person experiences rejection or devaluation and then exhibits discriminatory behavior in which Goffman (1963) states that when stigma is perceived by a person with mental illness a person with MI "will exhibit a peculiar behavior" (Gronholm et al., 2017). Understanding how stigma impacts a person's behavior is important for overcoming barriers within treatment.

The second perspective which researchers suggest should be taken into consideration is stigma as being action oriented. This viewpoint looks at who or what gives and receives the stigma. Under action-oriented stigma it is suggested that these stigmas be understood as *public stigma, structured stigma, self-stigma,* and *provider stigma* (Groholm et al.,2017). Another challenge that may impact the use of using a stigma treatment is the relationship between pharmaceutical companies and government funded organizations who utilize medications that are psychotropic for persons with mental illness to promote certain medications for self-gain (Groholm et al., 2017). Researchers suggest that to reduce stigma and discrimination one's mental disorder must be included. The type of stigma experienced or perceived, the duration of the stigma and the impact stigma made on the person's mental health must also be considered for overcoming challenges when using a stigma reduction treatment (Groholm et al., 2017). Taking into account the factors that may impact treatment outcomes such as the type of stigma perceived is essential for positive treatment outcomes.

However, professionals who have a more negative attitude about approaching their users because they do not know how to contribute to their treatment can present a challenge for both user and receiver (Grandón et al., 2021). Another challenge that can create the misuse of a stigma reduction treatment is not knowing what level (micro or macro) the stigma was perceived on (Holder et al., 2018). Focusing on specific individual dimensions and not taking other factors into consideration such as the type of stigma perceive limits the scope of treatment and presents future challenges (Grandon et al., 2021). Considering where the stigma occurred and whom the stigmatizer was can reduce the negative impact the stigma has for the receiver and provider.

It could be beneficial to persons with mental illness if clinicians have a basic understanding of how the different types of stigmas not only affect a person with mental illness but can influence cultural perspectives on mental illness. There is a possibility that having knowledge of these cultural views that the challenge of positive outcomes with stigma reduction treatments can be reduced. Nonetheless, there are still barriers with stigma treatments that should be considered as clinicians seek to overcome the challenge of using stigma treatments on person with mental illness. I will further describe this in the next section.

Barriers With Stigma Treatments

Experiencing mental illness stigma is a barrier for persons with MI who are help seeking mental health services and contributes to the mental health treatment gap (Kaur et al., 2021). Mental illness stigma currently constitutes as one of the most substantial barriers to using mental health services (Casados, 2017). Mental illness stigma consists of public, self, and internalized stigma and these types of stigmas can have a different impact on a person with MI. Becoming familiar with these different types of stigmas could possibly reduce some of the challenges and barriers to reducing a person with MI stigma experience.

The use of mental health services is crucial to persons with mental illness because it is the only source of assistance in which a person with MI can seek the needed help for their mental well-being and communicate ongoing issues and concerns that limit services. Issues that prevent barriers with stigma reduction treatments can lead to negative outcomes with patients. Some of these issues are patient safety concerns due to perceived stigma, lack of therapeutic relationships and the discontinuation of services too early due to stigma experienced (Knaak et al., 2017). Researchers suggest that using an effective method to reduce barriers with stigma treatments should first be modeled by program facilitators. It is suggested that a key ingredient to reducing barriers with stigma treatments include hearing the lived experience of a person with mental illness who is trained to speak about their diagnosis, stigma experience, recovery as well as healthcare treatment (Knaak et al., 2017). This step could be used as a preventive measure to overcome barriers with stigma outcomes.

Another suggested ingredient to reducing challenges with stigma treatments should be the use of including myth busting and transformative learning to target unconscious biases with the hope of correcting false beliefs that may be negatively impacting care (Knaak et al., 2017). Researchers suggest that including action-oriented elements that are focused on changing the behavior of both the provider’s attitude toward the client as well as the attitude of the client toward the practitioner can lead to increase in positive treatment outcomes (Knaak et al., 2017). However, implementing an action such as the practitioner actively meeting with a person with mental illness in different stages of recovery to learn about that person’s life and experience stigma can assist with barriers to stigma treatments (Knaak et al., 2017). Understanding the stages of recovery can be used as a prevention method to overcome barriers and increase positive outcomes within treatment settings.

When stigma treatments are incorporated within the treatment plan of those with mental illness it is important to consider a person’s diagnosis, culture, and stigma experience. Considering these factors could reduce barriers, challenges and increase positive outcomes with stigma treatments for persons with mental illness.

Summary

Stigma affects the help seeking behavior of persons with mental illness in such a way that challenges and barriers for human service professionals are experienced to the degree that positive outcomes with Stigma treatments are limited (Tan et al., 2020). Chapter two provided detail influences that not only contributed to stigma experiences of mental illness but explained how mental illness stigma affects treatment outcomes. Some of these factors that contribute to the challenges of human services professionals and create barriers to treatment for persons with MI are not always made known. Considering how different cultures view mental illness and understanding their perception of having an attribute is an important factor for positive treatment outcomes. For successful treatment outcomes to take place researchers suggested that including specific ingredients when using stigma reduction treatments can assist with reducing challenges and barriers of treatment. It was noted that having a basic understanding of multiple types of stigmas experienced and understanding how these experiences reduce engagement within treatment can be beneficial to the success of treatment. Keeping in mind that one's religious belief and knowledge of one's caregiver belief can also be used to help overcome some of the challenges face by human service professionals who treat persons with mental illness.

Understanding the many factors that contribute to how a person with mental illness perceives and believes stigma is not only beneficial to the outcome but can help reduce barriers and challenges experienced by human service professionals who use stigma reduction treatments in an outpatient treatment setting. In Chapter 3 included the research methodology of my study.

Chapter 3: Research Method

The purpose of this generic qualitative study was to explore the experiences of stigma reduction treatments that are used by human service professionals to reduce stigma while treating people with MI. Challenges with stigma hinder people with MI from seeking out or following through with treatment; further, stigma interferes with the life opportunities of people with MI, including finding housing, employment, and meaningful relationships (Kondrat et al., 2018; Kondrat & Wilkins, 2014). In chapter 3, I provide the research design, rationale, my role as the researcher, the methodology, the instrument used, data analysis, and trustworthiness.

Research Design and Rationale

This generic qualitative study explored the perceptions of human service professionals regarding barriers, challenges, and successes in addressing stigma among people with MI that involved the use of a stigma reduction treatment. Using a generic qualitative design allowed me to explore, discover, and understand a phenomenon, a process, or the perspectives of the people involved in my study (see Cooper & Endacott, 2007). The use of qualitative methodology in my study was justified by these four key factors: (a) Stigmatization is complex, and qualitative research is well suited for exploring complex phenomena; (b) qualitative research is participatory and offers substantial opportunities for meaningful community engagement, which promotes agency and empowerment and redresses power imbalances; (c) qualitative research is imperative to effective stigma reduction; and (d) qualitative research informs further scientific inquiry and plays an important role in ensuring that researchers focus on important and relevant aspects of the research topic (Denzin & Lincoln, 2017; Stutterheim & Ratcliffe, 2021).

The generic qualitative approach, also called the basic or interpretive approach, can stand alone in which research questions are driven by the personal interest of the researcher, data are collected, and findings are constructed by researchers who may overidentify with participants and/or overinterpret data (Stutterheim & Ratcliffe, 2021). Generic qualitative research is also used to understand the perceptions or experiences of a phenomenon. Generic qualitative research is designed to focus on answering a research question that focuses on the perceptions or experiences of social problems or concerns. Conceptual and theoretical frameworks are used to support the research question and/or phenomenon (Maxwell, 2021). However, generic qualitative research draws on the strengths of one or more qualitative approaches. Patton (2015) noted that “because each qualitative study is unique, the analytical approach used will be unique” (p. 5227). Depending on the nature and goals of a study, researchers may find that one coding method will suffice, or that two or more are needed to capture the complex processes or phenomena in the data (Saldana, 2021). The aim is to draw out participants’ ideas about things that are outside themselves; rather than focusing on their feelings, the researcher seeks to understand a phenomenon, a process, or the perspectives of participants (Bellamy et al., 2016).

Research Question

What are human service professionals’ perceptions of challenges, barriers, and successes addressing stigma among clients with a mental illness in a treatment program that involves using a stigma reduction treatment?

Role of the Researcher

In qualitative research, the role of the researcher is primarily the data collection instrument (Ravitch & Carl, 2016). In the current study, I explored the perceptions of the participants to understand their interpretations of barriers, successes, and challenges. This process can be challenging at times because it requires the researcher to ask participants to recall moments that may be sensitive (Sutton & Austin, 2015). It is important that the researcher safeguards the participants and their data being collected (Sutton & Austin, 2015). As the researcher, I secured all data on a password-protected computer.

Although the researcher is listed as the primary instrument in qualitative studies, additional tools, surveys, and questionnaires can be used to collect data. During my social work journey, I observed and worked with members of the community who experience mental health issues and seem to decline in their physical and mental health. During numerous conservations with these members of the community, I asked why they thought their mental and physical health were declining. Some of the responses range from being labeled, fear of being committed to a mental institution, and they do not help me anyway. As a community social worker, I will continue to research topics that affect vulnerable populations and educate others within my scope of professional practice that can lead to social change.

Understanding the challenges experienced by human service professionals and people with MI because of stigma may help clinicians create the best practices and reduce the stigma experiences of those with MI. People with MI face many stereotypes including labels that suggest they are dangerous, incompetent, or weak. Internalizing these beliefs can lead to poorer self-esteem and self-efficacy, lower treatment engagement, decreased coping skills, depression, and hopelessness (Treichler et al., 2018). Targeting the behavioral outcomes of the stigmatization process both at the individual and the institutional levels is necessary to promote full and effective social participation for individuals with MI (Stuart, 2016). Having knowledge of the challenges that stigma can create alerted me to the impact that bias and personal opinions could have on the results of my study (see Pannucci & Wilkins, 2010). Relying on opinions without having factual evidence will create negative implications for research. A thorough understanding of bias and how it affects a study is essential for the practice of evidence-based medicine (Pannucci & Wilkins, 2010).

Methodology

This study included a generic qualitative approach. Human service professionals working in an outpatient setting with 1 or more years of experience working with people with MI were included in this study. Participants were also required to have knowledge and experience using a stigma reduction treatment in an outpatient setting. Using a generic qualitative approach allowed me as the researcher to seek an understanding of the challenges, barriers, and successes that are perceived by human service professionals in an outpatient setting (see Denzin & Lincoln, 2017). This approach did not require me as the researcher to use a specific framework or theory to guide the research question.

Using this approach, I could make interpretations without studying hermeneutics. I conducted open-ended interviews and made observations that were exploratory in nature (see Denzin & Lincoln, 2017; Patton, 2015). Qualitative research informs further scientific inquiry and plays a significant role in ensuring that the focus is on important and relevant aspects of the phenomenon being research (Stutterheim & Ratcliffe, 2021). Saldana's (2021) six-step process guided me in analyzing the data collected.

Participant Selection Logic

The population for this study consisted of human service professionals who had used a stigma reduction treatment with a person who has MI. Purposeful sampling was used to select the participants for this study. Purposeful sampling is widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest (Palinkas, 2015). Participants were selected using inclusion and exclusion criterion that allowed me to select a specific group of human service professionals who had worked with people with mental illness and used a stigma reduction treatment. This was vital to answering the research question. Inclusion criteria are the key features of the target population that the investigators will use to answer their research question, and exclusion criteria are the features of the potential study participants who meet the inclusion criteria but present with additional characteristics that could interfere with the success of the study or increase the risk of an unfavorable outcome (Patino & Ferreira, 2018). Sample sizes for qualitative studies are not always accurate because saturation needs to be reached.

The prevailing concept for sample size in qualitative studies is saturation. Saturation is closely tied to a specific methodology, and the term is inconsistently applied (Malterud et al., 2016). I used Saldana's (2021) first- and second-cycle coding methods to analyze data and answer my research question. Malterud et al. (2016) suggested that the size of a sample depends on (a) the aim of the study, (b) sample specificity, (c) use of established theory, (d) quality of dialogue, and (e) analysis strategy. Data saturation is reached when there is enough information to replicate the study, when the ability to obtain new information has ended, and when further coding is no longer feasible (Fusch & Ness, 2015).

Instrumentation

A researcher conducting a qualitative study is the main instrument (Denzin & Lincoln, 2017; Ravitch & Carl, 2016). In the current study, the main instrument that was used to conduct interviews consisted of a set of interview questions that were guided by an interview guide. This interview guide was created to answer my research question and allow me to gain a better understanding of the participants' perceptions.

The interviews were semistructured,and the questions were open-ended. The questions were created from reading multiple articles and reflecting on concerns that might open a dialogue with participants regarding their experiences using stigma reduction treatments. I also included some additional questions that were not created using the interview guide. These questions were formed from probing the participant during the first interview (see Appendix B). These interviews were conducted by Zoom to limit health concerns.

Data Collection

Procedures for Recruitment and Participation

To solicit participants for this study, I posted a flyer (see Appendix A) on social media accounts such as Facebook, LinkedIn, and Instagram. Participants were asked to respond by email after viewing my flyer on social media if they were interested in volunteering to participate. I replied via email to participants who expressed interest in my study.

To collect the necessary data for any type of research, the researcher must decide on the best methods that align with the study. For the current study, I used a sampling method that allowed me to purposefully select my participants. This allowed me to select participants who met my inclusion criteria and who were best suited to help me answer the research question.

Purposeful sampling is widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest (Palinkas, 2015). Included in my invitation to participate in my study were details about the study. The consent form was sent after I confirmed the participant’s eligibility. Once a participant responded to my flyer, an email was sent to the participant asking the participant to participate in a 5-minute phone call. During this phone call I asked the participant some screening questions to verify eligibility for participation:

1. Do you work in an outpatient setting that treats persons with mental illness?

2. How long have you worked in this outpatient setting?
3. Do you personally treat persons with mental illness?
4. Have you used a treatment that reduces the stigma experience of a person with MI in your current position?

Procedures and informed consent were communicated to participants before the interview. Interview procedures, voluntary nature of the interview, risks, privacy, contact, and interview question information was sent and discussed before any interview. After I reviewed the selected participants' information, I sent an email confirming their participation along with a consent form. I asked the participants to provide consent by replying to my email with "I consent." The form that I sent them was for their own records and did not need to be signed and returned.

Once the consent email was received, I emailed the participant to request their preferred interview platform (phone or Zoom). Before the interview began, I explained the purpose of the interview and informed the participant that they could withdraw from the interview at any time. I also informed the participant that the interview would be recorded via voice recorder on my phone or Zoom for research purposes only. I explained that the data collected would be kept in a protected file for authorized users only and then destroyed per IRB guidelines. To reach saturation, I used a sample size consisting of eight human service professionals.

Data were collected by me during one-on-one phone or Zoom semistructured interviews. I used a tape recorder or online recording capabilities, depending on the format of the interview and the capability of the software. I recorded phone interviews on a phone voice recorder. I recorded Zoom interviews on the Zoom platform. Each interview was guided by a series of questions that were prepared using an interview guide (see Appendix B).

At the scheduled time of each interview, I reviewed the information regarding informed consent, ethical research, and participants' rights. I also left time for any questions before proceeding with the interview. Participants had the opportunity to stop the interview at any time or drop out of the study if they wished.

Transcripts of each interview were created after the interview. I transcribed the conversation on a voice recorder or made use of software-based live captioning or transcription depending on the format of the interview. I also used transcript review to validate the responses of my participants.

In addition to interview transcript data, I also collected and analyzed data via member checking, analytic memos, and reflexive journaling. Member checking, also known as respondent or participant validation, is the process of soliciting feedback from participants or stakeholders about the data or interpretations. Member checking is commonly used to validate, verify, or assess the trustworthiness of qualitative results (Motulsky, 2021). Analytic memos were also used as a part of collecting data. This method allowed me to think carefully about the information received from my participants. Using this form of data collection can assist with key stories and their meanings (Tracy & Herberger, 2018). According to Tracy and Herberger (2018), some of the characteristics that this method provides are assisting with coding, providing examples of raw data that illustrate coding, and providing a connection to other codes.

Reflexive journaling was also used to help me as the researcher identify any biases that may occurred throughout data collection. Using this method increased my self-awareness and allowed me as the researcher to reflect on my feelings so that I did not impact the results of my study (see Gauthier et al., 2022). Reflective journaling is an important tool for self-reflection on information received and allows you to process important events shared. Writing a reflective journal provides the space to develop connections between theory and practice, and to examine thoughts, feelings, and beliefs to promote a deeper understanding of those experiences (Gauthier et al., 2022). Thus, data collection consisted of my interviews with participants, member checking with participants after each summary has been written, analytic memos to myself during the research process, and reflexive journaling to check my own thoughts and mitigate researcher bias.

Data Analysis

Data analysis is an important part of collecting information and breaking it down into feasible sections in which data can be used to assist with suggested conclusions. In this study, I used Saldana’s (2021) first and second cycle coding methods to analyze data and answer my research question. The six steps that were used to analyze and break down my data is as follows (see Saldana, 2021; Onwuegbuzie et al., 2016):

1. Identify and extract relevant data to analyze and synthesize.
2. Organize the data using a CAQDAS program
3. Determine what subsets of the data to code
4. Analyze what method of first coding should be used based on data collected

5. Apply the selected Saldana coding method to data chosen
6. Conduct a cross-case analysis of inference (categories, themes, & sub-themes).

After the first cycle of Saldana’s coding process was completed, I then implemented Saldana’s second cycle coding method. The primary goal during second cycle coding is to develop a sense of categorical, thematic, conceptual, and/or theoretical organization from the array of first cycle codes (Saldana, 2021). I looked for concepts and ideas that were repeating and that address my research question.

After coding and reviewing the interview data and my notes multiple times, I created categories. Categories are groups of themes that help a researcher to manage and make sense of data (Saldana, 2021). Categories indicate the main topic areas that the codes fall into and from which the researcher can begin to generate themes (Saldana, 2021). Themes are the ultimate goal of coding and answer the RQ.

To generate themes that can be used to better understand the perceptions of human services challenges, barriers, and successes I created a table presenting my codes and categories. A Microsoft document and table was created to track the use and frequency of the codes, as well as organizing them into categories. Then, I used the frequencies of codes and categories to point me toward frequently used codes. This is how a researcher generates themes (Saldana, 2021). The final step consisted of reviewing themes that emerge to summarize the perceptions of human service challenges, barriers, and successes with stigma reduction treatments.

Issues of Trustworthiness

Credibility

Promoting trustworthiness within qualitative research means first involving the process of *credibility* which includes the researcher having confidence in the findings. Peer debriefing and journaling are strategies to establishing credibility (Amankwaa, 2016). A reflexive journal was utilized to provide reinforcement of rigorous research habits and rich notes once the data collection begun. Reflective journals are used in literature to promote students' learning, develop writing skills, assess students' reflection level, promote teachers' professional development, and gather research data (Ahmed,2019).

Transferability

Transferability, or external validity, within qualitative research, means demonstrating that the findings may have applicability in another context (Amankwaa, 2016). The nature of transferability, the extent to which findings are useful to persons in other settings, is different from other aspects of research in that readers and researchers determine how applicable the findings are to their situations (Connelly, 2016; Polit & Beck, 2014). Transferability can be promoted by the researcher supplying a rich, detailed description of the context, location, and participants studied, and by being transparent about analysis and trustworthiness (Connelly, 2016). Reflexive journaling can also help with promoting transferability.

Dependability

Dependability refers to the stability of the data over time and over the conditions of the study (Connelly, 2016; Polit & Beck, 2014). In qualitative research dependability can be established by using a technique named inquiry audit which audits are conducted by having a researcher that is not involved in the research process examine both the process and product of the research study (Amankwaa,2016; Lincoln & Guba, 1985). This study use semi structure interviews guided by an interview guide and purposeful sampling. Reflexive journaling and rich descriptions also help promote the dependability of the data.

Confirmability

Confirmability means the degree findings are consistent and could be repeated (Connelly, 2016). Confirmability is also concerned with establishing the fact that the data and interpretations of an inquiry were not merely figments of the inquirer's imagination (Schwandt, 2007). Reflexivity and reflexive journaling can help promote confirmability. However, for a researcher to achieve reflexivity the researcher must have self-awareness and be actively involved in the research process. It is a continuous process of reflection by researchers on their values (Parahoo, 2006) and of recognizing, examining, and understanding how their "social background, location and assumptions affect their research practice" (Hesse-Biber, 2007, p. 17; Palaganas, 2017). The use of reflexive journaling will be used weekly to help work through the researcher's biases, thoughts, and assumptions regarding data collection. Researcher reflexivity is the active and ongoing awareness of addressing the researcher's role and influence in the construction of and relational contribution to meaning and interpretation throughout the research process (Ravitch & Carl, 2016). Acknowledging these biases, journaling, and specific descriptions of the data collection and analysis processes can help promote confirmability.

Ethical Procedures

Before collecting data, I obtain approval from the Walden Institutional Review Board). All participants' personal information was kept confidential. Participants were not coerced, intimidated, or pressured to participate. The option for withdrawal was made known before the study took place. All data that is provided with actual names will remain confidential to protect the participant and the client of the participant. All interviews and personal information including data were kept securely on a password protected computer.

Only those who are authorized to see supporting documentation (i.e., committee members) will have access to the collected data. All data from the study will be destroyed after 5 years, as required by IRB guidelines.

Summary

The purpose of this qualitative study was to explore the challenges, barriers and successes of human service professionals who have experience using a stigma reduction treatment. In Chapter 3 the focus was to present an understanding of the research design and the rationale for using the design. The methodology used in this study was also discussed, as well as how it supports the phenomenon and the research question. The researcher role was also established along with providing information on the trustworthiness of the study. I Also discussed the potential participants, as well as the data collection, and data analysis procedures.

The literature provided under the trustworthiness section of the study also identifies the importance of the researcher’s credibility, nature of transability and the dependability of the techniques used. The researcher instrument was discussed and how data would be collected along with the use of tools needed for data collection. Knowledge of who could participate in the study was also discussed along with the criteria for participants who voluntarily choose to participate. The type of sampling technique was also discussed along with why that method was chosen. There was also a brief mention of how the data would be collected and the two methods used to collect the data using Covid 19 safety precautions. The ethical procedures were also discussed as well as what happens with the data after it is no longer being utilized. Chapter 3 concluded with an overview of the procedures and policies that were used to guide the results that will be discussed in Chapter 4.

Chapter 4: Results

Reducing the stigma experienced by a person with MI is important for successful treatment. Stigma experienced by people with MI can affect the outcome of treatment and cause a gap in future treatment. The purpose of this generic qualitative study was to understand the human service professionals' perceptions of challenges, barriers, and successes addressing stigma among clients with MI in a treatment program that involves using a stigma reduction treatment. This chapter provide an overview of the results that were used to answer the following research question: What are human service professionals' perceptions of challenges, barriers, and successes addressing stigma among clients with a mental illness in a treatment program that involves using a stigma reduction treatment? The results in this chapter focus on the challenges and successes of human service professionals who used an intervention that focused on reducing the stigma of a person with MI. Four themes were generated from participants' perceptions of the challenges, barriers, and successes using a stigma reduction intervention. This chapter also includes a description of the setting in which the interviews took place, participant demographics, data collection, data analysis, and evidence of trustworthiness.

Setting

The study was conducted virtually through Zoom video conferencing to limit the risk of COVID-19 transmission. All interviews were held in a room in which I protected the data being received. I did not turn the camera on to protect the identity of each participant and to allow the participant to feel comfortable while responding. All interviews were recorded and saved in a lock file on the researcher computer. The interviews were uploaded to Microsoft Word and transcribed to a Word document in which transcript review was used to confirm the data received. Each participant was notified that the transcription of the interview was complete and was sent an email with a copy of their transcript to confirm what was recorded and transcribe during the interview. After the transcription was verified, the transcript was placed in a folder labeled with the participant’s number and kept in a secure place.

An interview guide guided the semistructured interviews and allowed me to obtain the data needed to answer the research question. The interviews were scheduled for 45to 60 minutes to allow the participants to provide rich information. Each interview lasted from 45 to 50 minutes. I conducted eight interviews in which data saturation was reached after the fifth interview. Data saturation was determined by the repetitive information that was received from the participants during the interview process. I completed all eight interviews that I had scheduled to ensure rich data from different perspectives. The participants were a cohesive group of human service professionals who provided treatment to people with MI and who used a stigma reduction intervention in an outpatient setting. The participants worked in outpatient settings throughout Pennsylvania.

Demographics

The sample consisted of eight human services professionals who had more than 1 year of experience working with people with MI. The sample included two nurses, two licensed social workers, two mental health therapists, one licensed psychologist, and one mental health supervisor. Each human service professional worked in an outpatient setting in Pennsylvania. Each participant was given a unique number beginning with the letters HP. The participants were also identified by their profession and years of service. I did not use any names of participants or organization names to protect the identity of participants. Table 1 provides a detailed overview of the participant's demographic.

Table 1

Participant Demographics

Participant	Occupation	Occupation tenure
HP001	Licensed social worker	6 years
HP002	Psychiatric nurse	5 years
HP003	Mental health therapist	2 years
HP004	Psychiatric nurse	5 years
HP005	Psychologist	14 years
HP006	Mental health supervisor	8 years
HP007	Mental health therapist	4 years
HP008	Licensed clinical social worker	7 years

Data Collection

The participant recruitment process started after I received notification from the IRB that my study was approved. I prepared a flyer (see Appendix A) containing detailed information about the study, participants' requirements, and my contact information. The recruitment of participants was conducted virtually by posting my flyer on social media sites such as LinkedIn and private groups on Facebook that focused on mental health and social services. Using purposive sampling and snowballing, I was able to recruit eight participants who were interested in participating in my study.

The eight participants who volunteered to participate in my study each received a consent form via email that explained the purpose, procedures, risks, and benefits of the study. The participants were reassured that their identity would be kept confidential and if they had any questions, they could email me or Walden’s IRB advocate. I also assured the participants that I would be the only one with access to their data and no one else could access their information without signed consent.

After the participants provided consent via email by replying “I consent,” I asked participants how they would like to conduct the interview by via phone or Zoom with camera off. All eight participants chose to have their one-on-one interviews conducted through Zoom. Each interview lasted 40–50 minutes. Before each video began, I made the participants aware that their camera did not need to be on and that the Zoom interview would be recorded as stated in the consent form. After each interview was conducted, I thanked the participants for their time and sent a $25 gift card via email.

All eight participants were reminded that the data would be stored in a locked file for 5 years and then properly destroyed. Within 48 hours after the interview was transcribed by Microsoft software, I conducted transcript review to ensure credibility and accuracy of the information provided. All participants were provided with a copy of the transcript to confirm the information and maintain the integrity of the study. I also set aside 25 minutes after each interview to conduct reflective journaling. Writing in a reflective journal provides an opportunity to develop connections between theory and practice and to examine thoughts, feelings, and beliefs to promote a deeper understanding of those experiences (Gauthier et al., 2022).

Data saturation was reached at the fifth participant; however, I continued to interview participants to provide a nonbiased sample. There was no new information obtained from the last three participants, and the information was consisted with the previous five participants. Smaller sample sizes allow the researcher to be focused on the in-depth understanding of a social or cultural context that is generally not possible through studying the larger samples (Subedi, 2021). Generic qualitative research is designed to focus on answering a research question that focuses on the perceptions or experiences of social problems or concerns (Maxwell, 2021)**.**

Data Analysis

The data were analyzed by using Microsoft Word. I transcribed the audio file of each Zoom audio recording into a Word document. I then listened to each Zoom audio recording to ensure that the accuracy of the interview was manually documented and to capture the verbatim participant response. To refrain from judging or displaying subjectivity, I conducted data bracketing before the transcription of all interviews. Bracketing is a method in which the researcher mitigates potentially deleterious effects of preconceptions that may taint the research. I journaled some notes about my feelings after each interview to prevent any biases and to reflect on the purpose of the interview. This method was used to mitigate potential assumptions, beliefs, and personal biases.

Using Saldana’s (2021) first- and second-cycle coding methods, I was able to analyze eight semistructured interviews. Using this method, I gained a better understanding of the information and reviewed each transcript twice to become familiar with the data. The analytic memos that I used in conjunction with reflexive journaling provided a significant and meaningful understanding of each participant’s responses to the research questions that were asked.

The next step that was taken was to use the unique identification number provided to each participant to set up a locked file for the transcription of the Zoom audio. After each Zoom audio recording was transcribed by Microsoft Word and added to that document, it was placed back in the locked file until all interviews were completed. The first step using Saldana’s (2021) six-step process is to identify and extract relevant data. This process was completed using a system call Delve. Using the Delve system, I was able to create a coding chart in which 18 codes were generated. Each interview was uploaded to Delve, and I was able to maintain and keep track of the codes generated and the use of the codes (see Table 2). The coding chart was generated by highlighting specific responses while looking at the interview questions.

Table 2

Coding Chart

Code	Participant	Frequency of use
Lack of funding/education	HP001, HP002, HP005	12
Focus on behavior	HP002, HP003, HP004, HP005, HP008	15
Meeting patient where they are	HP003, HP002, HP001, HP006, HP004, HP008	10
Family communication	HP004, HP003, HP005	6
Nonmedical interventions	HP005, HP001, HP002, HP003 ,HP008	11
Lack of understanding	HP006, HP002, HP001	8
Resentment	HP007, HP002, HP001, HP004	12
Lump together	HP008, HP004, HP003	10
Medication focus	HP001, HP002, HP005, HP006	12
Staff shortage	HP001, HP003, HP005	5
Prevention training, educational traing	HP002, HP005, HP004, HP008	8
Labeling, lack of confidence	HP001, HP002, HP003, HP004, HP008, HP005	19
Motivation through incentives	HP001, HP002, HP003, HP005	8
Patient not understanding diagnosis	HP002, HP006, HP008	5
Fear/embrassment, repeated cycle	HP001, HP002, HP004, HP006, HP008	8
Standard assessments, general procedues, standard protocol	HP001, HP002, HP003, HP005, HP004, HP,006, HP007, HP008	9

Saldana’s (2021) second-cycle coding consisted of reviewing prior codes generated through Delve and condensing similar code words to create categories. Delve allows researchers to organize their codes and quotes by uploading the transcripts to the program and highlighting the quotes while giving them code names. Delve organizes all quotes and codes for all transcripts and keeps them in one file. This process consisted of highlighting specific phrases that shared similar code words and then placing those code words into a category.

After categorizing the data using Delve, I was able to generate seven themes. The code words were put into categories to generate the themes . These seven themes provided the answer to my research question:

- working through the shortage of resources
- generalizing standards and procedures
- making use of one-to-one time
- the importance of education and communication with family
- use of medical and nonmedical interventions
- remembering people are still human beings
- pressing through the revolving door

Evidence of Trustworthiness

Establishing trustworthiness in a qualitative study is a vital component in the research process. Trustworthiness involves four major components that assist with the reliability of the study: credibility, transferability, dependability, and confirmability. To establish trustworthiness, I endeavored to be transparent with my participants. According to Shufutinsky (2020), employing the use of self for transparency allows other researchers to repeat or test a study, and it permits readers and stakeholders to understand the steps that were taken for the study.

Credibility has been defined as the internal validity of a study, or the establishment that the researcher's interpretation matches their participants or the factual accuracy of the account (Morris & Paris, 2022). To establish credibility in my study, I used a process call transcript review. Transcript review involves the researcher sending the transcript back to participants for confirmation of its accuracy (Morris & Paris, 2022). Each participant received a follow-up call and a copy of their transcript to ensure the accuracy of the data collected. To ensure the credibility of the study, I also used reflexive journaling in which I journaled my thoughts and feelings after each interview, which allowed me to separate my biases and opinions from the study. Using reflexive journaling helped me increase my self-awareness throughout the interview process and identify biases that I was unaware of.

Transferability was addressed by using purposeful sampling. Purposeful sampling is a method in which the researcher seeks rich information by purposefully selecting participants. According to Nyirenda et al. (2020), transferability is the applicability of findings to other contexts achieved through thorough description of the study context and assumptions. Eight participants were purposefully selected and interviewed to provide data to answer the research question.

Dependability (reliability) is the degree to which a study can be replicated, and whether, when there is more than one observer, members of the research team agree about what they see and hear (Nyirenda et al., 2020). The dependability of the current study was bolstered by providing a clear explanation of how the study was conducted from beginning to end. Guidance from expert faculty members was also used to maintain the integrity of the study. I also provided definitions, interpretations, an interview guide, and digital recordings in which data were gathered to answer the research question.

Confirmability (objectivity) is neutrality of the researcher in interpreting findings these findings being free from bias, including social-desirability bias (Nyirenda et al,2020). To help maintain confirmability reflexive journaling was used in which my self-awareness of my own beliefs, experiences and biases was separated from the participant's response to avoid false misrepresentation of the study. Reflexivity is how one's beliefs and experiences can influence the research process, including participant responses and how data are collected, interpreted, analyzed, and presented and can be challenging for new researchers (Nyirenda et al,2020). Journaling after each interview assisted me with reflexivity and identifying biases that I was aware and unaware of. However, creating memos after each interview helped me maintain the integrity of my study.

Results of the Study

This study was conducted and led by the following research question: What are human service professionals' perceptions of challenges, barriers, and successes addressing stigma among clients with a mental illness in a treatment program that involves using a stigma reduction treatment? As the researcher conducting this study it was important for me to understand the challenges that human service professionals experience as well as the successes and barriers. These perceptions that were provided from the eight participants who work in an outpatient setting and treat persons with mental illness who have experienced stigma answered my research question.

Understanding how stigma affects persons with a mental illness and having knowledge of the challenges, successes, and barriers that human service professionals experience while treating this population can assist with evidence base practices. The eight participants that participated in the study all meant the criteria that was listed on the flyer (Appendix A). The following seven themes emerged from the data collected.

- working through a shortage of resources
- generalizing standards and procedures
- making use of one-to-one time
- the importance of education and communication with staff and family
- Use of medical and nonmedical interventions
- remembering that people are still human beings
- pressing through the revolving door

Each of these themes were generated by the participants' perceptions which were transcribed, coded, and categorize.

Theme 1: Working Through a Shortage of Resources

This theme was built from the following code words which were categorized to create the theme: lack of funding, lack of staff, and lack of education. Each of the participants shared how they experienced working with limited staff which presented a challenge when treating patients in the clinic. The question asked was: Please explain to me in your own words what other challenges stigma of mental health can have on human service professionals who provide services to persons with mental illness? These participants stated how not having enough staff can shorten the length of a patient’s treatment. For example, HP002 stated that” I would say that short staffing is another challenge because if we are down a nurse and I have to jump into another role it causes problems with the current treatment I am trying to provide.” Participants HP0001, HP0003, and HP0005 concluded that the length of the treatment affects the outcome of the intervention being used. For example, HP0003 stated that if the organization is down a MH therapist and she must increase her caseload to accommodate patients being seen, the treatment time can be cut short by 15 minutes to allow all patients to be treated. HP003 stated that this causes challenges with the outcome of the intervention being successfully implemented.

HP0001, HP0002, and HP0005 reported that when an organization experiences lack of funding it presents barriers to participants receiving continuing treatment which causes challenges for not only the staff but participants whose treatment is paid by the funding that is cut. These participants expressed how important funding is to persons with mental illness. It was communicated that funding is important because it provides additional staff, continuing education training, and resources that assist with the use of stigma interventions used in treatment. Participants HP0002, HP0005, HP0008 and HP0004 felt that the lack of education presented as a barrier when patients came for treatment. HP004 stated that” sometimes patients don’t understand their own behaviors or diagnosis which causes them to act a certain way and if they were educated on their diagnosis it could help reduce some of the anxiety experience during treatment.”

These participants stated that the lack of education prevented some patients from receiving the needed treatment to help reduce the stigma experience because not all staff was properly education on mental illness and types of stigmas that can be experienced by persons with a mental illness. They also felt that some of the staff who only specialized in drug & alcohol disorder created a barrier to treatment for persons with mental illness because if they were assigned to a person with a mental illness for treatment, the focus was geared on the alcohol or drug disorder.

The participants expressed some concern for education to be geared around both mental illness and addiction to help assist with the use of stigma reduction interventions. For example: HP004 stated that her role in her current setting is a detox psyche coordinator who treats persons with schizophrenia, and it is important to her to understand how both disorders if a patient has two diagnoses listed one being mental illness and another of drug or alcohol so that the intervention is geared around the whole person and their experiences not just the diagnosis. The second theme below was categorized by these code words: standard test, general procedures, and standard protocol.

Theme 2: General Standards and Procedures

This theme was generated primarily based on Interview Question Number 9 in which each participant was asked to tell if their organization has standard treatments or assessments that are used for clients with mental illness to reduce stigma experience while in treatment or receiving services. Participants HP0001, HP002, HP003, HP004, HP005, HP006, HP007, and HP008 all stated that their organizations used standard test, follow general procedures and protocol when assessing a person with mental illness as well as creating any type of stigma intervention used for persons with mental illness.

For example: HP001 stated that when a person with mental illness comes into the clinic for treatment standard protocol is the patient meets with the social worker first and completes paperwork that goes over basic demographics, presenting problem, and diagnosis.HP001 also stated that" behaviors never come out in the beginning, so there always just that generic care plan for a patient that has whatever mental health issues at that time." Then the patient meets with the counselor or MH therapist for treatment planning. After that the patient meets with the treating physicians in which medication may or may not be prescribed. HP001 added that this standard protocol creates what we call in our setting the patient's interdisciplinary team. HP001 stated that this team is responsible for overseeing the treatment of persons with mental illness and creating interventions that are focus on the patient's behavior. When this same question was asked to HP004 the response was similar but HP004 concluded that the focus is not so much on the behavior but on the issue creating the barrier which is more than likely related to the stigma or labeling of the patient. HP004 also added that when a person with mental illness comes in for treatment and intervention planning begins, their organization takes the stigma experienced by a person with MI serious because of the affect's stigma has on the patient returning for treatment. HP006 stated that their organizations standard assessments do include coping mechanisms that assist with reducing the stigma experienced by persons with mental illness.

Participants HP002, HP003, and HP004 stated that standard assessments are seen as barriers because they do allow the treating provider to add any additional information that may be beneficial to reducing the stigma experienced by persons with MI. For example, HP003 stated that when an assessment is being completed and the participant elaborates on a time when he or she experienced stigma that should be added to the assessment to help with intervention planning. HP003 also stated that “structural family therapy model is a model we use that goes over information from everyone in the household that may have experience serve emotional or behavior disturbance.” However, all eight participants did agree that standard procedures and protocols can be seen as challenging as well as a barrier to treatment.

Theme 3: Making Use of One-to-One Time

This theme was generated mainly from the category and the code words: focused on behavior, meeting a person where they are at and the patient not understanding their diagnosis. Six of the eight participants explained how they take the opportunity to help participants and create their own stigma reduction intervention when they are spending one on one time with patients. For example, HP002, HP003. HP004, HP005, and HP008 stated that when they are spending one on one time with a patient that focus is not primarily on the behavior of the client. These participants stated that the reason why the focus was not on the behavior of the client is because they view one on one time as an opportunity to get to know the patient more so that the patients’ interventions are helpful in reducing the stigma experienced. HP003 shared that “race and mental health are important as a black woman because I was helping a patient overcome stigma and the patient as me if I understood the effects of her race because she was of European descent and did not feel comfortable disclosing her experience because she was not sure if she knew anything about European women. So, I explain to the woman that I am just helping you processed what happen and we can revisit this in our next session if your uncomfortable, so the woman agreed and this is how you meet them where they are at, if that answers your question."

Participants HP001, HP002, HP003, HP004, HP006, and HP008 stated that one on one time is the perfect opportunity to meet the person where they are, meaning understanding their stigma experienced and how it affects them mentally thinking that everyone is talking about them. These participants stated that meeting a person where they are opens the door for trust and eliminates challenges and barriers with trust while using a stigma reduction intervention. However, these participants HP002, HP006, and HP008 stated that even though one on one time is valuable using a stigma reduction intervention can be challenging if the patient is uneducated on his or her diagnosis. These three participants agreed that when a patient understands their diagnosis it makes it easier to assist with a stigma reduction intervention because the patient is aware of his or her triggers that interfere with treatment. HP006 stated that the majority of the patients that come to treatment have been labeled or experienced stigma that has prevented them from seeking assistance. HP006 "shared that I reward my patients with accolades and gifts when they are compliment with treatment, this is something I do on my own with some of my patients. "This information communicated was consisted with the previous research on this subject. Mental illnesses pose a significant burden worldwide (Greory et.

Al,2020). Furthermore, the treatment gap for mental disorders is large (Gregory et. Al,2020). A contributor to this treatment gap is the perceived stigma towards mental illness (Gregory et. Al,2020). Most of the participants indicated that getting to know the patient and meeting them where they are at will help with the success of using a stigma reduction intervention on a person with mental illness.

Theme 4: The Importance of Education and Communication With Family

The fourth theme was generated by categorizing these code words: Prevention training, educational training, and family communication. This theme appears to be more critical to the successes of using a stigma reduction intervention on persons with a mental illness. The importance of education was also expressed in theme one briefly. Participants HP001, HP002, HP004, HP005, and HP008 all expressed how important it is for staff to be educated in prevention training. HP004 stated that when a patient comes into the clinic for treatment and has experienced stigma it can be difficult to use a stigma reduction intervention on the patient because the patient sometimes will be retriggered in the client if staff are standing around talking and whispering. HP002 shared that “everybody goanna come in with their prejudice and their negative especially in a world where mental illness has its own stigma.” HP004 stated that the whispering is perceived by the patient as a conversation about him which creates barriers to reducing the prior stigma experienced. HP005 stated that prevention training is needed because most of the staff does not understand how to deescalate a patient that is paranoid and believes that the staff is talking about them. HP007 shared “ some of our staff can be very ignorant to families and really don’t know how to communicate and its embarrassing, so education and communication is a must."HP005 concluded that in her 14 years of being a clinical psychologist if the staff is not properly trained on deescalating a patient when a patient is displaying threating behaviors because of labeling and prior stigma experience, using any type of intervention on a patient that is perceived to be violent will lead to an unsuccessful event. HP001 and HP005 both stated that prevention training and family communication is important because sometimes what triggers the patient before they come in for treatment could occur at home.

Having an open dialogue with families can sometimes assist with stigma reduction interventions because the family are the ones who spend the most time with the patient. HP008 stated that she tries to maintain a relationship with the family to better understand how the patient functions when he or she is not in treatment. Educating the patient's family on the patient's diagnosis and helping the family understand the patient's triggers can help the patient have a successful outcome with treatment. HP002 stated that if the family is educated on the patient's diagnosis and their triggers, and communication is present with the family it becomes easier for her as a treating providing to create a stigma reduction intervention that focuses directly on what the patient has been experiencing. All participants did acknowledge that increasing prevention training for de-escalation purposes and communicating with the family will assist with some of the challenges using a stigma reduction intervention on persons with a mental illness. One of the challenges perceived was not knowing how the patient copes at home when stigma was experienced. This was due to lack of communication with the patient's family which created a challenge using the stigma reduction intervention in the treatment setting.

Theme 5: The Use of Medical and Nonmedical Interventions

The fifth theme emerged from the following categorized codes: Medication focus, motivation through incentives and non -medical interventions. Theme five provided clarification of how human service professionals got over some barriers and achieved some successes using a stigma reduction intervention. The participants in the study described the barriers as being challenging in which they had to think outside the box and meet the patient where they were at. For example: participant HP001 shared a success story in which she created her own non-medical intervention to help the patient overcome stigma and continue treatment. HP001 stated that one of her patients would come to therapy and expressed how she thought everyone was talking about her and watching her. So HP001 created her own non-medical intervention in which the patient had to focus on positive things in her life for week one of her treatment. After week one the patient would be allowed to go into what HP001 call the motivation chest and retrieve something she wanted. HP001 stated that inside the chest were things that the patient valued important to them. HP001 stated that this technique reduced the stigma that was been experienced and motivated the patient to come to treatment daily. It provided the patient with a reason to continue treatment while reducing the negative thoughts that were barriers to prior use of stigma reduction intervention. HP001 shared “a lot of doctors think that medication is the key but it’s not but as the social worker its only such I can do, so that’s why I create my own interventions.” The following participants HP002, HP003, HP005 shared similar stories of how they overcame barriers using a stigma reduction intervention. HP003 shared “ no one really likes medication but there are some patients who really need it because they cannot cope with the effects of their disorder, like those voices they be hearing.” HP005 reported that she spends time understanding the patient’s cultural background and how stigma is viewed in the patient’s culture and community to help better create interventions that algin with the patient’s culture and stigma experienced. HP005’s approach was consistent with some of the literature shared in Chapter 2. HP005 mention how human service professionals need to meet people where they are but also take into consideration the patient’s cultural background. HP005 stated that understanding the patient’s cultural background can assist with using interventions including one that is focus on reducing the stigma experience by a person with mental illness.

For example, HP005 shared that her organization does not like to use the word stigma in front of the client, but part of the patient’s intervention is to allow them to label it whatever the patient chooses to call it because there is a possibility that in the patient’s culture it is define as something else and not stigma. Understanding how different human service professionals get over barriers to reduce the stigma of a person with mental illness can provide the opportunity to create positive social change not just within the organization for human service professionals who provide care for persons with mental illness. As the researcher it is beneficial for me to understand how a person’s culture can create challenges, barriers, and successful outcomes reducing a person with mental illness stigma experience.

During the interview process participants HP001, HP002, HP005, and HP006 mentioned that there are some patients who required medication to help control some behaviors before the attempt of reducing any type of stigma experience can begin. HP006 stated that persons with schizophrenia can sometime present as challenging when trying to reduce the stigma experience because persons diagnosis with schizophrenia are more likely to shy away from treatment because of the side effects some medications can cause that are prescribe to schizophrenia patients. HP006 concluded that his experience in using a stigma reduction intervention was less challenging with patients that are diagnosis with depression, anxiety, or bipolar disorder because the side effects of medications ordered for this population of patients are less severe and allows the patient to be coherent during the period the intervention is implemented.

However, human service professionals continued during the study to express the importance of reducing a person's stigma in experiences and how their perceptions created challenges and barriers to successful outcomes in their individual treatment settings using a stigma reduction intervention.

Theme 6: They Are Still Human Beings

Theme 6 emerged from the following words that were categorized and supported the theme: lump together and labeling. This theme emerged not only from the code words categorized but from the data received during the participants individual interviews that reference how a patient with mental illness can sometimes feel dehumanized by stigma and labeling which is consistent with Goffman's theory. Theme six provided the perceptions of human service professionals challenges and barriers while trying to implement a stigma reduction intervention and using one on a person with mental illness who experienced labeling by human service professionals who assist with treatment.

Theme 6 included perceptions of why some stigma reduction interventions will not work on their patients after multiple attempts of altering the intervention due to the stigma experienced. Table two provided the unique number for each human service professional that participated and how many times during the interview a word was used. Looking at table two the following participants' HP001, HP002, HP003, HP004, HP005, and HP008 mentioned that their patients expressed how they either heard someone labeling them while they were in treatment setting or experienced labeling in a public setting in which the patient lack confidence to continue treatment and began to isolate. HP002 shared that "sometimes I overhear staff talking about someone that has bipolar disorder and they start saying o here they come, they're crazy." For example, participant HP003 stated that she was providing a group therapy session with about eight patients in the group, and she asked a question to the group "what is the most challenging part of coming to therapy"? HP003 reported that some of the responses were as followed:" the most challenging part is when you overhear staff saying here come the crazy people, look at her, she zone out on that medication, he looks angry,". HP003 stated that these comments being overheard by patients presented barriers to continuing treatment especially with the use of a stigma reduction intervention. HP003 also stated that the lack of education is not just a barrier with the use of a stigma reduction intervention but with most of the staff having an ignorance about mental illness.

HP001 and HP002 also both had experiences where educating staff on mental illness is sometimes a barrier because when you work with people who label the people you are helping, it makes it more challenging for a patient to trust the person implemented the intervention during treatment. HP002 stated that patients will say during treatment “we are still human, and being label does hurt.” HP004 stated that he expresses during treatment to his patients that being diagnose with a mental illness does not mean that you are not human. HP004 stated that this is something he discusses with his patients during treatment. HP005 shared that I ‘ve had clients say that they felt I spoke to them in a condescending manner earlier in my therapy journey. The responses and information from HP003 and HP005 were consistent with Goffman’s theory and how Goffman states that people will treat patients with a mental illness different because they do not understand their diagnosis. Goffman explained that an individual becomes discredited by other people and society through various stigmas because of the differences they possess or unwanted behavior that they exhibit in their everyday life (Goffman,1963). All eight participants’ during the interview process communicated that lack of education on mental illness and labeling by their peers is a barrier to successful outcomes in their outpatient treatment setting.

Theme 7: Pressing Through a Revolving Door

Theme seven was emerged from these code words which were categorized to create theme seven: fear, embarrassment, and repeated cycle. The participants used these codes words to explain the perceptions of their challenges, barriers, and successes of using a stigma reduction intervention on persons with mental illness. Within this theme, participants shared not only their challenges and barriers but some successes using a stigma reduction intervention. All participants shared that a major challenge with being successful using a stigma reduction intervention is having the patient complete their treatment. Participants HP001, HP002, HP004, and HP008 shared that their patients do not complete treatment because of fear and embarrassment of discontinuing treatment due to stigma and restarting treatment again in the same environment with staff that are familiar with them.

For example, HP004 stated that patients will start treatment and will show some consistently but then something happens, and the patient never returns. HP004 stated that the challenge with having a successful outcome with using a stigma reduction intervention is the patient stops treatment in the middle of making progress due to stigma and other personal reasons. HP004 stated that this becomes challenging because sometimes the reason is not given why the patient abruptly stop treatment and sometimes the reason is provided when the patient returns months later to restart treatment over again. Some of the responses from the participants that have experienced a gap in treatment with their patients verbalized that patients sometimes will stop treatment because something personal happens in their life or they have experienced some type of stigma, and they are just not motivated to continue treatment.

Participant HP008 shared that her experience was that patients are embarrassed because “they are seen by staff as repeated offenders meaning that they have been in and out of treatment multiple times within the same year and fear that they will be labeled”. HP002 stated that her experience with using a stigma reduction intervention was that patients are embarrassed to come back into treatment if they are regular patients who never successfully completed prior treatment. HP002 also stated that patients feels they will be labeled and look upon differently during treatment. HP002 shared that” some of the patients are aware of the labels that they are giving and that interferes with them returning for services and they feel embarrassed of it, especially if they are frequent flyers they come in and see the same staff."

HP001 shared that a part of meeting someone where they are at, begins when a patient comes into the clinic and starts to do well in treatment and then no longer shows up, she stated that reaching out to the patient in the stage that they are in and informing them of how well they were doing in treatment with the hopes that they will return is a step to meeting the patient where they are at. HP001 stated that she had multiple successes in reaching out to patients to get them to return to treatment which contributed to the success of the use of a stigma reduction intervention on a person with mental illness who experienced some type of stigma.

HP008 shared that she achieves successful outcomes in treatment using a stigma reduction intervention by reminding the patient on how well they are doing in therapy, she also stated that she provides literature for her patients to read on various types of stigmas, so that they understand the why and how stigma affects treatment outcomes. HP008 stated that" to be successful in achieving a positive outcome in treatment it is important to first meet the patient where they are at, second be transparent with the patient and establish repour with the patient's family in the event that the patient does not show back up for treatment." HP008 also added that challenges and barriers will always arise it is up to the individual organization to provide protocols that allow the treating practitioner to utilize other tools that are not standard assessments or general procedures to create the success that is needed to help persons with mental illness overcome stigma."

Chapter four provided insight to understanding how The Mental Illness framework in conjunction with the Goffman theory was used to support the data received. The Mental Illness framework is used to show how a person with mental illness is stigmatized and how the stigmatizer is identify. The human service professionals indirectly experienced challenges and barriers using a stigma reduction intervention because some of the stigma created in and out of the outpatient setting affected the treatment outcomes . The stigma created within the outpatient setting created a gap with treatment for persons with MI, and cause persons with MI to isolate and feel discouraged. Goffman theory supports the data because Goffman states that a person with a mental illness will be look at and treated different which creates labels and stigma for persons with MI. However, human service professionals can assist with reducing the stigma created by educating themselves on the various types of stigmas and create stigma free outpatient settings.

Summary

All the participants within the study shared information that answered the research question of: What are human service professionals’ perceptions of challenges, barriers, and successes addressing stigma among clients with a mental illness in an outpatient treatment program that involves using a stigma reduction treatment? These seven themes emerged from the data provided: Working Through a Shortage of Resources, General Standards and Procedures, Making Use of one-to-one Time, The Importance of Education &Communication with Family, The Use of Medical & Non-Medical Interventions, They are still Human Beings and Pressing through a Revolving Door. A detailed explanation of why human service professionals using a stigma reduction intervention experienced challenges, barriers, and successes using a stigma reduction intervention in an outpatient setting. The setting in which the interviews took place was discuss, the participants' demographics was shared along with tables that supplied codes words that were categorized and given a theme based on the data received. Based on the data received the research question was answered and saturation was met after the fifth interview. Chapter 5 will supply the study's interpretations of the findings, the study's limitations, recommendations, and implications for positive social change. The literature review and recommendations for future studies will also be discussed in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to gain an understanding of the challenges, barriers, and successes of human service professionals who use a stigma intervention to reduce the stigma experienced by people with MI. Stigma experienced by people with MI can have a negative impact on treatment outcomes and create challenges and barriers for human service professionals. However, understanding how various elements such as standardized testing, limited resources, and continuing education can also impact the outcomes of treatment that human service professionals experience while using a stigma reduction intervention is important for people with MI. One-to-one Zoom interviews were conducted to gain an understanding of the perceptions of human service professionals who used a stigma reduction intervention on a person with MI and experienced challenges, barriers, or successes while using this intervention. The interviews were guided by an interview guide that consisted of 18 interview questions to answer the research question: What are human service professionals' perceptions of challenges, barriers, and successes addressing stigma among clients with a mental illness in a treatment program that involves using a stigma reduction treatment? Chapter 5 provides the interpretations of the findings, study limitations, recommendations, and social implications.

Interpretations of the Findings

Several themes were discovered during the data analysis process: working through a shortage of resources, general standards and procedures, making use of one-to-one time, the importance of education and communication with family, the use of medical and nonmedical interventions, people are still human beings, and pressing through a revolving door. The results indicated that multiple factors contributed to the challenges, barriers, and successes of human service professionals who used a stigma reduction intervention on a person with MI. All participants who were involved in the study had more than 1 year of experience working with people who have MI and experienced some form of stigma. The participants also served on an interdisciplinary team that works together to set goals, create interventions, and assist with chronic illnesses. Most of the participants reported that lack of funding, lack of staff, and lack of education on MI created barriers or challenges to the outcome of using a stigma reduction intervention.

A common theme used to express how human service professionals perceived challenges and barriers using a stigma reduction intervention was working through a shortage of resources. Human service professionals reported that working while short of staff contributed to the misuse of stigma reduction intervention, which did not allow the allotted time for the intervention to be fully used. Participants also mentioned that lack of funding created barriers to improving current stigma interventions as well as additional funding for patients who use state-allotted funding for treatment. The use of standardized testing and procedures created challenges in treatment because human services professionals were not allowed to deviate from the standard protocol of assessing patients for customized interventions that cater to a person’s stigma experienced. Meeting patients where they are in treatment and spending one-on-one time with patients led to multiple successes using a stigma reduction intervention. The code words “lack confidence” and “labeling” were scored as having the highest use by six of the eight participants during the interview process. Theme 7 provided the most insight on the challenges and barriers of getting patients to complete treatment and why stigma is documented as a global problem, which is consistent with the research information reported in Chapter 1.

Theme 1: Working Through a Shortage of Resources

Funding plays a major role in supporting human service professionals with continuing education and current evidence base practices that support the revision of stigma reduction interventions used to reduce the stigma experienced by people with MI (Proctor et al., 2020). Six of the eight participants reported that the lack of funding and education created challenges and barriers with the use of stigma reduction intervention. One of the challenges reported was the misuse of the stigma reduction intervention due to shortage of staff. Human service professionals reported that lack of staffing created a challenge using a stigma reduction intervention because the time allotted per patient during treatment was cut short to make sure that all patients were seen. The first step in understanding this challenge was recognizing the importance of the needed staff to use the stigma reduction intervention correctly and reduce challenges in the future during treatment.

Theme 2: General Standard and Procedures

General and standard procedures are tools that are put in place by each individual organization. These tools are used as guides to assist and evaluate patients when they come in for needed services. All participants in the study stated that their organization has used general and standard procedures for assessing services needed for people with

MI. The participants reported that these general standards and procedures are not enough to obtain a positive outcome when using a stigma reduction intervention on a person with MI.

The participants all indicated that thinking differently or incorporating other tools that are not standard practice provides a better outcome with using a stigma reduction intervention on a person with MI. Economic health interventions provide useful information to policymakers, payers, and health professionals; however, they can also be considered a challenge because the information must be conveyed to allow for scrutiny (Husereau et al., 2022). Combing the use of interventions and assessments that are not considered standard but assist with the treatment of a person with MI who experienced stigma can contribute to reducing the barriers human service professionals face according to the data in this study.

Theme 3: Making Use of One-to-One Time

Psychosocial interventions that are low-cost and make use of a patient's existing personal and social resources are an effective strategy in settings that lack funding and trained professionals to provide specialized mental health services (Sikira et al., 2022). The human service professionals who used one-to-one time with patients outside of the provided treatment time confirmed that low-cost interventions were effective in reducing the stigma experienced by people with MI. The participants who reported that they used one-to-one time as an intervention stated that this intervention was successful because it allowed the use of psychosocial education to address the stigma experienced by people with MI. Using psychosocial education to address stigma is consistent with the mental illness stigma framework, which explains the mechanisms of MI and stigma. A key benefit in using this framework is that it ties together the immense and varied body of MI stigma research, which is important for the outcomes of treatment for people with MI. Incorporating low-cost interventions that are effective and can be used in conjunction with stigma reduction interventions may help human service professionals overcome challenges and barriers in an outpatient treatment setting.

Theme 4: The Importance of Education and Communication With Families

Sikira et al. (2022) reported that family interventions have provided an improvement in a patient with MI’s quality of life and decreased the number of hospitalizations. This is an important detail to remember because Fox et al. (2018) stated that stigma can impact the quality of life for a person with MI and increase the risk of social isolation. The participants in the current study reported how education and communication were important to overcoming barriers using a stigma reduction intervention. Three of the participants reported that the lack of communication with families decreased the chances of successfully using a stigma reduction intervention because there was no follow-up from families if the intervention was working outside of the treatment setting. One human service professional reported that the use of incorporating the patient’s family in the intervention was successful in overcoming barriers to using the stigma reduction invention. This human service professional stated that communication between families and treatment providers can bolster the success of using a stigma reduction intervention in an outpatient treatment setting. Educating families on the stigma associated with MI is the first step to increase communication between families and staff, which can prevent barriers that create lack of care and isolation and can assist with the use of a stigma reduction intervention for people with MI. Grandon et al. (2021) supported multiple interventions that assist with preventing gaps in care for people with MI and increase the positive outcomes by trying different approaches between the stigmatized and the stigmatizer.

Theme 5: The Use of Medical and Nonmedical Interventions

According to Gronholm et al. (2017), the use psychotropic drugs and the distribution of these drugs between the government and health organizations created barriers to using a stigma reduction intervention because the distribution was seen as a financial gain and not as beneficial to assisting the patient. The participants in the current study reported that the use of medical interventions such as psychotropic drugs did not assist with reduce the stigma experienced by a person with MI and contributed to the barrier of using a stigma reduction intervention. The participants who experienced the use of these psychotropic drugs with the stigma reduction intervention stated that the prescribed medical intervention slowed down the patient’s progress due to the patient being incoherent during the use of the psychotropic drug. Participants who used nonmedical interventions with their patients reported that goal setting, meeting the person where they are, and spending one-on-one time talking resulted in success with the use of a stigma reduction intervention. Knaak et al. (2017) stated that actively meeting with a person with MI and understanding where they are in the moment can assist with overcoming barriers to using a stigma reduction intervention and increase positive outcomes with treatment. Meeting with the patients one-on-one and understanding where they were with the stigma experienced helped human service professionals incorporate additional practices that were supported by the literature.

Theme 6: People Are Still Human Beings

One of the barriers to people with MI is the stigma associated with MI, which results in a gap in care for people with MI (Kaur et al., 2021). Theme 6 provided information that human service professionals perceived to be barriers that contributed to the unsuccessful use of a stigma reduction intervention on a person with MI. Meeting patients where they are appeared to be an intervention that assisted with some successes when using a stigma reduction intervention. Some of the barriers that prevented human service professionals from obtaining a positive outcome were consistent with Goffman's (1963) theory used to support the research question. Three participants reported that labeling and staff who were not educated on MI increased the likelihood of a negative outcome in a stigma reduction intervention. However, not meeting the patient where they were also increased the chances of a negative outcome in treatment. Hack et al. (2020) mentioned in the literature that poor engagement with providers can also contribute to the negative outcome of a stigma reduction intervention. An important role for human service providers to understand in increasing the positive outcomes using a stigma reduction intervention is meeting the patient where they are and establishing rapport that is consistent in the treatment setting and outside of the treatment setting. This may assist with the gap in care for people with MI who isolate due to their stigmas experienced.

Theme 7: Pressing Through the Revolving Door

Individuals who have a mental illness are targets for discrimination, labeling, and prejudice, which can cause this population to internalize stigma perceived by others (Fox & Earnshaw, 2022). Theme 6 provided detailed information on labeling and the self-perception of how the patients perceived staff. One of the barriers to successfully using a stigma reduction intervention for human service professionals was getting the patient to complete treatment. A consistent code word that was mentioned throughout the study and seemed to bring successes with using a stigma reduction intervention was “meeting the patient where they are at.” Multiple participants shared that meeting the patient where they are and following up with a phone call seemed to engage the patient to continue treatment and led to a positive outcome using a stigma reduction intervention. Goffman’s (1963) theory was consistent in supporting the data received throughout the current study. Goffman’s theory states that a person with MI is looked upon as being different and is sometimes rejected by society. Some of the challenges and barriers occurred because of the stigma perceived by patients, which caused them to isolate and shy away from treatment. Human service professionals who use stigma reduction interventions must first understand how stigma interferes with a person with MI’s life on a daily basis. Having a basic understand of this and meeting a person where they are in the treatment stage may increase the number of positive outcomes using a stigma reduction intervention in an outpatient setting.

Limitations of the Study

Human service professionals' perceptions of challenges, barriers, and successes addressing stigma among clients with MI in a treatment program that involved using a stigma reduction treatment were explored in this study. The phenomenon was explored by conducting one-on-one interviews through Zoom. The first limitation of the study was the small sample size of eight participants. Hennink and Kaiser (2022) recommended that nine to 16 interviews be conducted to reach data saturation in qualitative studies. In the current study, data saturation was reached with the fifth participant. Purposeful sampling can be considered a second limitation of the study. Although purposeful sampling is widely used to recruit participants who are needed to answer the research question, the misinterpretation of data can have important consequences for minimizing bias, which is key to undertaking research (Bruce, 2018; Pannucci & Wilkins, 2010).

The third limitation of the study was the location of the participants selected, which was the same geographic area. This may limit the transferability of findings to other parts of the world where MI patients may be treated in an inpatient setting rather than an outpatient setting. It would have been beneficial to see how human service professionals who work in inpatient settings overcome barriers and challenges and attain success using a stigma reduction intervention on people with MI.

Implications

Human service professionals who work with patients who have been diagnosed with MI and who use any type of stigma reduction intervention to help reduce the stigma experienced should have a basic understanding of the various types of stigmas and how they influence the mental well-being of patients in the treatment setting. Human service professionals should also understand the cultural aspect of how stigma is viewed within a patient's culture and community. Human service professionals should also identify what stage of relapse a patient is in when there is a gap in treatment and a patient does not return for treatment by following up with a phone call. Human service professionals should communicate with patients' families and involve them in the treatment process to better understand the effectiveness of interventions used outside of the treatment setting. Human service professionals should always meet patients where they are to reduce any challenges or barriers that may arise in the treatment setting to achieve more positive outcomes using a stigma reduction intervention.

Implications for Positive Social Change

Goffman (1963) defined stigma as a mark on a person that discredited them in society because of a physical illness (see also Saguem et al., 2022). Stigma of mental illness is among the top priorities of most worldwide organizations given its devastating consequences to individuals with mental illness and their families (Saguem et al.,2022). Understanding the effects of stigma on a person with mental illness is crucial for treatment with this population. Building repours with families according to the data received and having an basic understanding of mental illness and how it is reference within a person's culture can increase the success rate of treatment with mental illness and help assist with the gap in care for this population. Identifying barriers early in treatment can reduce the negative outcomes in the treatment setting. Continuing education for human service professionals who do not have an basic understanding of mental illness according to the data received during the study can assist with the lack of knowledge when treatment is involve and reduce the stigma experienced by persons with mental illness in the treatment setting. This study can help human service professionals who are looking to work with persons with mental illness understand the importance of the stigma and how its effect persons with mental illness in an outpatient treating setting.

Recommendations for Future Research

Future studies should look at integrating mental illness diagnosis and barriers to treatment into a person’s with mental illness care plan. Some of the barriers reported in this study created challenges for human service professionals. One of the barriers reported was understanding how a person’s with mental illness cultural belief plays a role within treatment. Boge et al., 2018 reported that understanding a person’s cultural belief can help human service professionals who treat persons with mental illness understand how stigma is viewed and perceived by the patient.

Future studies should also consider the type of stigma experienced by a person with mental illness and how the stigma experienced created barriers within treatment. Chapter two explained how the various types of stigmas can affect a person with mental illness. The current study reveal that public stigma and the fear of embarrassment from repeated admissions to outpatient treatment cause a gap in treatment which also created barriers to using a stigma reduction intervention. Incorporating these two factors in future research studies could be beneficial to human service professionals challenges and barriers using a stigma reduction intervention on a person with mental illness.

Conclusion

Mental illness is a worldwide problem that was discussed in the beginning of chapter one. Understanding the challenges that are faced by persons with mental illness and stigma was discussed in chapter two of the literature. This study aimed to understand the challenges, barriers and successes faced by human service professionals who use a stigma reduction intervention in an outpatient setting. This study provided an understanding of the challenges and barriers of human service professionals which were described as lack of education, lack of staff, and lack of funding.

Some of the factors that helped with positive outcomes in treatment were understanding stigma and how it is represented within a person's culture, communication with families, and meeting the person where they are at are all prerequisites to have before the use of a stigma reduction intervention is used. Mental illness is something that happens to people of all races and cultures, understanding how it is define within a person's culture and race can assist with the gap in treatment and the negative outcomes experience by human service professionals. Chapters one provide an understanding of the issues that created barriers to treatment for persons with mental illness. Chapter two reviewed the factors associated with mental illness stigma and how stigma can impact the treatment for a person with mental illness. Chapter three provided the details of the study and how the study would be conducted, and the criteria needed to participate. Chapter four provided data that explained the challenges, successes and barriers of human service professionals who used a stigma reduction intervention on a person with mental illness.

Chapter five provided an overview of the challenges, barriers, and successes of human service professionals.

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Appendix A: Flyer

Interview study is looking for Human Service Professional who currently or previously used an treatment that has reduce the stigma experience of a person with Mental Illness

The study is focused on the challenges, successes, and barriers of Human Service Professionals' use of a stigma reduction treatment. The purpose of the study is to gain a better understanding of how to reduce the stigma experience of a person with mental illness. This study can help doctors, nurses, and other organizations who provide care to persons with mental illness understand how stigma can affect the treatment and treatment outcomes of person with mental illness.

About the Study:

- One 45–60-minute phone or zoom interview that will be audio recorded.
- To protect your privacy, the published study will not identify participants by name or organization.
- The first 10 participants who volunteer and complete the interview will receive a $25 Starbucks gift card as a thank you.

Volunteers must meet these criteria requirements:

- Human Service Professionals that work with or treat persons with a diagnosed mental illness (nurses, doctors, mental health tech, therapist, social workers)
- Have at least one year of experience using an intervention that helps a person with mental illness overcome stigma.
- Work in an outpatient setting

This interview is a part of the doctoral study for Maureen Epps, Ph.D. student at Walden University. Interviews will take place during the Spring of 2023.

Appendix B: Interview Questions

1. Tell me, what your current role is in this outpatient setting and how long you served in your current role?

2. What types of mental illness do you treat among your clients?

3.Tell me in your own words how the stigma of mental illness can indirectly interfere with a person with mental illness well-being.

4. Please explain what type of services and treatments are provided in this outpatient setting.

5. Specifically, what type of stigma-focused treatment do you use with your patients?

6.Describe what challenges you experienced with providing treatment or any type of service to a person with mental illness who experienced stigma in any form.

7. Explain to me how you proceeded to engage this client or clients with overcoming stigma and participate in receiving a service or needed treatment.

8. Please explain to me in your own words what other challenges stigma of mental health can have on human service professionals who provide services to persons with mental illness.

9. Please tell me about whether your organization has standard treatments or assessments that are used for clients with mental illness to reduce stigma experiences while in treatment or receiving services.

Sub a Are these (standard) treatments or assessments were successful in achieving the goal of reducing stigma?

10. Describe for me what treatments are used within the setting you work to reduce stigma and how often are they used.

11. Please explain how a person’s mental health diagnosis is used for the purposes of designing treatments that are used to reduce stigma.

12. What if any of the treatments designed to reduce stigma based on a person’s mental illness diagnosis have been successful and why?

13. Are you aware of any challenges experienced using a stigma reduction treatment that was designed based on a person’s mental illness diagnosis and not the stigma experience?

14. Tell me about an experience in which you used a stigma reduction treatment that was either successful or presented challenges.

Sub a How did the success or challenge make you feel?

15. How did you overcome any barriers that may have interfered with any stigma reduction treatment you have used?

16.Can you tell me about an experience in which you used a stigma reduction intervention that was either successful or presented challenges?

17. How did the success or the challenge make you feel?

18. What additional feedback do you think is helpful for future researchers who seek to understand the best practices in implementing stigma reduction treatments for persons with mental illness?

19. Please share a teaching moment that started out with challenges and ended with a success story using a stigma reduction treatment on a person with mental illness.