



# Developing Organizational Interventions to Address Stigma Among Mental Health Providers: A Pilot Study

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## Abstract

This article outlines a pilot study of “It’s Just Us,” an organizational intervention designed to reduce stigma among mental health providers by increasing awareness of the stigma they hold toward both clients and other providers with lived experience of mental health challenges. The targeted organization was the Mental Health Service Line in a large, Midwestern VA health care system. About 30% of the clinicians in the service provided information about their levels of stigma toward clients and providers who manage mental health challenges at baseline, 1 year later, and 2 years later. Educational and contact interventions targeting stigma are detailed; the first year included education and short-term contact interventions, while the second year included continuous contact interventions. At the end of the first year, scores on a measure of stigma toward mental health providers with lived experience were significantly lower, while scores on (a) a self-report measure of stigma toward clients and (b) self-disclosure of lived experience to professional peers were unchanged. At the end of the second year, scores for stigma toward clients had improved, and providers in the sample were more likely to share their lived experience with professional peers. Further research is necessary to validate these findings. Data provides preliminary support for the use of the “It’s Just Us” curriculum as a means of reducing stigma among mental health providers. This model may also be useful in addressing stigma among other types of health care providers as well.

**Keywords** Stigma · Mental health · Health care providers

## Introduction/Rationale

Despite professional values on advocacy (Carr et al. 2014), most studies find that mental health providers express stigma about mental illness at levels that are similar to or higher than the general public (Lauber et al. 2004; Schulze 2007; Peris et al. 2008; Wahl and Aroesty-Cohen 2010), although there are specific exceptions (Nordt et al. 2006; Stuber et al. 2014). In the general stigma literature, both education and contact with the stigmatized group have been shown to decrease stigma (Bamgbade et al. 2016; Corrigan et al.

2012; Ungar et al. 2015). However, mental health providers have high levels of education about stigmatizing mental health conditions, and ongoing contact with the stigmatized group in their day-to-day professional duties. Despite this, mental health care providers still maintain stigma about mental health conditions (Harris et al. 2016; Servais and Saunders 2007). There is evidence that mental health providers’ stigma may impact care, as it is related to their opinions about the types of mental health services that should be available (Sercu and Bracke 2016), lower expectations for recovery (Alexander et al. 1997; Hugo 2001) and overdiagnosis (Peris et al. 2008).

One factor that likely perpetuates stigma among mental health providers is the “culture of nondisclosure” (Boyd et al. 2016a, b; Harris et al. 2016). In at least some settings, health care providers describe concerns about disclosing lived experience with mental health challenges; in many cases such disclosures could interfere with licensure (Bender et al. 2015; Beran 2014; Boyd et al. 2016a; Cohen et al. 2016). In the context of ethical requirements to disclose if

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impaired (American Psychological Association 2002), many mental health providers may assume that any professional who discloses lived experience must be impaired. The subsequent fear of being perceived as an impaired professional creates a cultural norm of nondisclosure. This norm systematically denies mental health providers of role models in similar social roles who acknowledge lived experience and are not impaired. In this culture, mental health providers may not know anyone who is “like me” that acknowledges lived experience. Being unaware of others in similar social with lived experience facilitates “disidentification”, e.g., perceiving self as qualitatively different from client populations (Servais and Saunders 2007). Over time, the culture of nondisclosure may have the potential to cause professionals who have strong values on empowerment and advocacy to make disidentified, stigmatizing assumptions about clients and adversely alter the care that they provide.

Research on mental health providers demonstrates that most have a measure of lived experience with mental health challenges broadly defined (Bike et al. 2009; Harris et al. 2016; Nachshoni et al. 2008), and many have a lived experience of even severe mental illness or psychiatric disability (Boyd 2013; Boyd et al. 2016a, b). It is possible that we need to look no further than the next office to find individuals who can act as role models to change the culture of nondisclosure.

## Previous Approaches to Stigma Reduction in Mental Health Care Providers

Approaches that have traditionally been used to address stigma among mental health providers generally include either stigma reduction education, or education supplemented by contact with people who manage mental health challenges (Knaak and Patten 2016; Ungar et al. 2015). Interventions that include social contact, especially live, rather than video contact, (i.e., “contact interventions,” and if brief, “short-term contact”), show the greatest promise (Corrigan et al. 2012, 2014; Knaak and Patten 2016; Ungar et al. 2015). To attain maximum effectiveness, it is best if the contact is with an individual in the same social role or class and ideally involve long-term, daily interaction with the interventionist (“continuous contact”) (Corrigan and Penn 1999; Corrigan et al. 2012, 2014). Intervention models that used video contact have achieved positive, but not robust results. For example, Chung (2005) found that education supplemented by video contact with a potential client improved attitudes toward people with lived experience, but did not change health care provider perceptions about a client’s readiness for medical care or ability to be responsible. Bamgbade et al. (2016) found that education supplemented by video contact with a potential client improved pharmacy

students’ willingness to counsel people managing schizophrenia about their prescriptions, but not to the same level as their willingness to counsel people managing diabetes or other less stigmatizing conditions. To date, however, there has not been published, empirical research on interventions using live continuous contact with another mental health professional working in the same setting as target group.

This paper details program evaluation outcomes of “It’s Just Us,” a pilot stigma reduction program that combines both education targeting culture of nondisclosure and continuous contact approaches to reduce stigma toward clients among mental health providers. The program evaluation goals included (a) reducing self-report of stigma toward clients and providers with lived experience, and (b) increasing access to ongoing, continuous contact resources by creating a professional environment in which disclosure of mental health challenges is safe and welcomed. Hypotheses were that (a) there would be statistically significant reductions in self-reported stigma toward clients from Baseline to the end of Year 1, and from Baseline to the end of Year 2, (b) there would be statistically significant reductions in self-reported stigma toward providers with lived experience from Baseline to the end of Year 1, and from Baseline to the end of Year 2, and (c) there would be statistically significant increases in providers’ self-disclosure of lived experience to professional peers from Baseline to the end of Year 1, and from Baseline to the end of Year 2.

## Methods

### Participants

Participants were mental health providers in a large, Midwest Veterans Affairs (VA) health care system. Data were collected at baseline and at 1 year and 2 years after the initial assessment. At baseline, 101 out of 328 clinicians provided usable responses to a needs assessment survey on mental health stigma. At the end of Year 1, 114 of 333 clinicians provided usable responses on the same measures. At the end of Year 2, 109 of 333 clinicians provided usable responses. The sample included psychologists, nurses, social workers, psychiatrists and a small number of other disciplines (recreation therapy, occupational therapy, peer support). The samples drawn at baseline, Year 1, and Year 2 were not statistically different in terms of distribution of gender, mental health discipline, or response rate.

### Procedures

The project was reviewed with both the Institutional Research Board (IRB) and labor unions representing all affected employees. The IRB indicated that this was a needs

assessment project, and therefore did not require IRB monitoring. Labor unions approved the project, as all data collection was both voluntary and anonymous. Demographic data collected was limited to protect employee anonymity, and data were collected and analyzed by an individual who did not have supervisory authority over any employees. Participation in data collection surveys and all aspects of the organizational intervention were voluntary. Both baseline and follow-up surveys were distributed and returned through interoffice mail. All respondents were instructed to avoid providing any information that would identify them personally.

## Measures

Baseline and follow-up surveys included questions about gender, mental health discipline, types of mental health services the respondent had used, and numbers of professional peers with whom the respondent had shared information about lived experience with mental health challenges.

Stigma was measured using a semantic differential scale originally used by Servais and Saunders (2007), and later revised by Harris et al. (2016). This semantic differential scale included 24 items assessing stigma toward people managing mental health challenges and 12 items assessing stigma toward mental health providers managing their own mental health challenges. The scale invited participants to

rate targets on a continuum between positive and negative descriptors, such as “safe...dangerous,” “understandable...incomprehensible,” and “similar to me...not at all like me.” Targets included “a person with depression,” “a person with borderline personality disorder,” “a person with schizophrenia,” “a mental health provider with PTSD,” “a mental health provider with schizophrenia,” etc. Internal consistency reliability is based on a Cronbach’s alpha of 0.95 for items assessing general mental health stigma and Cronbach’s alpha of 0.94 for items assessing stigma specific to providers managing mental health challenges. Higher scores indicate higher levels of stigma. Validity has been substantiated in a previous study by negative correlations with both knowledge of recovery model care and work engagement (Harris et al. 2016). Providers who report lived experience themselves obtain lower scores on the subscale assessing general mental health stigma (Harris et al. 2016).

## Intervention

The interventions developed for the pilot study were identified as the “It’s Just Us” education series, as the focus was on breaking down perceptions of providers and those managing mental health challenges as “us” and “them.” Several types of specific education for Mental Health Service leadership were provided; see Table 1 for details. Education for direct care staff was designed to fit into regularly

**Table 1** Interventions and assessments over the course of the Study

Year 1 interventions	
Leadership training I	Seek support for organizational intervention from executive leadership
Leadership training II	Share project with program managers; seek support/encouraging staff participation
Baseline assessment	
Leadership training III	Share assessment results with executive leadership, plan interventions for Year 1
Leadership training IV	Engage program managers/supervisors, especially those who express resistance, sharing the value of program in recovery oriented care and workforce development
Leadership training V	Work with training directors and discipline leads in planning for work with short-term contact interventionist
Leadership training VI	External consultant provides training for all executive leadership and supervisors in workforce development advantages of environments that welcome self-disclosure
Grand Rounds I	
	Education on:
	(a) Impact of stigma
	(b) Results of baseline assessment
	(c) Culture of nondisclosure
	(d) Research on successful providers with lived experience
Grand Rounds II	NAMI speaker on stigma
Grand Rounds III	Guest speaker: successful mental health provider with lived experience
Brown Bag I	Same content as Grand Rounds I with discussion rather than lecture format
Brown Bag II	Discussion with guest speaker/provider with lived experience
Year 1 assessment	
Year 2 interventions	
Grand Rounds I	Review of last year’s training material, results of Year 1 assessment
Brown Bag I	Several providers within the service shared their lived experience of both a mental health challenge and stigma
Year 2 assessment	

occurring continuing educational offerings at this institution, which included formal Grand Rounds presentations and less formal, Brown Bag discussions/presentations. Over the course of the 2-year intervention, clinicians had the option to participate in any of four Grand Rounds presentations and three Brown Bag discussion groups. All clinicians in the mental health service were invited to participate in each of the Grand Rounds and Brown Bag presentations. Data on attendance for each of the Grand Rounds and Brown Bag presentations are detailed in Table 2. Note that the full intervention manual, including power point presentations and relevant materials, are available from the first author. Descriptions of these educational interventions are as follows:

### Leadership Training I

All discipline leads provided with initial education in the severity and effects of mental health providers' stigma, were involved in the decision to assess and consider an organizational intervention to address mental health providers' stigma. Initial training was based on available research literature on provider stigma, and was provided by the Chief Psychologist and a research psychologist. This training was 20 min in length, and took place as part of a regularly scheduled executive meeting.

### Leadership Training II

The project and its rationale were described to program managers, and their assistance in encouraging participation in the baseline survey was secured. This training was provided by the research psychologist in a 20-min segment of a regularly scheduled program managers meeting.

### Leadership Training III

All discipline supervisors were informed of the results of the baseline survey; results were discussed and an initial plan for organizational intervention was developed, proposed, and

**Table 2** Attendance at Grand Rounds and Brown Bag sessions

Event	Number in attendance
Grand Rounds I: education on disidentification	116
Grand Rounds II: NAMI guest speaker	103
Grand Rounds III: psychologist with lived experience	123
Grand Rounds IV: summary of year 1 research	68
Brown Bag I: discussion of disidentification	16
Brown Bag II: discussion with a psychologist with lived experience (short-term contact)	27
Brown Bag III: initiation of continuous contact	64

approved. The research psychologist led this information/discussion session, which was a 30-min segment of a standing executive meeting, and included discussion of options to address stigma based on survey results.

At this point, *Grand Rounds I*, *Brown Bag I*, and *Grand Rounds II* (see descriptions below) were implemented, each about 1 month apart. Educational e-mails on stigma and recovery model care resources were sent to all providers about twice per month during this portion of the intervention.

### Leadership Training IV

Some supervisors below the executive level expressed concerns/discomfort with the organizational intervention, so the research psychologist provided 30 min of additional leadership training that (a) contextualized the organizational intervention within the scope of longer-term programmatic interventions to increase recovery model care, and (b) described the organizational/workforce consequences of stigma affecting employees who are managing mental health challenges.

### Leadership Training V

Key discipline leads, training directors, and program managers were involved in specific planning for work with an external consultant with expertise in stigma and mental health care providers who have lived experience. This took place in a series of 3 1-h meetings in collaboration with the Chief of Psychology, the research psychologist and another psychologist on the implementation team.

### Leadership Training VI

The external consultant provided training and consultation in mental health stigma. Techniques were presented for creating a welcoming workplace for people who manage mental health challenges. Training participants included executive leadership, supervisors, and program managers; each group received an hour of training with the external consultant. This training was based on Welder and Salzer (2016).

*Grand Rounds III* and *Brown Bag II* (see descriptions below) were both presented by the external consultant over a 2-day period.

### Leadership Training VII

Following work with the external consultant, some leaders had questions about the utility of providers' openness about mental health challenges from a workplace/agency perspective; the "It's Just Us" team (research psychologist,

and another psychologist on the implementation team) provided additional information on the negative organizational/workforce consequences of employee closeting, based primarily on Jones and King (2014).

**Grand Rounds I** The research psychologist and another psychologist on the implementation team presented basic education on mental health providers' stigma, including

- (a) The impact of stigma on care and clients' quality of life
- (b) Results of the needs assessment survey (outlined in Harris et al. 2016), which indicated that 75% of the respondents from that organization had used mental health services, but despite that, the group expressed more stigma toward people with depression and borderline personality disorders than other published samples of clinicians. Also, despite the high rate of respondents with lived experience, the sample rated mental health providers who managed mental health challenges significantly more negatively than themselves. The needs assessment survey also demonstrated that lived experience is an asset, in that those with a history of such experience reported less stigmatizing attitudes toward clients.
- (c) Professional culture mechanisms that perpetuate stigma among mental health providers, including the clinician's illusion, the culture of nondisclosure, and use of language that marginalizes individuals who manage mental health challenges.
- (d) A review of Boyd et al.'s (2016a, b) work on high achieving mental health providers with lived experience.

**Grand Rounds II** Leadership of the local chapter of the National Alliance on Mental Illness (NAMI) presented the impact of stigma on individuals who manage mental health challenges and their families, including video recordings of discussions of the matter from affected individuals and family members. This presentation also included a section on media/advertising portrayals of individuals who manage mental health challenges, as well as a section on language that marginalizes individuals who manage mental health challenges.

**Grand Rounds III** An external consultant, who was an internationally known researcher in stigma and is open with her own experience of bipolar disorder, presented making the following key points:

- (a) Effective recovery from mental health challenges is common across a wide range of disorders.
- (b) Mental health providers who have lived experience are an asset to the field; they enhance credibility with

clients, operate with lower levels of stigma than those without lived experience, and can use their experience with mental health challenges and treatment to provide perspectives that improve care.

- (c) Examples of high achieving mental health providers who have lived experience were provided. The presenter specifically referred to her own experience with a mental health challenge as well.
- (d) Practices that violate the Americans with Disabilities Act that affect mental health providers who manage mental health challenges were outlined.
- (e) The presenter provided information on the VA's Mental Health Lived Experience Community of Practice, a group of VA mental health providers from around the US who have lived experience with a mental health challenge and use their background and professional roles to address stigma.

**Brown Bag I** The same two psychologists who led *Grand Rounds I* led a Brown Bag discussion group 1 month before the initial survey. The training content for this discussion group included the same education points as the Grand Rounds I presentation, without the (not yet available) results of the survey, and with the following additions:

- (a) Examples of microaggressions that reveal stigma, for example "We don't have the same kinds of problems our clients do."
- (b) Opportunities to discuss our language and other ways our professional culture perpetuates stigma that is accidental and inconsistent with our professional values.
- (c) Encouragement to participate in the planned assessment survey.

**Brown Bag II** The external, expert consultant led a discussion of training and professional practices, language practices that perpetuate stigma among mental health providers, the work of the Mental Health Lived Experience Community of Practice, and steps that we can take as professionals to reduce stigma.

**Year 1 Meeting** At an all-staff meeting, the "It's Just Us" team briefly reviewed the findings from the baseline survey, steps that the organization had taken to address stigma, information facilitating engagement in the Mental Health Lived Experience Community of Practice, and encouraged participation in the endpoint survey to facilitate accurate evaluation of stigma reduction.

**Grand Rounds IV** The research psychologist presented the results of the second survey at Grand Rounds, noting progress in the area of stigma toward professional peers, as well as lack of change in stigma toward clients and disclosure

to professional peers, contextualizing these findings in the research literature on stigma.

**Brown Bag III** In this discussion, the research psychologist shared lived experience with a mental health challenge, as well as the personal and professional impact of stigma in her own life; one psychiatrist and two other psychologists present shared similar experiences.

## Results

At Baseline, 101 surveys were returned, and 75% reported lived experience with a mental health challenge. At the end of Year 1, 114 surveys were returned, and of those, 89% reported lived experience with a mental health challenge. At the end of Year 2, 109 surveys were returned, and 83% of these reported lived experience with a mental health challenge. In the first year, Grand Rounds attendance ranged from 68 to 127, and Brown Bag attendance ranged from 16 to 64. In the second year, Grand Rounds was attended by 68 providers, and the Brown Bag was attended by 64 providers. The total number of providers in the Mental Health Service Line is 333, so the direct reach of the program extended to 38% of the providers. It is unknown the extent to which the providers who responded attended discussed the programming. All were exposed to advertising about the topic of the events.

Means and standard deviations for stigma toward clients and providers with lived experience, as well as numbers of disclosures of mental health challenges to professional peers are in Table 2. Because it was vital to keep responses anonymous, it is not feasible to do time-series analyses across time points, as it is not possible to determine which responses came from the same participant. As a result, comparisons across Baseline, Year 1 and Year 2 of the intervention are based on independent samples t-tests.

From Baseline to Year 1 (the education and short-term contact interventions), there was a statistically significant reduction in stigma toward providers with lived experience ( $t = 2.55, p = .01$ ), but changes in stigma toward clients and self-disclosure to professional peers were not statistically

**Table 4** Independent samples t-tests

Variable	Baseline to Year 1	Baseline to Year 2
Stigma toward clients	$t = 1.66, p = .09$	<b><math>t = 2.17, p = .01</math></b>
Stigma toward providers with lived experience	<b><math>t = 2.55, p = .01</math></b>	<b><math>t = 3.00, p &lt; .01</math></b>
Self-disclosure to other providers	$t = 1.19, p = .23$	<b><math>t = 2.17, p = .03</math></b>

Bold values indicate statistical significance ( $p < 0.05$ )

significant (See Table 3). From Baseline to Year 2, there were statistically significant reductions in stigma toward both clients ( $t = 2.49, p = .01$ ) and providers ( $t = 2.49, p = .01$ ) with lived experience, as well as a statistically significant increase in self-disclosures to professional peers ( $t = 2.17, p = .03$ ) (Table 4).

## Discussion

Our main findings were that there was greater evidence of reduction in stigma when education was followed by continuous contact with an individual in the same social role and social class. These results represent preliminary, program evaluation level information on a new approach to reducing stigma towards clients among mental health care providers; focusing on the role of nondisclosure in the perpetuation of stigma in a population that values recovery and empowerment. There is general support for the idea that continuous contact is more effective than the educational approach in reducing stigma among mental health providers. The “It’s Just Us” program provided a scaffolded approach designed to reduce the risks associated with initiating a continuous contact intervention; Year 1 interventions functioned to reduce stigma toward providers with lived experience well enough to make continuous contact interventions safer for the interventionists in Year 2.

By developing interventions that can be delivered in standing organizational continuing education formats, we were able to reach 38% of the providers in the facility with at least some portion of the intervention. One of the advantages of continuous, rather than short-term contact, is that

**Table 3** Means and standard deviations

Variable	Baseline (n = 101) Mean (SD)	End of Year 1 (n = 114) Mean (SD)	End of Year 2 (n = 109) Mean (SD)
Stigma toward Providers with lived experience	34.72 (12.73)	30.39 (12.15)	29.83 (10.83)
Stigma toward clients	86.42 (22.28)	81.12 (24.25)	77.29 (29.80)
Number disclosures to professional peers	4.20 (3.62)	4.74 (3.01)	17.13 (59.82)

after the initial contact session, organizational communication patterns will likely increase awareness of the same social role model over time, so the effect of the intervention is likely to spread beyond those who attend the initial disclosure over time. At the same time, it is acknowledged that a continuous contact intervention requires that the interventionist take on a high level of personal and professional risk in making the types of disclosure necessary to be effective (Corrigan and Penn 1999). Another perceived barrier to continuous contact interventions is that a same social role interventionist may not be available within the organization. While this may indeed be the case, research on mental health providers indicates that this group experiences mental health challenges at rates similar to the general population (Bike et al. 2009; Harris et al. 2016; Nachshoni et al. 2008), and it may be more likely than perceived that such a role model is available.

There are many limitations to this study; data were collected in an employment setting, potentially invoking social desirability as a response bias, and also necessitating great care to keep responses anonymous. The requirement of anonymity reduced statistical power by precluding time-series analyses. Data from providers in multiple disciplines is combined in this sample, potentially obscuring relationships specific to any particular discipline. Participation was voluntary and non-randomized to meet ethical requirements for conducting such program evaluation in an employment setting. It is unknown the extent to which the providers who responded to surveys attended the programming, significantly reducing the power to find differences. It is not completely clear that the differences in obtained results in Year 1 and Year 2 were due completely to the addition of a continuous contact element, or if the effects of the educational interventions provided in Year 1 increased over time, or whether the additive effects of both types of interventions were necessary to achieve the results. Time-series designs with experimental and control groups would be necessary to address this question. Note that many of these limitations reduce, rather than enhance the power to find an effect for the intervention, so these results are a conservative estimate of the effectiveness of the complex combination of interventions in the “It’s Just Us” program.

In summary, the findings are consistent with the theory that changing the culture of nondisclosure may be an effective way to change stigma among mental health providers. Decisions about such disclosures are difficult, individual decisions, however, should future research replicate these findings, training programs and professional community settings should consider taking steps to change social norms that may be reinforcing stigma.

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## Compliance with Ethical Standards

**Conflict of interest** None of the authors have any conflict of interest.

**Ethical Approval** This project was reviewed by our IRB and declared exempt from IRB oversight, as the data was collected for continuing education needs assessment. Labor unions representing the employees also reviewed and approved the project.

**Informed Consent** Participation in baseline and endpoint surveys for this project were voluntary and anonymous. To protect anonymity, we used a passive consent system. Every survey had a cover letter explaining the purpose of the survey, the risks/benefits for participating, and noting that participation was completely voluntary and anonymous. This approach to consent was reviewed and approved by both the IRB and labor unions.

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