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Published in:
BMC Psychiatry

Publication status and date:
Published: 19/11/2024

DOI (link to publisher):
[10.1186/s12888-024-06262-5](https://doi.org/10.1186/s12888-024-06262-5)

Document Version
Publisher's PDF, also known as Version of record

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Citation for the published version (APA):
Defourny, P., van Sambeek, N., van de Bovenkamp, H., Scheepers, F., & Heerings, M. (2024). Dynamics of recovery in psychosis, stigmatization, and microaggressions in mental healthcare: A qualitative study of service users' narratives. *BMC Psychiatry*, 24(1), Article 825. <https://doi.org/10.1186/s12888-024-06262-5>
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RESEARCH

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Dynamics of recovery in psychosis, stigmatization, and microaggressions in mental healthcare: a qualitative study of service users' narratives

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Abstract

Background Collaborative care relationships form a key component of recovery-oriented mental healthcare, but can be disrupted if service users feel judged by professionals. Professionals can express stigmatizing attitudes through microaggressions, i.e. subtle forms of discrimination that have a negative cumulative effect. People with psychosis have been found to regularly experience overt and subtle forms of stigma in mental healthcare. This study aims to expand our understanding of the various forms and consequences of microaggression from a service user perspective.

Methods In this qualitative study, we analysed narratives of people with psychosis purposefully selected from two collections of Dutch patient-authored stories ('Verhalenbank psychiatrie' and 'Patient ervaringsverhalen'), including two books and nine transcripts of low-structured interviews. We performed thematic analysis to identify different forms of microaggression and additionally used narrative analysis to gain insight into the experienced consequences for recovery.

Results We identified three main forms of microaggression: microaggressions that dehumanize; microaggressions that disregard service users' perspectives; and microaggressions that convey hopelessness. Experienced consequences of microaggression included feelings of loneliness, powerlessness and uselessness, acts of despair, resistance or withdrawal, and disengagement from services. Microaggressions were found to create additional recovery needs that were often addressed outside mental healthcare.

Conclusion Our findings illustrate the gap between ideals concerning collaborative care relationships and the everyday experiences of service users. Service users often experienced an absence of relationship-building in mental healthcare, with negative consequences for their recovery process. Our identification of different forms of microaggression can raise awareness and effectuate behavioural change in professionals and contribute to the emancipation of people with psychosis.

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Keywords Service users' perspective, Microaggression, Stigma, Personal recovery, Person-centred mental healthcare, Care relationship, Narrative research

Background

A good collaborative relationship between service users and professionals in mental healthcare is important for the experienced quality of care [1] and is associated with better treatment outcomes [2, 3]. Service users often evaluate their care experiences in terms of relationships and highlight the importance of trust and good communication [4]. A good relationship is of particular importance in person-centred, recovery-oriented mental healthcare [5, 6]. As recovery is understood as a personal and unique process, care should be tailored to service users' goals and vulnerabilities [7]. Trusting relationships with professionals are a prerequisite for service users to disclose and deal with disruptive experiences [8–10] and explore their goals and desires [5]. Good relationships with professionals can furthermore facilitate different processes of personal recovery, such as rebuilding identity, and facilitating empowerment, connectedness and hope [11, 12]. Additionally, mental healthcare professionals can play a salient role in rebuilding identity and empowerment by aiding service users' development of higher self-esteem and self-efficacy [13] and by dispelling stigma [14, 15]. The relationship between mental healthcare professionals and service users is also important in facilitating a nourishing context for recovery, as professionals can support service users to build a social support network and a safe space to live [7].

Mental healthcare professionals can thus play a vital role in supporting service users' recovery by maintaining an open and respectful relationship with them [16]. Research, however, indicates that this is not always the case. Service users regularly report stigma and discrimination in clinical encounters [17, 18] and stigmatizing professionals have been identified as a prominent barrier in the recovery process [12, 19, 20]. The World Health Organization therefore strongly advocates a human rights-based approach to mental healthcare that tackles power imbalances between mental healthcare staff and service users, including stigmatizing attitudes of professionals [21].

According to Goffman, expressions of stigma 'reduce someone from a complete and usual person, to a devaluated, tainted one' [22, p. 3]. Stigma consists of negative stereotyping that results in discrimination when acted upon [23]. One way in which mental healthcare professionals may communicate stigmatizing attitudes is by expressing microaggressions [24]. Microaggressions are subtle forms of prejudice enacted in everyday interpersonal interactions [25]. They differ from overt forms of discrimination in that they are more subtle and harder to

attribute, as people expressing them might be unaware of the negative underpinnings and effects of their communication [26–28]. The term was originally coined to describe the subtle forms of maltreatment experienced by members of racial minorities [29]. In recent years the concept has been applied to other marginalized groups, including people in mental distress [28]. Although microaggressions are more subtly expressed than overt types of discrimination, it should not be concluded that they have fewer negative effects. Daily exposure to subtle forms of stigma and discrimination is thought to have a bigger cumulative negative effect than overt stigma and discrimination [24, 28]. This effect includes low self-esteem, self-doubt, and isolation [30]. The subtlety of microaggressions can also cause a downward spiral in which service users question the validity of their own experiences [28]. The negative effect of microaggressions on the therapeutic partnership and overall satisfaction with care has been demonstrated in research on microaggressions that target service users' racial and sexual orientation [25].

Although the negative impact of stigma and discrimination against people with mental illness is well researched, studies on microaggressions targeting people with mental illness are scarce [31]. A few broad studies exploring microaggressions as experienced by individuals with mental illness found that mental healthcare professionals are among the offenders [31, 32]. Given the crucial role of a good relationship in supporting service users in their recovery process [11, 12], our aim was to explore microaggressions in the context of mental healthcare, focusing specifically on the experiences of service users with psychotic disorders, the most stigmatized group of people with mental illness [33, 34] and therefore likely to be affected by microaggressions. One previous study [26] based on interviews with service users classified with schizophrenia and their family members identified three forms of microaggression: those communicating that lived experience is irrelevant; those communicating that there is no hope for the future; and those communicating that it was unnecessary to share and discuss professional knowledge. The study in question only focused on the presence of microaggressions in diagnostic communication. People with psychosis often receive various forms of long-term care, however, and it is therefore important to understand how microaggressions manifest in a broader spectrum of mental healthcare experiences [25] and the effects of microaggressions over time, especially given their cumulative negative effect. Further research into the occurrence and possible negative effects of microaggression can help service users validate their experiences

and voice these experiences in quality improvement efforts [35], and also raise mental healthcare professionals' awareness of their expression so that they can alter their behaviour and build better relationships, thereby enhancing recovery-oriented care. The present study therefore aims to investigate microaggressions and their consequences as experienced by people with psychosis in long-term mental healthcare.

Methods

Study design

To gain insight into service users' experiences of microaggressions in mental healthcare, the researchers undertook a qualitative study of service user narratives, which provided them with non-directed and in-depth accounts of service users' experiences [36]. Narrative interviews and ego documents such as books are interesting data sources for exploring microaggressions, as they recount specific and cumulative care interactions and narrate their long-term effects. These descriptions help to foster a deeper understanding of what the actions of mental healthcare professionals mean to service users, and the consequences of these actions.

Story selection

Two different collections of service user stories in the Netherlands were used for this study: the collection of written and published service user stories maintained by Erasmus University Rotterdam,¹ and the collection of anonymized service user interviews in the Psychiatry Story Bank² maintained by University Medical Centre Utrecht. These collections were both founded to improve care by studying first-person accounts: of service users both forms of narrative data provided the researchers with detailed descriptions of service user experiences and allowed them to identify microaggressions and how they relate to service users' negative care experiences and their consequences. Combining different narrative resources helped the researchers maximize variation in service user characteristics. For instance, published stories are more likely to be written by people who have substantial resources at their disposal (e.g. in terms of verbal and cognitive skills, financing, networks), while being interviewed is accessible to a broader group of service users. The books analysed were publicly available, whereas the interviews were collected with the explicit informed consent of the participants. Details of the latter procedure are described elsewhere [37].

The sample was composed by first selecting eligible narratives based on the following criteria: [1] narrator has experienced psychosis or is diagnosed with a

psychosis-related disorder; [2] narrator mentions experiences with mental healthcare staff; [3] narrator describes experiences with care institutions that took place in the past 25 years, ensuring the applicability of the results to healthcare today; [4] narrator describes or illustrates instances of microaggressions or stigmatization by healthcare professionals. These criteria led to the selection of 32 books from the service user story database of Erasmus University Rotterdam, and 33 interviews from the Psychiatry Story Bank. These books and interviews were screened for case richness, i.e. whether they provided rich descriptions of mental healthcare experiences and detailed accounts of microaggressions and their consequences. This strategy of intensity sampling [38] resulted in the selection of nine interviews and two books that were analysed in depth. A relatively large number of books were excluded because they focused on subjects other than care experiences, such as the crisis before first diagnosis, psychotic symptoms, or the service user's life story before and after illness. Interview transcripts had an average length of 15 pages, while the two books ran to 160 and 235 pages respectively. Characteristics of the narrators are provided in Table 1.

Data analysis

A combination of thematic and narrative analysis was performed to examine the selected stories. Thematic analysis was used to identify microaggressions, whereas narrative analysis was performed to gain insight into the experienced consequences of microaggressions. For the thematic analysis, we used guidelines for a reflective thematic approach [39, 40] following an abductive method [41], thus alternating between data analysis, theory and previous empirical studies. To identify microaggressions, we developed a conceptual framework based on the existing literature on microaggressions, including Sue, Capodilupo [25], Amsalem, Hasson-Ohayon [26] and Peters, Schwenk [31]. We used this framework, consisting of subcategories of microaggressions, deductively in addition to inductive coding to allow us to construct new conceptualizations. This involved first coding microaggressions in the selected books or transcripts, resulting in 105 instances of microaggression. We then categorized codes by identifying similarities and differences in separate expressions, allowing us to group the microaggressions into three forms. After identifying these main categories of microaggression, we reread the excluded 24 interviews to check whether service users' experiences with less articulated or chaotic stories were sufficiently covered. This did not result in additional categories of microaggression.

For narrative analysis, we performed the first two steps of Murray and Sools [42] framework for storyline analysis, consisting of identification of different storyline

¹ www.patientervaringsverhalen.nl.

² www.psychiatrieverhalenbank.nl.

Table 1 Narrators' characteristics

Name (pseudonym)	Sex	Age	Diagnosed with	Educational level	Employment	Current use of mental healthcare
<i>Interviews</i>						
Tim	male	68	Schizophrenia	Vocational education	Employed	Only medication checks
Ria	female	60	Schizophrenia	Secondary school	Unemployed	No
Joyce	female	44	Schizoaffective disorder	University	Volunteer work	Yes
Eva	female	52	Bipolar disorder	Professional education	Volunteer work	Yes
Lida	female	22	Schizophrenia	Secondary school	Unemployed	Yes
Dolores	female	38	Schizoaffective disorder	Vocational education	Unemployed	Yes
Roy	male	48	Schizophrenia	Professional education	Employed	Yes
Zoey	female	26	Unspecified psychotic disorder	Secondary school	Unemployed	Yes
Miles	male	47	Unspecified psychotic disorder	University	Employed	No
<i>Books</i>						
Janet	female	32	Schizophrenia	Vocational education	Volunteer work	Only medication checks
Marja	female	50	Schizophrenia	Vocational education	Employed	No

Table 2 Microaggressions: care setting and offender

Care setting	Percentage (quantity)	Offender	Percentage (quantity)
Outpatient care	39% (41)	Psychiatrist	33% (35)
Inpatient care	61% (65)	Psychiatric nurse	27% (29)
		Psychologist	4% (4)
		Other or unspecified staff*	36% (38)

elements (agent, events, means/helpers, setting, purpose, and breach). Subsequently, we wrote a narrative summary of each narrative that matched the author's voice. These summaries helped to clarify the links between microaggressions, their consequences, and the recovery context. After initial analysis, a comparative analysis was performed to identify similar storylines, resulting in three main plots that were constructed by integrating multiple individual storylines.

Interpretative research requires critical reflection on researchers' subjectivity and the application of quality measures to enhance validity and reliability [43]. In this study, data triangulation (books and interviews) and methodological triangulation (narrative and thematic analysis) were applied for this purpose [44]. Furthermore, researcher bias was mitigated through researcher triangulation: analysis was carried out by PD who has a background in medicine and healthcare management, and NvS who is a psychologist. Both have clinical experience that sensitized them to the importance of supportive attitudes of healthcare staff. The research process was supervised by MH. Meetings with Hvdb and FS were held during the various stages of analysis to discuss and refine preliminary findings, identify blind spots, and enrich interpretation of the narratives through multidisciplinary teamwork.

Results

We identified 106 instances of microaggression in the narratives we analysed (see Table 2 for details on the care setting and offenders). Comparative analysis gave rise to three distinct forms of microaggression: microaggressions that dehumanize; microaggressions that disregard service users' perspectives; and microaggressions that convey hopelessness. These forms of microaggression and how they are expressed are based on service users' narrative meaning-making of negative care experiences and will be illustrated below.

Microaggressions that dehumanize

Microaggressions that dehumanize communicate the idea that the person is regarded merely as a disorder that requires treatment, rather than as a fully-fledged human being in need of care. Care experiences with this type of microaggression are defined by the professionals' lack of reciprocity, lack of interest and attention beyond the disease, and shaming and blaming.

First of all, service users described a lack of reciprocity in their relationships with professionals. They felt that professionals did not fully engage with them, and made no effort to build a relationship. This lack of reciprocity was communicated when professionals did not participate actively in conversations, for example by not responding to patients or merely taking notes:

I was sitting there without a story and I never got anything back. I just told how bad I was. But that person [psychiatrist, Ed.] just sat there and wrote a little bit on a notepad. And that made me so desperate. I often dissociated with him because I found it so horrible. I remember that I just stepped out of my body and saw myself sitting on that couch.
–'Joyce'

Second, service users described professionals showing little or no interest in who they were beyond their disease.

Just not being paid attention to at all, you know. They seem to work from the principle: swallow your pills and keep your mouth shut. And I think there should be um, much more attention there precisely to have serious conversations with you. Because at least I missed that very much in psychiatry... And um, I, I think um, yeah, I don't know, but I didn't feel treated like a full human being. So like um, you don't have a disease, but you are your disease, you know, that kind of idea.
Ria.

Patients experienced a lack of human interest when professionals did not ask them about their personal life or life history in individual consultations. During hospitalizations, they also experienced a lack of interest when staff were unavailable or inattentive, providing little opportunity for personal conversations.

Third, patients described how professionals blamed and shamed them for 'deviant' behaviour that gave expression to their mental distress and that they felt unable to control. For instance, professionals would express disapproval of acts of despair, instead of responding to them with empathy. One patient recalled how a nurse reacted to her self-harming behaviour:

After half an hour the night nurse came to visit. She was angry because of my wound and that I called her. She put a plaster on my hand without looking at it first. This approach was not okay, I was looking for help. A plaster? Of course it did not help, so I tied a washing glove around my hand.... I did not dare to call again.
Marja.

Microaggressions that disregard service users' perspectives

Microaggressions that disregard service users' perspectives communicate the idea that their perspectives and lived experiences are irrelevant in care provision. Care experiences with this type of microaggression are defined by: neglect of service user perspectives in diagnosis and treatment; a lack of shared information and decision-making; and a lack of therapy options.

First of all, people describe care experiences in which professionals do not ask or take seriously what is relevant to them when it comes to their illness and treatment, for instance by not engaging in conversation about their struggles and fears, and by neglecting connections between different problems in their life. Patients explain that they would have preferred a 'deep discussion' in

order to get to 'the core of problems.' Some of those who heard voices felt as if the voices were treated merely as a symptom to be erased, whereas for them they entailed meaningful content that should have informed their treatment:

I stopped going to the institution, because I just had better conversations with my home care worker... Before I became psychotic, our son had been slightly abused. I have been abused myself, so then you notice that better too... And I actually made it stop. That was very difficult. And I was afraid of him [the perpetrator, Ed.], so in my psychosis I really psyched out about that. But there was a real danger. And we actually barely talked about that at the institution. And that's something you do need to talk about. Because when I heard voices, it was often his [the perpetrator's, Ed.].
Eva.

Second, this form of microaggression can be expressed through a lack of shared information and decision-making. Narrators describe situations in which professionals treated them as if they did not have and were unable to develop any insights, for instance by not offering a detailed explanation of what was happening to them, or by not informing them about the proposed diagnosis. Other instances included situations in which professionals did not involve patients in decisions about treatment, or neglected to motivate their treatment or intervention choices.

I always needed to fill in some kind of diagram, and I needed to bring people along, I never really understood why. He did not do any diagnostics, we did not have a treatment plan... And I had been through a series of traumatic experiences. So I had done a lot of research on the effects of trauma. But when I presented that to him, he was basically like; oh yes, yes, he knew all that. So I was like, why don't you do anything with that, man? You're really making money here off the backs of people in a vulnerable position. So that really infuriated me. And then I was done with it, I said goodbye to the mental health services.
Miles.

Additionally, when service users reported negative consequences of treatment they felt that nothing was done with their feedback. This was often the case for drug side-effects that had a significant and devastating influence on their life.

I was taking Seroquel and at one point the psychiatrist said I know a better drug. But Haldol turned

out to be an intense drug, because I started shaking eh, it made me stiff and I gained thirty kilos. Um, yes, I found that really terrible, that medicine. Especially the weight gain... I tried talking about it with my nurse, but instead of having a conversation about it, she would just say every time, "Yes, but wouldn't you rather be fat than psychotic?"
Dolores.

Third, the service user's perspective was also disregarded when professionals offered limited or no treatment options that worked at the level of meaning-making and insight. Service users recounted that their treatment focused solely on stabilization and medical treatment. Psychotherapies common for other mental illnesses were often not provided. Some narrators had educated themselves in mental health and treatment options, but felt their treatment suggestions were ignored or rejected.

Microaggressions that convey hopelessness about the future

The third form of microaggression conveys hopelessness about the future, with professionals expressing negative expectations about people's future prospects and ability to recover. Care experiences defined by this type of microaggression are those in which professionals take away purpose and emphasize chronicity. In many cases, service users first experienced this sense of hopelessness about the future during their hospitalization, when they lacked meaningful activities or even mundane tasks. They frequently reported that they were just 'serving their time' and that they were offered few if any planned activities or therapies. They also stated that mundane tasks that would normally structure their day - such as doing laundry - were taken away from them. The lack of purposeful activity during hospitalization was often accompanied by an experienced lack of purpose going forward, as the professionals did not offer service users the possibility of working towards a meaningful life outside the mental health facility, for instance by not allowing them to go on leave or by talking to them about sheltered living options. Below, Roy recounts that his psychiatrist did not have faith in his preferred living situation.

I was 25 and I had no relationship, I had no house, I had no job, I had nothing at all. And I saw a lot of clients from that youth group going home after six months. But I spent two years and two months there, because I didn't have a home... So I had to wait until I could go to sheltered housing. Because they thought I should live in sheltered housing first. And the psychiatrist insisted that I go back to sheltered living in my village, because he thought the city was much too big for me. But I couldn't go back to the countryside,

because of my homosexuality, and just being very different.
Roy.

Finally, hopelessness is communicated when professionals tell service users that their diagnosis is 'for life', emphasizing chronicity over the possibility of recovery.

Service users also describe being encouraged by professionals to always communicate their diagnosis to others, even if they have not had symptoms in a long time, as illustrated in the quote above.

It is hard to have been a client. It is something that you have to deal with. It causes self-stigmatization and a need for confirmation... And I see myself more and more as normal, not as a client, because it's been so long now... I have not had a psychotic episode in five years. It is weird, but they say that if you get a diagnosis, that it is for life. That's just unfair when your psychoses fade and you are able to handle them. Why do you still have to say: I have a schizoaffective disorder?
Dolores.

Consequences of microaggressions

Microaggressions expressed by healthcare professionals can influence the recovery of people with psychosis in a variety of ways. The consequences we have identified are based on service users' narrative meaning-making of the relationship between negative care experiences and the effects of these experiences over time. Consequences were mostly described in terms of feelings and actions and categorized accordingly. Specific relationships between the form of microaggression and consequences are displayed in Fig. 1.

To capture the relationship between microaggressions and consequences as narrated by the service users, we have displayed the results as narrative summaries of the three main plots identified in our sample. The three plots were similar in that there was friction between the narrators' recovery goals and the mental healthcare setting in which various forms of microaggression took place. The feeling of being in the wrong setting for recovery created an urgency in the narrators to find more supportive settings. These are captured in the three recovery plots described below.

Consequences of dehumanization

Consequences of microaggressions that dehumanized service users consisted of feelings of unsafety and loneliness, self-stigma, and acts of despair. Whereas loneliness was often associated with a lack of reciprocity and interest, feelings of unsafety and self-stigma resulted mostly

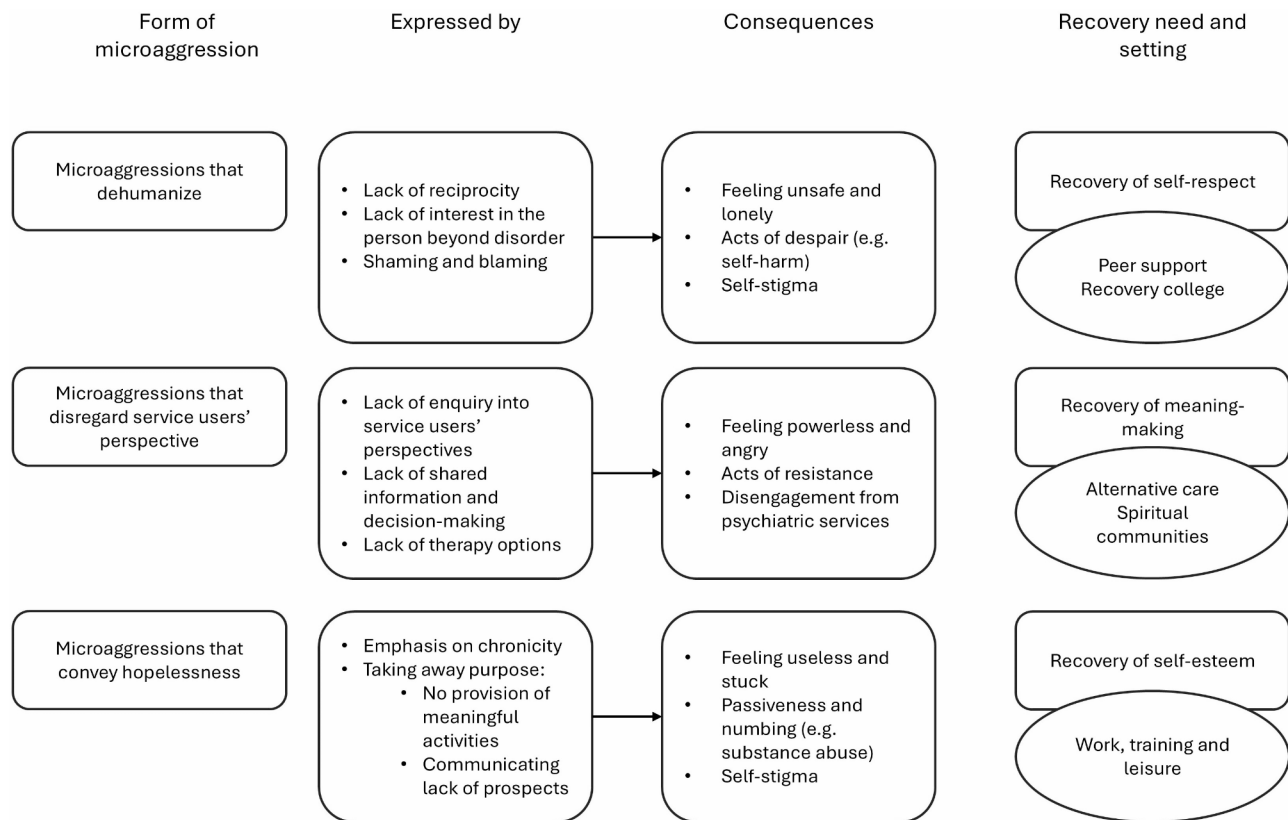


Fig. 1 Microaggressions and their consequences

from shaming and blaming. People described how these feelings aggravated their despair, often leading to an increase in the destructive or self-destructive behaviour they had sought help for.

Plot type I: nobody saw my despair

During my crisis, I often felt lonely while seeking support from my care providers. Care providers were not really involved and they did not create a secure environment for me to tell them about my experiences and my past. Instead I felt observed and unsafe, making me hesitant to discuss these experiences with them. They tried to fix everything with medication, which made me feel as if I was just insane and unworthy to talk to. I felt unheard and unsafe, which sometimes led me to inflict self-harm. Those attempts were a cry for help, but the professionals would react with incomprehension, they judged my behaviour as impulsive and told me that they would teach me to behave. I could not see how this kind of care could be beneficial. I felt misunderstood and invisible, I did not understand why they showed so little interest in me. They were supposed to support me, right? I felt horrible and trapped as others could not recognize my suffering.

These experiences created a need to recover not only from the psychosis but also from the dehumanization. In these stories, peer-settings were often experienced as the right setting to restore a sense of self-respect.

Recovery plot I: I just needed some love and attention

My friends, our conversations were my salvation. And I've experienced a lot of support at the recovery college. There you are treated as a full human being, on the basis of equality. That's very important. In the end you just need a bit of love and attention. People who simply ask you to tell them what's going on inside you. And who react empathically when you tell them about your struggles. It is very important for counsellors in psychiatry to do that more, instead of merely asking whether you've taken your medication yet.

Consequences of disregarding service users' perspective

Not having a say in their own care made service users feel powerless. In most cases, this powerlessness turned into anger and resistance and led to disengagement from psychiatric services. Disengagement took various forms. In some cases, people would continue treatment to avoid

coercive admission, but cooperate only minimally. In other cases, people would act out and overtly resist treatment. In both cases, care became an ineffective ritual that opposed recovery. Disengagement from services could also take the form of avoiding or quitting mental healthcare.

Plot type II: I had no say in my own care

When I realized that I was extremely chaotic and that I was experiencing things that other people were not, I made the decision to get professional help. I expected that professionals would help me explore and understand what was happening. However, I never found out what they thought. They did not even inform me about my diagnosis and I had little to say about my treatment. I did not feel involved or in control of my own trajectory. They never showed interest in my thoughts about or experience of treatment. It gave me the impression that they did not value my opinion. They made decisions for me rather than with me, and assumed that I could not make sense of it all.

Indignation often motivated people to take the responsibility for their recovery out of the hands of formal services and into their own. In this process, they searched for other forms of support and knowledge to recover from having their perspectives and meaning-making disregarded. In these stories, alternative care settings and spiritual or religious communities were often experienced as the right setting to gain or regain one's own voice.

Recovery plot II: I took back control

My trust in healthcare faded. The lack of communication enraged me to the point where I began to act out. I decided that I did not want to cooperate anymore. I knew deep down that the issues that I needed assistance with would not be resolved by the treatment that they provided. I decided to deepen my knowledge about psychosis and different therapy forms, which helped me to understand why this had happened to me and how I could take responsibility for my own life. As a result, I decided to discontinue treatment in psychiatry and find a therapist in alternative care. I was fortunate that I succeeded, but I believe that many things could have been done better in regular care.

Consequences of hopelessness

Consequences of microaggressions conveying hopelessness entailed feelings of uselessness and being stuck. These feelings would often arise while service users were

hospitalized and lacked purposeful activities. The pessimistic perspectives that professionals communicated aggravated such feelings. Service users felt 'given up on' and 'depreciated' and lost faith in the prospect of ever returning to a normal life. The lack of prospects made them passive and depressed. In some cases they started to numb themselves through substance abuse.

Plot type III: my life was not going anywhere

Before my admission, I was extremely restless and my personal life was a mess. I needed structure and support in all aspects of my personal life, and I expected that my healthcare professionals would assist me in resolving these issues. I was motivated to solve my problems and work for a better future. Instead, during my admissions, they took all of my responsibilities away from me. There was no structure, no activity, and they did not provide many therapies due to budget cuts. This made me feel stuck and bored. I could only drink coffee and smoke cigarettes, was not even allowed to go outside. I did not understand how this could help me improve my life. My psychiatrist didn't take me very seriously. He also gave me the prognosis that, with a diagnosis of schizophrenia, I could forget about a social life, independent living and education. That had quite an impact on me at the time. Because if you can't do anything anymore, then you become passive. Then you no longer actively engage in your own development.

In other cases, people were motivated to prove pessimistic healthcare professionals wrong. In these stories, recovery of self-esteem frequently began by re-engaging in meaningful activities with other people, often in the form of leisure activities, education, or volunteer work. Through these activities, people regained confidence in their ability to grow and gradually disentangle from self-stigma.

Recovery plot III: I proved them wrong

I knew I was not stupid, and I wanted to show them that I could recover and live a fulfilling life. Eventually, I succeeded in finishing my training to become a peer worker in three years. That was really a victory for me. It was like giving them the finger, like saying yes, I can do this, I have proved it.

Discussion

The aim of this study was to identify different forms of microaggression and their consequences as experienced in mental healthcare by service users with psychosis. By performing a qualitative analysis of service users'

narratives, we identified three forms of microaggression: microaggressions that dehumanize; microaggressions that disregard service users' perspectives; and microaggressions that convey hopelessness.

Consistent with previous research on this topic, service users described negative care experiences in which they felt defined by their disorder and treated as inferior by mental healthcare professionals [28]. In our study, we categorized these experiences as microaggressions that dehumanize, as this term seems to best capture the experience of being approached only as a disordered individual, without empathy or attention for other aspects of one's life history and identity. Narrative analysis demonstrated that this made service users feel lonely and unsafe in mental healthcare settings, which aligns with previously described effects of microaggression [32]. Microaggressions that dehumanize could further contribute to self-stigma and a lack of self-respect, as people did not feel entitled to the same treatment as others. The narratives taught us that, in particular, blaming and shaming contributed to actions of despair, such as self-harm or suicidal behaviour.

Microaggressions that disregard service users' perspectives overlapped with previous research identifying invalidation of lived experience and a lack of shared decision-making as microaggressions [26]. This microaggression can be understood as a form of epistemic injustice, as people are invalidated in their capacity to know themselves [45]. We identified a lack of therapy/psychotherapy options as an additional expression of a microaggression that disregards the service user's perspective, as the absence of these options appeared to stem from professionals' low trust in service users' ability to make sense of their situation or develop self-insight. Previous research indicates that this kind of 'therapeutic pessimism' and undertreatment can lead to a vicious circle of ineffective interactions in which the service user is labelled as difficult and may be held responsible for a lack of progress [46]. Our analysis demonstrated that such interactions can also result in the service user disengaging from mental healthcare services. Treatment non-adherence has been identified as a consequence of microaggression in previous research [32]. In our study, we saw that disengagement could take various forms, ranging from minimal cooperation to quitting treatment.

Finally, and similar to the outcomes of Amsalem, Hasson-Ohayon [26], we identified a form of microaggression that conveys hopelessness and entails pessimistic views on recovery from psychosis by emphasizing chronicity. In addition, we found that hopelessness also ensued from taking away purpose. The more indirect version of this microaggression was a lack of mundane and meaningful activity during hospitalization, which caused an immediate feeling of uselessness; the more direct version was

explicit communication by professionals about impossibilities going forward, which had the more gradual effect of evoking depression, passiveness, and self-stigma. Our results show similarities with the 'Why try effect' of stigmatization, as described by Corrigan, Larson and Rüsçh [47], in which people internalize pessimistic expectations, resulting in low self-esteem and self-efficacy, and anticipate failure by giving up attempts to achieve personal goals.

As recovery research has demonstrated, recovery from serious mental distress such as psychosis is not merely about recovering from the illness, but also about recovering from stigma and adverse care experiences [12, 48]. In our study, we saw that microaggressions in mental healthcare resulted in added or heightened recovery needs, which can equally be understood as struggles for social justice, such as recovery of self-respect and self-esteem [49], and epistemic justice [45]. These added recovery needs were often resolved outside mental healthcare. In our study, the anger roused by epistemic injustice appeared to be most strongly associated with resistance, non-adherence to treatment, and empowerment outside mental healthcare. Peer support and alternative care and work settings all played an important role in recovery from the consequences of microaggression. The recovery plots we identified illustrate the resilience of people with psychosis. The narratives, however, also taught us that recovery was a long and difficult process requiring many resources (e.g. a supportive network, energy, assertiveness, cognitive skills, etc.). When these resources were not available to people, they were likely to get stuck in care situations of damaged trust and minimal engagement, leading to relapse or stagnation of recovery.

Implications

Research on microaggression is subject to debates about the boundaries of the concept [29]. The findings of this study can help to further elaborate the concept empirically within the context of mental healthcare. Microaggressions are generally described as distinct from discrimination because they express prejudice less publicly and less overtly [27]. According to Williams [29], the concept of microaggression overlaps considerably with the well-studied concept of 'everyday discrimination', but better covers experiences of not being seen, or being socially excluded. In line with this differentiation, our results imply that it might be useful to rethink microaggression in mental healthcare not only for what is actively done to people but also in terms of what they are deprived of. Strikingly, service users often described negative care experiences in terms of the *absence* of relationship-building and not being treated as equal or worthy of humane interaction. For microaggression research in mental healthcare, we therefore propose extending the

analysis of microaggressions beyond negative remarks or actions to include the aspects of 'normal' human interaction that are lacking in institutionalized practices. This would also make the distinction between microaggressions and overt and deliberate forms of aggression (see [57]) and discrimination clearer.

Furthermore, the long-term consequences of microaggressions identified in this study challenge the notion that the prefix 'micro' implies an innocuous or negligible form of aggression, as critics of the concept have argued (see [27]). The adverse consequences we found highlight the importance of researching stigma and discrimination beyond their overt manifestations. Rini [27] proposes understanding microaggression as a functional part of systematic oppression, characterized not so much by size but by the ambiguous experience that victims undergo. Microaggressions seem to cause psychological harm precisely because their subtlety complicates the attribution process: it makes victims doubt whether they are being treated unjustly or whether they are just being hypersensitive or wrong [27, 50]. In the case of service users with psychosis, this attributional doubt might be further enhanced because psychosis by definition entails experiences and perspectives that are not socially shared. In our study, we saw that the experience of microaggressions resulted in enhanced self-stigma as people started to believe the prejudices that the microaggressions conveyed (e.g. not being able to hold down a job, not being worthy of a real conversation).

The lack of overtness and the plausible unintentionality that is inherent to the concept of microaggression also make it more challenging for victims to address microaggressions [27]. Users of mental health services might find it particularly hard to gain acknowledgement of this form of injustice, given the risk of 'diagnostic overshadowing' of professionals [51], i.e. the tendency to disqualify service users' behaviour and perspectives as part of the psychopathology. By identifying different forms of microaggression within mental healthcare, this study can help service users with similar experiences to validate and articulate their experiences and enhance their empowerment.

This study also clarifies the added value of the concept of microaggression in relation to other, more widely shared concepts related to power differences in mental healthcare. Different ways in which mental healthcare workers exercise power beyond formal coercion have been captured in the growing literature on informal coercion, which proposes a hierarchy of behaviours (ranging from persuasion to threats) meant to pressure people to accept mental health treatment [52, 53]. The concept of microaggression highlights types of behaviour other than informal coercion. Informal coercion - however questionable it may be ethically - is deployed intentionally

by mental healthcare professionals to ensure treatment while avoiding formal coercion, such as involuntary admission. By contrast, microaggressions are unintentional expressions of stigma that do not have a defensible aim. Whereas informal coercion might result in treatment in which the relationship between professionals and service users can be restored, our study shows that microaggressions are more likely to result in disengagement from mental health services.

For clinical practice, our findings illustrate the urgent need to improve relational care for people with psychosis. Dignity and respect for every person are at the heart of recovery-oriented mental healthcare, and should at all times be reflected in professionals' communication and practice [54]. Overt and covert forms of stigma and discrimination against people with severe mental distress, and people with psychosis in particular, are a society-wide problem [33]. Their expression by care professionals is particularly harmful, however, because of the influence and power professionals can exert over the lives of service users [17]. The occurrence of microaggression in mental healthcare raises questions about why offenders are often unaware of the negative underpinnings and effects of their communication [26]; after all, professionals receive extensive training in the communicative and therapeutic skills needed to work with people in vulnerable positions. One explanation might be that members of a dominant group are usually not sensitized to identifying microaggressions [27]. Our study provides rich descriptions of instances of microaggressions experienced in mental healthcare that could inform the further training of this group and raise professionals' awareness and recognition of microaggression as a first and vital step towards behavioural change [55]. Beyond unawareness, it is important to look at other explanations for harmful behaviour in healthcare as well. For instance, dehumanizing behaviour on the part of care professionals has been explained as a protective strategy that allows them to cope with suffering [56]. Viewed through the lens of microaggression theory, it is of particular importance to focus on the way microaggressions reinforce power differences between social groups [29]. Dependency on care gives rise to complicated power inequalities between service users and providers that might result in harmful behaviour if not mitigated carefully [57]. Additionally, power dynamics between staff members can also trickle down to service users [51]. Fontesse, Rimez and Muraige [51], for instance, found that psychiatric nurses who feel dehumanized by their superiors are more prone to dehumanizing their patients. Sensitizing professionals for microaggressions might therefore only be effective when simultaneously addressing the power dynamics within care organizations.

Strengths and limitations

This study contributes to the emerging field of microaggression research in mental healthcare and focused on the stigmatized group of service users with psychosis. To our knowledge, this is the first study that provides insight into their experiences with microaggressions in long-term care trajectories. One important strength of this study is that we made use of service users' narratives that were not, or only minimally, structured by the researchers. In both the interviews and self-authored books, the narrators had the liberty to construct their own story about what mattered most to them. We learned that when people have the opportunity and space to tell their story without the usual restrictions of a clinical or research setting, they mostly produce stories about their life and self across several decades. This made it possible for us to gain insight into the long-term consequences of microaggressions in care and their effect on recovery in psychosis, thereby complementing previous research on microaggressions in psychosis care [32]. Given the cumulative negative effect of microaggressions described in the literature [17, 24], studying their long-term consequences is of particular importance in microaggression research.

A limitation of our study is that we were unable to specify all the relevant variations between service users and their care trajectories, such as differences in illness severity, or differences between coercive and voluntary care. Future research could establish whether the particular form of microaggression being experienced is related to specific service user or care setting variables. Furthermore, to enhance conceptualizations of microaggression in the context of mental healthcare, we purposefully selected stories about the occurrence and elaboration of negative care experiences. We did not examine the stories of people with psychosis who had predominantly positive healthcare experiences. Although our study did not aim to provide an overall assessment of care experiences, future research could include a wider range of experiences to learn from the contrasts. Conceptualizing positive care experiences could also offer more insight into how to combat microaggressions within the mental healthcare system. For instance, Topor, von Greiff and Skogens [58] used the concept of 'micro-affirmation' to study subtle care interactions that create helpful relationships between persons with alcohol and drug problems and their professionals. Studying both microaggressions and micro-affirmations in care for people with psychosis can help to identify further entry points for care improvement. Finally, it would be helpful and complementary to examine the perspectives and deliberations of healthcare professionals in psychosis care. Their stories can shed light on the challenges and power dynamics they face in everyday care interactions. Analysing care experiences from different perspectives and combining these analyses

can inform dialogue and form a basis for reflexive methods for co-designing care improvements [59].

Conclusion

In conclusion, we found that people with psychosis regularly experience subtle enactments of stigma in mental healthcare. Accumulation of such microaggressions was associated with negative consequences, such as acts of despair and disengagement from mental health services. Microaggressions in mental healthcare created additional recovery needs that were better resolved outside traditional mental healthcare settings. Our findings additionally illustrate the gap between recovery-oriented mental healthcare policies and the everyday experiences of service users. The different forms and consequences of microaggression we identified can help raise awareness of harmful behaviour by mental health professionals and improve their services.

Author contributions

MH and PD designed the study and led the initial conceptualization. PD and NS performed the analysis and interpretation of data and drafted the manuscript. NS contributed to the conceptualization of microaggressions in relation to personal recovery and drafted the figure. MH, FS and HB were involved in the interpretation of the data and revised the manuscript. All authors reviewed and approved the submitted version.

Funding

Not applicable.

Data availability

Interview data from the Psychiatry Storybank is not readily available because of participant confidentiality and privacy. Books from the 'patientervaringsverhalen' collection (Erasmus university) are publicly available and are accessible through the university library of the Erasmus University.

Declarations

Ethics approval and consent to participate

The Psychiatry Story Bank project was evaluated by the Medical Ethical Review Committee of University Medical Centre Utrecht (Utrecht, the Netherlands), who confirmed that the Dutch Medical Research Involving Human Subjects Act (WMO) did not apply. Subsequently, official approval of this study by the Medical Ethical Review Committee was not required (reference number WAG/mb/16/030724). Informed consent to participate and publish was obtained from all participants.

Competing interests

The authors declare no competing interests.

Consent to publish

Informed consent to participate and publish was obtained from all Psychiatry Story Bank participants.

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Received: 9 July 2024 / Accepted: 6 November 2024

Published online: 19 November 2024

References

- Borg M, Kristiansen K. Recovery-oriented professionals: helping relationships in mental health services. *J Mental Health*. 2004;13(5):493–505.
- Wampold BE, Flückiger C. The alliance in mental health care: conceptualization, evidence and clinical applications. *World Psychiatry*. 2023;22(1):25–41.
- Kidd SA, Davidson L, McKenzie K. Common Factors in Community Mental Health Intervention: a scoping review. *Commun Ment Health J*. 2017;53(6):627–37.
- Gilbert H, Rose D, Slade M. The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Serv Res*. 2008;8(1):1–12.
- Hamovitch EK, Choy-Brown M, Stanhope V. Person-centered care and the Therapeutic Alliance. *Commun Ment Health J*. 2018;54(7):951–8.
- Newman D, O'Reilly P, Lee SH, Kennedy C. Mental health service users' experiences of mental health care: an integrative literature review. *J Psychiatr Ment Health Nurs*. 2015;22(3):171–82.
- Law H, Morrison AP. Recovery in psychosis: a Delphi Study with experts by experience. *Schizophr Bull*. 2014;40(6):1347–55.
- Campodonico C, Varese F, Berry K. Trauma and psychosis: a qualitative study exploring the perspectives of people with psychosis on the influence of traumatic experiences on psychotic symptoms and quality of life. *BMC Psychiatry*. 2022;22(1):213.
- van Sambeek N, Franssen G, van Geelen S, Scheepers F. Making meaning of trauma in psychosis. *Front Psychiatry*. 2023;14:1272683.
- Berring LL, Georgaca E, Hirsch S, Bilgin H, Akik BK, Aydin M, et al. Factors and processes facilitating recovery from Coercion in Mental Health Services—A Meta-ethnography. *Healthcare*. 2024;12(6):628.
- Leamy M, Bird V, Le Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry*. 2011;199:445–52.
- Dell NA, Long C, Mancini MA. Models of mental health recovery: an overview of systematic reviews and qualitative meta-syntheses. *Psychiatr Rehabil J*. 2021.
- Kilbride M, Morrison AP, Nothard S, Pitt L, Welford M. Impact of a diagnosis of psychosis: user-led qualitative study. *Psychiatr Bull*. 2009;33(11):419–23.
- Rao H, Mahadevappa H, Pillay P, Sessay M, Abraham A, Luty J. A study of stigmatized attitudes towards people with mental health problems among health professionals. *J Psychiatr Ment Health Nurs*. 2009;16(3):279–84.
- Loch AA, Guarniero FB, Lawson FL, Hengartner MP, Rössler W, Gattaz WF, Wang Y-P. Stigma toward schizophrenia: do all psychiatrists behave the same? Latent profile analysis of a national sample of psychiatrists in Brazil. *BMC Psychiatry*. 2013;13(1):92.
- Frese IJF, Knight EL, Saks E. Recovery from schizophrenia: with views of psychiatrists, psychologists, and others diagnosed with this disorder. *Schizophr Bull*. 2009;35(2):370–80.
- Thornicroft G, Rose D, Kassam A. Discrimination in health care against people with mental illness. *Int Rev Psychiatry*. 2007;19(2):113–22.
- Burke EM, Wood L, Zabel E, Clark A, Morrison AP. Experiences of stigma in psychosis: a qualitative analysis of service users' perspectives. *Psychosis*. 2016;8:130–42.
- Onken S, Dumont J, Ridgway P, Dornan D, Ralph R. Mental Health Recovery: what helps and what hinders? A National Research Project for the Development of Recovery Facilitating System Performance indicators Phase One Research Report. A National Study of Consumer Perspectives on What Helps and Hinders Recovery; 2002.
- Wood L, Alsawy S. Recovery in psychosis from a service user perspective: a systematic review and thematic synthesis of current qualitative evidence. *Commun Ment Health J*. 2018;54(6):793–804.
- Guidance on community mental health services. Promoting person-centered and rights-based approaches. Geneva: World Health Organization; 2012.
- Goffman E, editor. *Stigma; Notes On The Management Of Spoiled Identity* 1964.
- Link BG, Phelan JC. Conceptualizing Stigma. *Ann Rev Sociol*. 2001;27(27):363–85.
- Young RE, Goldberg JO, Struthers CW, McCann D, Phills CE. The subtle side of Stigma: understanding and reducing Mental Illness Stigma from a contemporary prejudice perspective. *J Soc Issues*. 2019;75(3):943–71.
- Sue DW, Capodilupo CM, Torino GC, Bucceri JM, Holder AMB, Nadal KL, Esquilin M. Racial microaggressions in everyday life: implications for clinical practice. *Am Psychol*. 2007;62(4):271–86.
- Amsalem D, Hasson-Ohayon I, Gothelf D, Roe D. Subtle ways of stigmatization among professionals: the subjective experience of consumers and their family members. *Psychiatr Rehabil J*. 2018;41:163–8.
- Rini R. Taking the measure of microaggression: how to put boundaries on a nebulous concept. *Microaggressions and philosophy: Routledge*; 2020. pp. 101–20.
- Barber S, Gronholm PC, Ahuja S, Rüschi N, Thornicroft G. Microaggressions towards people affected by mental health problems: a scoping review. *Epidemiol Psychiatr Sci*. 2020;29:e82.
- Williams MT. Racial microaggressions: critical questions, state of the Science, and new directions. *Perspect Psychol Sci*. 2021;16(5):880–5.
- Torino GC, Rivera DP, Capodilupo CM, Nadal KL, Sue DW. *Microaggression theory: influence and implications*. Wiley; 2018.
- Peters HJ, Schwenk HN, Ahlstrom ZR, McIlwain LN. *Microaggressions. The experience of individuals with mental illness*. *Counselling Psychol Q*. 2017;30(1):86–112.
- Gonzales L, Davidoff KC, Nadal KL, Yanos PT. Microaggressions experienced by persons with mental illnesses: an exploratory study. *Psychiatr Rehabil J*. 2015;38(3):234–41.
- Wood L, Birtel M, Alsawy S, Pyle M, Morrison A. Public perceptions of stigma towards people with schizophrenia, depression, and anxiety. *Psychiatry Res*. 2014;220(1):604–8.
- Luhrmann TM, Marrow J. *Our most troubling madness: case studies in schizophrenia across cultures*. University of California Press; 2019.
- Carel H, Kidd JJ. Epistemic injustice in healthcare: a philosophical analysis. *Med Health Care Philos*. 2014;17:529–40.
- van de Bovenkamp HM, Platenkamp C, Bal R. Understanding patient experiences: the powerful source of written patient stories. *Health Expect*. 2020;23(3):717–8.
- van Sambeek N, Baart A, Franssen G, van Geelen S, Scheepers F. Recovering Context in Psychiatry: What Contextual Analysis of Service Users' Narratives Can Teach About Recovery Support. *Front Psychiatry*. 2021;12.
- Suri H. Purposeful sampling in qualitative research synthesis. *Qualitative Res J*. 2011;1(2):63–75.
- Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Res Psychol*. 2006;3(2):77–101.
- Braun V, Clarke V. Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling Psychother Res*. 2021;21(1):37–47.
- Tavory I, Timmermans S. *Abductive analysis: theorizing qualitative research*. University of Chicago Press; 2014.
- Murray M, Sools A. Narrative research in clinical and health psychology. In: Rohleder P, Lyons AC, editors. *Qualitative research in clinical and Health psychology*. London: Palgrave Macmillan; 2015. pp. 133–54.
- O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245–51.
- Noble H, Heale R. Triangulation in research, with examples. *Evid Based Nurs*. 2019;22(3):67–8.
- Fricke M. Epistemic Justice and a role for Virtue in the politics of knowing. *Metaphilosophy*. 2003;34(1–2):154–73.
- Koekkoek B, Hutschemaekers G, van Meijel B, Schene A. How do patients come to be seen as 'difficult'? A mixed-methods study in community mental health care. *Soc Sci Med*. 2011;72(4):504–12.
- Corrigan PW, Larson JE, Rüschi N. Self-stigma and the why try effect: impact on life goals and evidence-based practices. *World Psychiatry*. 2009;8(2):75–81.
- Lu W, Mueser KT, Rosenberg SD, Yanos PT, Mahmoud N. Posttraumatic reactions to psychosis: a qualitative analysis. *Front Psychiatry*. 2017;8(129).
- Honneth A. *The struggle for Recognition: the Moral Grammar of Social conflicts*. Polity; 1996.
- Jones KP, Arena DF, Nittrouer CL, Alonso NM, Lindsey AP. Subtle discrimination in the workplace: a vicious cycle. *Industrial Organizational Psychol*. 2017;10(1):51–76.
- Fontesse S, Rimez X, Maurage P. Stigmatization and dehumanization perceptions towards psychiatric patients among nurses: a path-analysis approach. *Arch Psychiatr Nurs*. 2021;35(2):153–61.
- Pelto-Piri V, Kjellin L, Hylén U, Valenti E, Priebe S. Different forms of informal coercion in psychiatry: a qualitative study. *BMC Res Notes*. 2019;12:1–4.
- Szmukler G, Appelbaum PS. Treatment pressures, leverage, coercion, and compulsion in mental health care. *J Mental Health*. 2008;17(3):233–44.

54. Jensen ME, Pease EA, Lambert K, Hickman DR, Robinson O, McCoy KT, et al. Championing Person-First Language: a call to Psychiatric Mental Health nurses. *J Am Psychiatr Nurses Assoc.* 2013;19(3):146–51.
55. Michie S, van Stralen MM, West R. The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implement Sci.* 2011;6:42.
56. Hoogendoorn CJ, Rodríguez ND. Rethinking dehumanization, empathy, and burnout in healthcare contexts. *Curr Opin Behav Sci.* 2023;52:101285.
57. van der Geest S, Platenkamp C. Care as tyranny: Miscellaneous observations. *Anthropology and Humanism.* n/a(n/a).
58. Topor A, von Greiff N, Skogens L. Micro-affirmations and Recovery for Persons with Mental Health and Alcohol and drug problems: user and professional experience-based practice and knowledge. *Int J Mental Health Addict.* 2021;19(2):374–85.
59. Heerings M, van de Bovenkamp H, Cardol M, Bal R. Ask us! Adjusting experience-based codesign to be responsive to people with intellectual disabilities, serious mental illness or older persons receiving support with independent living. *Health Expect.* 2022;25(5):2246–54.

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