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Behind the Stigma: A Narrative Inquiry into the Perception and Experiences of Mental Health, Addictions, and Forensic Nurses

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Abstract

Mental health and forensic nurses work at the intersection of healthcare, law, and social justice, yet their roles remain undervalued within the nursing profession. This study explored how these nurses construct professional identity and resilience while navigating stigma and systemic inequity. A qualitative narrative inquiry design was used to gather written reflections from 14 nurses in Ontario and British Columbia, including registered nurses, registered practical nurses, and nurse practitioners. Participants responded to open-ended prompts through a secure online platform, describing experiences of stigma, workplace hostility, advocacy, and meaning in their work. Data were analyzed thematically and through a composite narrative approach to capture both individual and collective perspectives. Six major themes emerged: stigma and systemic misrepresentation, stigma toward patients, advocacy and emotional labor, workplace hostility, purpose and resilience, and systemic barriers. Findings demonstrate that nurses experience both external and internalized stigma that diminishes professional legitimacy, yet they construct identities grounded in empathy, advocacy, and relational expertise. The study applies Goffman's concept of courtesy stigma and social identity theory to interpret how hierarchies shape belonging within healthcare. These results stress the need for stigma-reduction education, mentorship programs, and policy investment in community mental health services. Centering nurses' voices

through narrative inquiry reframes mental health and forensic nursing as advanced, relational, and justice-oriented practice.

Keywords: forensic nursing, mental health nursing, stigma, narrative inquiry, lateral violence

Behind the Stigma: A Narrative Inquiry into the Perception and Experiences of Mental Health, Addictions, and Forensic Nurses

Mental health, addictions, and forensic nurses require advanced relational, assessment, and crisis-management skills (Tulloch et al., 2025). Despite this expertise, these specialties remain marginalized within nursing, often perceived as less technical or prestigious than acute care domains (Sercu et al., 2015). Media portrayals frequently depict forensic environments as violent and mental illness as synonymous with danger, reinforcing fear and misunderstanding (Stuart, 2006). These portrayals contribute to stigma toward both patients and the nurses who care for them (Halter, 2008). Although stigma toward people with mental illness is well documented, limited attention has been given to the associative stigma and professional identity challenges faced by mental health and forensic nurses (Martin et al., 2020; O'Brien et al., 2025). Few studies center the voices of forensic nurses, leaving a gap in understanding how they navigate diagnostic overshadowing, workplace hostility, and moral distress within complex institutional contexts (Marshall & Adams, 2018). Within healthcare teams, lateral violence, including bullying and subtle exclusion, undermines collaboration, identity, and nurse retention (Marshall & Adams, 2018). This study addresses these gaps by foregrounding the experiences of mental health and forensic nurses and exploring how they make sense of stigma, identity, and resilience within systemic and interpersonal environments.

To ensure conceptual clarity for the analysis that follows, key terms used in this study are defined here. Forensic nursing is defined as the integration of nursing practice with the criminal justice and mental health systems, focusing on the care of individuals at the intersection of health and law. The term lateral violence refers to hostile, aggressive, or harmful behavior among colleagues within the same profession, including bullying, exclusion, or demeaning remarks (Embree & White, 2010). The phrase workplace hostility is used interchangeably to encompass these behaviors. To explore how these nurses understand and experience their professional roles within these intersecting systems, a qualitative narrative inquiry design was employed.

Methods

A qualitative narrative inquiry design captured the lived experiences of nurses in their own words (Clandinin & Connelly, 2000; Riessman, 2008). Narrative inquiry privileges storytelling and meaning-making, emphasizing how professionals construct identity and interpret experience. This design aligns with a constructivist and interpretivist paradigm, recognizing that knowledge is co-constructed through the sharing and interpretation of lived experiences (Dahal et al., 2024). Participants provided written reflections guided by open-ended prompts, enabling deep, self-paced storytelling, a respectful approach to sensitive topics such as stigma and workplace conflict (Halter, 2008).

Composite Narrative Design

In addition to thematic and holistic narrative analysis, a composite narrative design was used to synthesize shared experiences into a cohesive interpretive story. Composite narratives integrate multiple participant voices into a single, representative narrative while maintaining the integrity and emotional tone of individual accounts (Clandinin & Connelly, 2000). This approach honors participant anonymity while providing a coherent depiction of collective experiences, allowing readers to engage with the findings as lived realities rather than abstracted themes (Clandinin & Connelly, 2000).

Participants and Recruitment

Nineteen nurses initially consented to participate in the study; however, five did not progress beyond the initial consent question and were excluded. The final sample included 14 participants: 10 Registered Nurses (RNs), 2 Nurse Practitioners (NPs), and 4 Registered Practical Nurses (RPNs). NPs were categorized separately from RNs for clarity. Participants represented both Ontario (n = 13, 93%) and British Columbia (n = 1, 7%), with 11 identifying as women (79%) and 3 as men (21%). Years of experience ranged from 2 to 25, with the largest group (n = 6) reporting between 6 and 10 years in mental health or forensic nursing. Practice settings included forensic psychiatric hospitals, correctional institutions, community mental health programs, and inpatient psychiatric units.

Recruitment employed purposive and snowball sampling through professional networks, academic contacts, and social media platforms. Invitations were distributed through the Canadian Forensic Nurses Association, the Registered Nurses' Association of Ontario Mental Health Nursing Interest Group, LinkedIn, and closed Facebook nursing groups. Inclusion criteria required current or recent (within five years) experience in mental health or forensic practice, professional registration (RPN, RN, or NP), and English fluency. Exclusion criteria included nursing students and individuals without direct patient care responsibilities. The target sample size of 10 to 15 participants was established a priori, consistent with narrative inquiry conventions emphasizing depth of data over breadth (Clandinin & Connelly, 2000).

Data Collection

Data were collected through written narrative submissions in response to open-ended prompts designed to elicit detailed reflection on participants' professional experiences. Participants were asked to describe how they understood their professional identity within mental health or forensic practice, to recount experiences of stigma or misunderstanding from colleagues, the public, or media, and to share examples of advocacy, resilience, or workplace hostility. They were also encouraged to reflect on what aspects of their work they most valued and how these shaped their sense of purpose as nurses.

Narratives were submitted electronically through a secure Qualtrics platform to ensure confidentiality. Participants were encouraged to write freely and at their own pace; most narratives ranged from 500 to 1,500 words. The data collection period remained open for six weeks. Data saturation was reached after 12 submissions, when no new themes or codes emerged, and was confirmed after analysis of the final two. Member checking was completed by 12 of 14 participants to validate interpretations and strengthen credibility.

Ethical Considerations and Analysis

Ethics approval was granted by the researchers' institutional Research Ethics Board (REB #127), and all participants provided informed consent prior to contributing their narratives. To

protect confidentiality, identifying information was removed, and pseudonyms were used in reporting.

To ensure rigor and trustworthiness, a triangulated approach to data analysis was employed. Both researchers independently coded the entire set of transcripts, identifying patterns and emergent themes across the narratives. Each participant's full response was first analyzed in its entirety to preserve narrative integrity and contextual meaning. Subsequently, responses were analyzed by prompt so that all answers to the same guiding question could be compared across participants. This layered process allowed for both within-case depth and cross-case consistency, ensuring that individual perspectives were honored while collective experiences were clearly represented.

Following coding, transcripts and summaries were returned to participants for member checking. Twelve of the 14 participants confirmed the accuracy of their narratives and interpretations, enhancing the credibility and dependability of the findings.

As a final analytic step, the research team used ChatGPT Pro as a supplementary validation tool to ensure that no patterns or themes were inadvertently overlooked. This step was intentionally conducted after the manual coding and synthesis were complete to prevent bias and to preserve the primacy of human interpretation. ChatGPT Pro was used to cross-check word frequencies, conceptual groupings, and semantic relationships within the anonymized dataset. Participants were informed that only de-identified data would be reviewed by AI software, and ethical compliance was verified according to Canadian privacy regulations. Privacy and deletion features were activated to maintain data protection standards. This multi-layered strategy, integrating researcher coding, participant validation, and AI-assisted comparison, provided a robust framework for triangulation and enhanced the trustworthiness of the study's findings.

Results

Six central themes were identified (Table 1), reflecting the intersecting experiences of stigma, systemic constraint, professional identity, and resilience among forensic and mental health nurses. To preserve participants' voices and narrative texture, excerpts from individual narratives are presented alongside a composite account.

Table 1
Theme Chart

Main Theme	Subthemes	Illustrative Quote
Stigma and Systemic Misrepresentation	• "Not real nurses" and professional devaluation • Media stereotypes and public fear • Structural and organizational stigma	People assume we don't do real nursing; they think our work isn't as technical or important.
Stigma Toward Patients and Diagnostic Overshadowing	• Labeling and prejudice in healthcare • Neglect of physical health needs • Internalized stigma and self-protection	The patient only got transferred so they could pass with dignity, not in our psychiatric intensive care unit.
Advocacy and Emotional Labor	• Burnout and moral distress • Constant defense of patient legitimacy	I find myself becoming burned out from having to constantly advocate and defend my patients.

Main Theme	Subthemes	Illustrative Quote
	• Emotional fatigue and compassion strain	
Resilience, Purpose, and Professional Identity	• Pride in relational expertise • Meaning-making through advocacy • Personal connections to the work	As the nurse, you are the therapeutic tool; not a dressing tray, not a machine.
Workplace Hostility and Hierarchical Devaluation	• Lateral violence and exclusion • "Loss of skills" stereotype • Institutional silence and undervaluation	When I chose this field as a new graduate, I was told I'd lose my nursing skills.
Systemic Barriers and the Quest for Change	• Fragmented services and resource gaps • Cycles of relapse and patient marginalization • Commitment to advocacy and reform	Patients seeking treatment for addiction often can't get sufficient support, leading to cycles of relapse.
Composite Narrative: "Finding Meaning in the Margins"	• Integrates shared experiences of stigma, resilience, and moral purpose. Serves as a synthesized representation of the collective voice, illustrating how nurses sustain professional identity amid marginalization.	It's hard work, but it's honest work, and it's ours.

Composite Narrative: Finding Meaning in the Margins

> *When I first told my peers I was moving into forensic mental health, someone laughed and said, "So, you'll just talk to criminals all day?" At first, I tried to explain, then I stopped trying. In this work, you learn to listen differently, to stories that aren't easy to hear. I've sat across from patients judged by society long before they spoke a word. Some days, the system feels like it's failing both of us. But there are moments, small ones, when trust builds, when someone says, "You treated me like a person." Those are the moments that keep me here. It's hard work, but it's honest work, and it's ours.*

Stigma and Systemic Misrepresentation

Participants described being perceived as "not real nurses," reflecting both professional and societal misunderstanding.

> *"People assume we don't do real nursing—they think our work isn't as technical or important."*

These misconceptions were reinforced by media portrayals that depicted forensic environments as violent or unsafe.

> *"The public associates forensics with scary movies they see on TV."*

Stigma also extended to the health system itself. Nurses described colleagues dismissing their expertise, assuming forensic care required less skill or intellect.

"Friends on other units made jokes about me being able to 'just talk to people,' as if that's all I do."

These narratives revealed how media stereotypes and professional hierarchies combined to marginalize forensic and mental health nursing within the broader discipline.

Stigma Toward Patients and Diagnostic Overshadowing

Participants expressed deep concern about the stigma their patients encountered.

"They're often treated as non-urgent, yet other frequent flyers like diabetics are treated urgently."

Others described instances where psychiatric labels led to fatal neglect.

"The patient only got transferred so they could pass with dignity, not in our psychiatric intensive care unit."

This pattern of diagnostic overshadowing reflected systemic inequities that devalued psychiatric patients' physical needs. Participants linked these experiences to broader patterns of healthcare discrimination, reinforcing their commitment to advocacy and holistic care.

Advocacy, Emotional Labor, and Professional Pride

Advocacy was central to participants' professional identity but also a source of emotional exhaustion.

"I find myself becoming burned out due to constantly having to advocate and defend my patients to other units and the ER."

Yet this emotional labor coexisted with profound pride in their work.

"As the nurse, you are the therapeutic tool—not a dressing tray, not a machine."

"I've developed into a confident advocate for our vulnerable population."

Nurses viewed relational skill, empathy, and patience as forms of advanced clinical practice. This balance between advocacy fatigue and professional pride emerged as a defining tension in their narratives.

Workplace Hostility and Professional Devaluation

Experiences of lateral violence and exclusion were common. Participants described being undermined by colleagues who questioned their competence.

"When I chose to go into this field as a new graduate, I was told I'd made a bad choice because I would lose my nursing skills."

Dismissive remarks and exclusionary behavior reinforced hierarchies within nursing, leaving many feeling isolated. Despite these challenges, participants also described supportive teams that valued emotional intelligence and de-escalation skills. These positive relationships sustained nurses in environments where hostility and misunderstanding were otherwise pervasive.

Purpose, Motivation, and Resilience

Participants' motivations to work in forensic and mental health nursing were often deeply personal.

"My father was incarcerated when I was a child. He had liver cancer that wasn't found until he was released."

Such experiences inspired empathy and determination to provide humane care. Others emphasized the meaning they found in small victories.

"Being able to help someone when they are in arguably the worst time of their life and teach them that they can still have a fulfilling life."

These moments of connection, though often fleeting, anchored their professional purpose and resilience.

Education, Awareness, and Systemic Barriers

Participants voiced a strong desire to educate others about the realities of their practice.

"I wish others knew that correctional nursing is absolutely a specialty. Our patients are some of the sickest in our population."

They called for greater representation of forensic and mental health content in nursing curricula to challenge persistent misconceptions. Nurses also highlighted systemic failures that hindered both patient care and professional fulfillment.

"Patients seeking treatment for addiction often can't get sufficient support, leading to cycles of relapse."

"We're patching holes in a sinking ship."

Long waitlists, underfunded programs, and societal stigma perpetuated these cycles, leaving nurses feeling frustrated and powerless.

Integrative Summary

The narratives revealed a profession simultaneously marginalized and deeply meaningful. Participants navigated a landscape shaped by stigma and systemic constraint yet found identity and purpose in relational care, advocacy, and resilience. The composite narrative and thematic findings together illuminate the tension between invisibility and pride that defines forensic and mental health nursing.

Discussion

This discussion explores how the narratives reveal the complex interplay of stigma, professional identity, and systemic inequity in mental health and forensic nursing, situating these findings within broader theoretical, educational, and policy contexts.

Interpreting Stigma and Professional Identity

This study illuminates how forensic and mental health nurses construct professional identity in the context of pervasive stigma and systemic inequity. The findings reveal how social labeling, professional hierarchies, and public misunderstanding collectively erode legitimacy, reflecting what Goffman (1963) termed *courtesy stigma*, the secondary stigma experienced by those associated with a stigmatized group. Participants' accounts of being seen as "not real nurses" demonstrate how stigma transfers from patients to providers, diminishing perceived professional value. This phenomenon aligns with Tajfel and Turner's (1986) social identity theory, in which group boundaries and hierarchies shape belonging and self-concept. Within

nursing, forensic and mental health practitioners occupy a "peripheral identity," often viewed as less technical or prestigious than acute care. This identity positioning fosters marginalization within both professional and public domains.

The findings further illustrate that stigma is not limited to external perception but is internalized and reproduced through workplace culture. Experiences of lateral violence exemplify how professional hierarchies manifest within the nursing collective, reinforcing divisions that mirror broader societal devaluation of mental health work. Goffman's framework helps explain this process: as nurses manage stigma, they engage in "information control," concealing aspects of their role to maintain professional legitimacy. Simultaneously, social identity theory clarifies the tension between belonging and differentiation—nurses express pride in their relational expertise even as they resist exclusion by dominant clinical groups.

Systemic and Emotional Dimensions of Care

Advocacy and emotional labor were central to participants' narratives. Nurses described the constant need to defend their patients' legitimacy within a healthcare system that privileges physical over psychiatric conditions. Diagnostic overshadowing and systemic neglect reaffirm O'Brien's (2025) observation that psychiatric labeling continues to distort clinical judgment. Yet these narratives also reveal resilience and meaning-making: nurses locate pride and professional identity in their ability to provide relational, human-centered care despite institutional constraints. This echoes the constructivist premise of narrative inquiry; meaning is co-created through lived experience and reflection.

Professional Identity Construction

The themes collectively suggest that forensic and mental health nursing is an act of identity negotiation. Participants situate themselves at the intersection of care and custody, humanity and control, empathy and safety. They construct professional meaning through what Riessman (2008) calls "restorying", transforming experience into purpose. Nurses' narratives resist deficit-based views by asserting that emotional intelligence and de-escalation are sophisticated clinical competencies. In doing so, they challenge biomedical hierarchies that equate technical skill with professional value.

Strengths and Limitations

This study demonstrates methodological rigor through triangulated analysis, combining whole-transcript and cross-question coding, member checking, and composite narrative synthesis. The narrative inquiry design generated authentic, nuanced accounts that illuminate complex emotional and structural dimensions of practice.

However, several limitations warrant consideration. The sample was geographically concentrated in Ontario, which may limit transferability to other jurisdictions. Recruitment through professional networks may have introduced self-selection bias, attracting participants with strong views on stigma or advocacy. Data were collected through written narratives, which allowed for reflection but limited opportunities for probing clarification. Attrition also occurred, with five participants not completing narrative submissions after providing demographic data. Additionally, while eight initial themes were identified, consolidation into six broader categories strengthened conceptual coherence but may have obscured some nuanced subthemes.

Implications for Education, Practice, and Policy

Nursing education should embed structured stigma-reduction modules that address both patient and provider stigma. Programs can incorporate simulation-based learning that challenges stereotypes about forensic and mental health populations, alongside reflective exercises that explore implicit bias and professional identity. Evaluation metrics could include pre- and post-training assessments of empathy, confidence, and stigma awareness.

Healthcare organizations should implement formal mentorship and structured debriefing programs in forensic and mental health settings. Mentorship success could be measured through retention rates, reduced burnout, and self-reported professional confidence. Debriefing sessions after critical incidents or ethical dilemmas would foster collective resilience and mitigate the emotional toll of advocacy fatigue.

At the systems level, policy reform should prioritize equitable funding for community-based mental health and addiction services to reduce crisis-driven admissions. Inclusion of forensic and mental health nurses in policy advisory and leadership roles would ensure that lived expertise informs workforce planning, scope of practice decisions, and intersectoral collaboration. The frameworks developed by the Canadian Nurses Association (CNA), the Canadian Mental Health Association (CMHA) and the Centre for Addictions and Mental Health CAMH) can guide implementation and evaluation of anti-stigma initiatives but must be operationalized through measurable outcomes such as improved access, staff training completion, and patient satisfaction.

Overall, the findings suggest that forensic and mental health nursing embodies both vulnerability and resilience. Nurses navigate stigma, systemic inequity, and emotional strain, yet derive meaning and strength from relational care. Their narratives challenge prevailing hierarchies and invite a reimagining of professional identity, one rooted in compassion, complexity, and justice-oriented practice.

Conclusion

Mental health and forensic nurses face persistent challenges of stigma, systemic neglect, and professional devaluation. Yet their stories also reveal resilience, ethical commitment, and a deep sense of purpose. Using a composite narrative, this study shows how these nurses collectively construct a counter-story that redefines their work as essential to compassionate and just healthcare. Stigma is shown to operate not only at the individual level but also within the structures and hierarchies of healthcare systems. Meaningful change therefore requires coordinated efforts across society, organizations, and policy to challenge stereotypes, promote inclusion, and provide adequate resources for both nurses and the patients they serve.

Reclaiming their professional voice allows these nurses to define their expertise on their own terms. Advocacy, empathy, and relational skill emerge as advanced forms of practice that sustain patient-centered care in difficult environments. Recognizing mental health and forensic nursing as vital specialties affirms their contribution to health equity and social justice. As one participant stated, *"We are not less because we choose to work in this field."* Their collective testimony reminds us that dignity, compassion, and commitment remain at the heart of nursing practice.

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