STUDY PROTOCOL

Healthcare Providers' Attitudes Toward ONCOlogy Patients with Mental Disorders (ONCO-MinD): A Multicentre Mixed-Method Design Study

Version 1.0 12/05/2026 English Translation of the Approved Italian Protocol

PRINCIPAL INVESTIGATOR

Carlo Alberto Camuccio
Clinical Research Case Manager, Integrated Department of Medical Oncology (IDMO)
Veneto Institute of Oncology (IOV-IRCCS), Padua, Italy

CO-INVESTIGATORS

- Erika Cavalletto
- Sara Craia
- Orejeta Diamanti
- Angela Grassi
- Elena Groff
- Elena Reginato
- Camilla Zanotto

BACKGROUND

International literature highlights substantial disparities in health outcomes among people living with mental disorders. Individuals affected by severe mental illness (SMI), including schizophrenia, bipolar disorder, and major depressive disorder, have a life expectancy approximately 15 to 20 years shorter than that of the general population. Furthermore, approximately 38% of individuals with SMI also experience a concurrent physical illness, including cancer. Previous studies have reported cancer mortality rates up to 72% higher among men and 59% higher among women who have had contact with mental health services.

A recent systematic review and meta-analysis by Elliott et al. (2025) found that women with breast cancer and a pre-existing mental disorder were 21% less likely to receive guideline-recommended treatments. Significant reductions were observed in the use of

chemotherapy (-44%) and radiotherapy (-21%), alongside a 38% increase in more extensive surgical procedures, such as total mastectomy, compared with breast-conserving surgery.

This excess mortality and morbidity reflects profound inequalities affecting the entire cancer care pathway, from diagnosis to end-of-life care, and involves the responsibility of all healthcare professionals. The causes of these disparities are multifactorial and operate across three interconnected levels:

1. The patient;
2. Healthcare professionals;
3. Healthcare organisations.

These dimensions intersect within the broader phenomenon of stigma.

In the present study, stigma is conceptualised as the primary construct and specifically refers to healthcare professionals' attitudinal stigma towards patients with mental disorders. Attitudes and beliefs are considered key dimensions of this construct, consistent with the theoretical framework underlying the Opening Minds Scale for Health Care Providers (OMS-HC).

Stigma may manifest both as self-stigma, whereby individuals internalise negative stereotypes, and as public stigma, characterised by stereotypes, prejudice, inadequate knowledge, and discriminatory attitudes.

Patient-Level Factors

Individuals with mental disorders are more likely to engage in health-risk behaviours, including smoking, alcohol consumption, and substance use. These behaviours increase the risk of developing cancer and contribute to higher treatment-related morbidity and mortality.

Lower health literacy and social disadvantage may also lead to reduced awareness of symptoms, decreased participation in cancer screening programmes, delayed diagnosis, and an increased likelihood of metastatic disease at presentation. During cancer treatment, these patients may experience lower treatment adherence and reduced tolerance to therapy.

Healthcare Professional-Level Factors

Among healthcare professionals without specialised mental health training, significant attitudinal barriers have been reported. Previous research suggests that a large proportion of

nursing staff do not feel adequately prepared to care for patients with mental disorders due to insufficient psychiatric training.

This lack of preparedness may generate uncertainty, fear, and concerns regarding safety, often reinforced by difficult previous experiences and inadequate organisational support. Such challenges may contribute to professional stress, burnout, and reluctance to engage with patients experiencing mental disorders.

One of the most critical mechanisms associated with stigma is diagnostic overshadowing, defined as the tendency to attribute physical symptoms to an existing psychiatric condition, potentially resulting in delayed diagnosis and less appropriate cancer treatment.

Organisational Factors

At the organisational level, fragmentation of services represents a significant barrier. The historical separation between mental healthcare and general medical care often hinders the development of integrated and person-centred models of care.

Although previous studies have identified protective factors associated with lower levels of stigma, including greater professional experience, previous employment in mental health settings, and personal or family experience with mental disorders, considerable barriers remain and may negatively affect the quality and equity of cancer care.

Within this study, the term "mental disorder" is used in a broad and inclusive manner. In addition to severe mental illnesses such as schizophrenia, bipolar disorder, and psychotic disorders, the study also encompasses common mental disorders, including anxiety disorders and depressive disorders. This approach reflects their high prevalence and the evidence that such conditions may influence clinicians' perceptions, treatment decisions, patient adherence, and the quality of the therapeutic relationship.

Importantly, healthcare professionals' attitudes may be influenced not only by a formally documented psychiatric diagnosis, but also by behaviours perceived as psychiatric, general information regarding previous psychological or psychiatric care, and informal clinical labelling.

Although several Italian studies have explored healthcare professionals' attitudes towards people with mental disorders in medical-surgical, emergency, and community settings, oncology remains largely unexplored. Consequently, substantial gaps remain in

understanding how stigma towards patients with mental disorders may affect clinical behaviour and decision-making within Italian oncology services.

Understanding not only the level of stigma but also its influence on therapeutic relationships and clinical decision-making is essential for developing targeted educational interventions, integrated care pathways, and effective psychosocial support strategies.

RESEARCH QUESTIONS

1. What is the level of stigma among oncology healthcare professionals towards patients with mental disorders?

2. Are stigmatising attitudes present among oncology healthcare professionals?

3. How do these attitudes manifest, and how do they influence care delivery and interactions between healthcare professionals and oncology patients with psychiatric comorbidity?

PRIMARY OBJECTIVE

To assess the level of stigma among oncology healthcare professionals towards cancer patients with mental disorders.

SECONDARY OBJECTIVES

1. To identify associations between attitudes towards mental disorders and individual or professional characteristics, including years of professional experience, previous personal or professional experience in mental health, and clinical area of practice.

2. To identify the presence of stigmatising attitudes and explore their potential impact on therapeutic relationships and barriers to care, including diagnostic overshadowing.

STUDY ENDPOINTS

Primary Endpoint

To measure healthcare professionals' level of stigma towards people with mental disorders using the Italian version of the Opening Minds Scale for Health Care Providers (OMS-HC).

The OMS-HC total score ranges from 15 to 75 points, with lower scores indicating more positive attitudes and lower levels of stigma.

Secondary Endpoints

1. To identify predictors of stigma by examining statistical associations between OMS-HC scores and independent socio-demographic and professional variables collected through the study questionnaire.

2. To explore healthcare professionals' experiences and perceptions through semi-structured interviews, including recurring themes such as:

- Perceived complexity of caring for oncology patients with mental disorders;
- Relational and organisational barriers;
- The impact of psychiatric diagnoses on cancer treatment decision-making;
- Diagnostic overshadowing;
- Potential facilitators to improve care delivery.

STUDY DESIGN

The study adopts a **sequential explanatory mixed-method design**, consisting of two distinct but interconnected phases: a quantitative phase followed by a qualitative phase.

The rationale for this design is that qualitative findings can be used to further explain, expand, and contextualise the quantitative results.

The quantitative phase consists of a multicentre observational cross-sectional study involving administration of the **Opening Minds Scale for Health Care Providers (OMS-HC), Italian version (15 items)** together with a socio-demographic questionnaire.

The qualitative phase comprises a descriptive-interpretive study based on semi-structured interviews guided by an interview schedule derived from the literature.

Integration points will connect the two phases, allowing findings emerging from the quantitative analysis to inform participant selection and guide the development of interview questions.

Quantitative and qualitative findings will subsequently be integrated through joint display analysis, facilitating the development of meta-inferences and an overall interpretation of the phenomenon under investigation.

The study will follow the STROBE guidelines for observational research and the COREQ guidelines for qualitative research.

STUDY POPULATION AND SAMPLING STRATEGY

Study Population

The study population consists of healthcare professionals working in oncology settings within the participating cancer centres. Eligible participants include:

- Physicians
- Nurses
- Psychologists
- Radiation Therapy Technologists (RTTs)
- Healthcare Assistants

Participants must be directly involved in the clinical care of cancer patients.

Participation is voluntary and requires provision of informed consent.

To ensure a representative assessment of attitudes among oncology healthcare professionals, no selection criteria related to previous experience caring for patients with psychiatric comorbidity will be applied during the quantitative phase.

Quantitative Phase Sampling Strategy

The quantitative phase will employ **exhaustive sampling**, whereby all eligible healthcare professionals working at participating centres will be invited to participate.

An institutional invitation containing study information and a link to the survey will be distributed through official communication channels.

Qualitative Phase Sampling Strategy

The qualitative phase will employ **combined purposeful sampling**, integrating:

- Extreme or deviant case sampling

- Maximum variation sampling

Following analysis of quantitative findings, participants demonstrating characteristics of particular interest to the research objectives will be purposively selected.

Selection will take place in two stages:

1. Examination of aggregated OMS-HC score distributions across clinical areas;
2. Identification of key informants with relevant professional experience and expertise.

The qualitative sample will aim to maximise diversity in professional background, experience, and observed attitudes.

Data collection will continue until thematic saturation is achieved, defined as the point at which no substantially new information emerges.

Approximately 15 to 20 participants are expected to be included in the qualitative phase.

ELIGIBILITY CRITERIA

Inclusion Criteria

- Physicians working in participating oncology centres.
- Nurses working in participating oncology centres.
- Psychologists working in participating oncology centres.
- Radiation Therapy Technologists working in participating oncology centres.
- Healthcare Assistants working in participating oncology centres.
- Direct involvement in the clinical care of oncology patients.
- Employment at one of the participating study sites at the time of enrolment.
- Ability to understand study information and provide informed consent.

Exclusion Criteria

- Refusal to participate or failure to provide informed consent.
- Students or trainees.
- Healthcare personnel working in services with very limited patient contact and without direct responsibility for oncology patient care.

Additional Note

No exclusion criteria based on previous experience caring for oncology patients with psychiatric comorbidity will be applied during the quantitative phase in order to preserve participant anonymity and obtain a representative assessment of attitudes among oncology healthcare professionals.

OPERATIONAL DEFINITION OF "MENTAL DISORDER"

For the purposes of this study, reference to a "mental disorder" does not imply the collection, verification, or processing of health information relating to identifiable patients.

Instead, the term refers to the general category of oncology patients with mental disorders as perceived by healthcare professionals during routine clinical practice.

The study aims to assess attitudinal stigma directed towards this patient category rather than specific clinical behaviours associated with identifiable individuals.

Accordingly:

Quantitative Phase

The OMS-HC questionnaire explores general opinions and attitudes towards people with mental disorders and does not refer to individual patients.

Qualitative Phase

Interviews explore general professional experiences and perceptions.

Should participants inadvertently refer to specific clinical situations, all potentially identifying information will be removed during transcription and anonymisation procedures.

This approach is consistent with international stigma research, which evaluates attitudes towards general patient categories rather than identifiable individuals.

STUDY DURATION

Phase	Activity	Duration
T0	Protocol approval and study preparation	1 month
T1	Survey administration and reminders	3 months
T2	Quantitative data analysis	2 months
T3	Recruitment and qualitative interviews	3 months
T4	Qualitative data analysis	2 months
T5	Joint analysis and integration of findings	2 months
T6	Dissemination and publication	5 months

Total Study Duration: 18 months

PARTICIPATING CENTRES

The study will be conducted at:

Coordinating Centre

Veneto Institute of Oncology (IOV-IRCCS), Italy

Including the following sites:

- Padua
- Castelfranco Veneto
- Schiavonia

Participating Centres

- Centro di Riferimento Oncologico (CRO-IRCCS), Aviano, Italy
- Istituto Tumori "Giovanni Paolo II" (IRCCS), Bari, Italy

STUDY PROCEDURES

Quantitative Phase

Participants will provide electronic informed consent before completing an anonymous online questionnaire through the REDCap platform.

The questionnaire consists of two sections:

Section 1: Socio-demographic and Professional Characteristics

Information collected includes:

- Age
- Sex
- Hospital
- Clinical area
- Professional role
- Years of work experience
- Previous professional experience in mental health services
- Educational level

- Personal or family experience with mental disorders
- Perceived mental health training provided by the organisation

Section 2: OMS-HC Questionnaire

Participants will complete the Italian validated 15-item version of the **Opening Minds Scale for Health Care Providers (OMS-HC)**.

The OMS-HC was developed to assess stigma among healthcare professionals towards people with mental disorders.

Responses are rated using a five-point Likert scale.

The total score ranges from:

- **15 points:** lower stigma
- **75 points:** higher stigma

The scale evaluates three principal domains:

- Attitudinal stigma
- Disclosure and help-seeking
- Social distance

The survey will remain open for approximately three months.

Reminder communications may be distributed to maximise participation.

SAMPLE SIZE

Quantitative Phase

The questionnaire will be distributed to all eligible healthcare professionals working at the Veneto Institute of Oncology (IOV-IRCCS) and participating centres.

According to estimates provided by the Management Control Unit of IOV, approximately 809 healthcare professionals are eligible at the coordinating centre, including:

- Approximately 227 physicians
- Approximately 22 psychologists
- Approximately 380 nurses

- Approximately 34 Radiation Therapy Technologists
- Approximately 180 Healthcare Assistants

As this is a descriptive observational study, the primary objective is to evaluate healthcare professionals' levels of stigma towards oncology patients with mental disorders rather than to test a specific intervention.

Participation is voluntary, and the study aims to recruit the highest possible number of eligible healthcare professionals.

The inclusion of additional participating centres, including CRO-IRCCS Aviano and IRCCS Istituto Tumori "Giovanni Paolo II" of Bari, is expected to further increase the sample size till 1000 healthcare professionals approx. and ensure adequate statistical power for the planned analyses.

A post hoc power analysis will be conducted following data collection.

Qualitative Phase

A combined purposeful sampling strategy will be used to identify participants able to provide particularly relevant insights into the research questions.

Participant selection will follow a two-stage process:

Stage 1

Aggregated quantitative results will be reviewed to examine OMS-HC score distributions across broad clinical areas, considering both central tendency and variability.

No individual respondent-level data will be used during this stage.

Stage 2

Within the identified contexts, key informants will be purposively selected according to professional role and clinical experience.

Examples may include:

- Senior healthcare professionals
- Nurse coordinators
- Healthcare professionals with substantial clinical experience

Participants will not be interviewed as formal representatives of their units but as experienced professionals able to provide reflective perspectives on clinical and organisational contexts.

Data collection will continue until thematic saturation is achieved.

Based on similar studies reported in the literature, approximately 15-20 participants are expected to be interviewed during the qualitative phase.

DATA COLLECTION

The study follows a sequential explanatory mixed-method design consisting of a quantitative phase followed by a qualitative phase.

The qualitative phase is intended to deepen, expand, and explain findings emerging from the quantitative survey.

Data collection will occur according to the study timeline described previously.

QUANTITATIVE DATA ANALYSIS

Questionnaire responses and socio-demographic information will be collected using REDCap (Research Electronic Data Capture).

Reliability Assessment

The internal consistency of the OMS-HC questionnaire will be assessed using Cronbach's alpha coefficient (α).

Values of $\alpha \geq 0.60$ will be considered acceptable.

Descriptive Statistics

Socio-demographic and professional characteristics will be summarised using:

- Frequencies and percentages for categorical variables
- Means and standard deviations for normally distributed continuous variables
- Medians and interquartile ranges where appropriate

OMS-HC total scores will be described using appropriate summary statistics.

Inferential Statistics

Differences in OMS-HC scores between groups will be analysed using:

- Independent sample t-tests
- One-way Analysis of Variance (ANOVA)
- Non-parametric alternatives, including the Mann-Whitney U test, when assumptions for parametric testing are not met

Regression Analysis

A univariable linear regression analysis will be performed using the OMS-HC total score as the dependent variable.

Independent variables demonstrating statistically significant associations ($p < 0.05$) will subsequently be entered into a multivariable linear regression model to identify independent predictors of stigma while controlling for potential confounding variables.

Statistical analyses will be conducted using:

- R
- SPSS

QUALITATIVE DATA ANALYSIS

Semi-structured interviews will be audio-recorded and transcribed verbatim.

Data management and coding will be supported by ATLAS.ti software.

Thematic analysis will be conducted according to the six-phase framework proposed by Braun and Clarke:

1. Familiarisation with the Data

Researchers will repeatedly read and review transcripts to gain a comprehensive understanding of the dataset.

2. Generation of Initial Codes

Meaningful units of text will be identified and coded systematically.

3. Theme Development

Codes will be grouped into preliminary themes representing patterns across participants' narratives.

4. Theme Review

Potential themes will be reviewed, refined, merged, or divided where necessary.

5. Theme Definition and Naming

Themes will be clearly defined and interpreted in relation to the study objectives.

6. Production of Findings

A narrative account of themes and subthemes will be developed and supported by representative quotations.

Analysis will be undertaken collaboratively by members of the research team to strengthen methodological rigour and analytical credibility.

MIXED-METHOD DATA INTEGRATION

Integration of quantitative and qualitative findings represents a core component of the ONCO-MinD study.

Several integration points will be implemented throughout the research process.

Connecting Phase

Quantitative findings will inform:

- Selection of interview participants
- Development and refinement of interview questions
- Identification of issues requiring deeper exploration

Joint Analysis

Following completion of both analyses, quantitative and qualitative findings will be integrated through the use of **joint displays**.

Joint displays are structured matrices and graphical representations that allow simultaneous examination of findings from both methodological strands.

Meta-Inferences

The final stage of integration will involve the generation of **meta-inferences**, defined as overarching interpretations developed through the combination of quantitative and qualitative evidence.

This approach aims to provide a comprehensive understanding of:

- The level of stigma among oncology healthcare professionals
- Factors influencing stigma
- The manifestation of stigma in oncology settings
- The impact of stigma on clinical relationships and decision-making
- Potential educational and organisational strategies to improve care

CONFIDENTIALITY AND DATA PROTECTION

Quantitative Phase

Participation in the survey is anonymous and voluntary.

The REDCap platform will be configured to prevent collection of:

- Names
- Email addresses
- IP addresses
- Employee identification numbers
- Other direct or indirect identifiers

Socio-demographic data will be collected in aggregated categorical formats to minimise the risk of participant identification.

The Principal Investigator will not have access to participants' specific clinical units or any information capable of identifying individual respondents.

Survey data will be stored on protected institutional servers of the Veneto Institute of Oncology.

Anonymous data will be retained for up to five years following publication of study findings and subsequently destroyed according to institutional policies.

Qualitative Phase

Participants will provide specific informed consent before participating in interviews.

During interviews, participants will be asked to avoid mentioning:

- Names
- Exact dates
- Detailed clinical circumstances
- Any information potentially identifying patients, colleagues, or specific contexts

During transcription:

- Identifying information will be removed
- Sensitive details will be generalised where appropriate
- Active anonymisation procedures will be applied

Audio recordings will be retained only for the time necessary to complete transcription and will thereafter be permanently deleted.

Only authorised members of the research team will have access to interview materials.

RISKS AND BENEFITS

The study is observational and non-interventional.

No modification of clinical practice, treatment pathways, or patient care will occur.

No direct risks are anticipated for participants.

Potential benefits are indirect and include:

- Improved understanding of barriers affecting oncology patients with mental disorders
- Increased awareness of mental health-related stigma in oncology settings
- Evidence to support future educational initiatives
- Development of organisational strategies aimed at improving equitable access to cancer care

ETHICAL CONSIDERATIONS

Participation in all phases of the study is voluntary.

Participants may withdraw at any time without consequences.

All procedures will be conducted in accordance with:

- The Declaration of Helsinki
- European General Data Protection Regulation (GDPR 2016/679)
- Institutional policies governing clinical research

The protocol was developed by the Veneto Institute of Oncology (IOV-IRCCS) and underwent methodological review before implementation.

DISSEMINATION PLAN

Study findings will be disseminated through:

- Peer-reviewed scientific journals
- National and international conferences
- Scientific meetings
- Educational activities
- Institutional reports

Results will be presented exclusively in aggregated and anonymised form.

The study aims to contribute to the development of educational, organisational, and policy interventions designed to improve the quality, inclusiveness, and equity of cancer care for people living with mental disorders.

REFERENCES

Ahmed, S. K., Mohammed, R. A., Nashwan, A. J., et al. (2025). Using thematic analysis in qualitative research. Journal of Medicine, Surgery, and Public Health, 6, 100198.

Al Saif, F., Al Shakhoori, H., Nooh, S., & Jahrami, H. (2019). Association between attitudes of stigma toward mental illness and attitudes toward adoption of evidence-based practice within health care providers in Bahrain. PLoS ONE, 14(12), e0225738.

Benoot, C., Hannes, K., & Bilsen, J. (2016). The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. BMC Medical Research Methodology, 16, 21.

Bouncken, R. B., Czakon, W., & Schmitt, F. (2025). Purposeful sampling and saturation in qualitative research methodologies: Recommendations and review. Review of Managerial Science, 1–37.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101.

Charlesworth, L., Fegan, C., & Ashmore, R. (2023). How does severe mental illness impact on cancer outcomes in individuals with severe mental illness and cancer? A scoping review of the literature. Journal of Medical Imaging and Radiation Sciences, 54(2S), S104–S114.

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. World Psychiatry, 13(2), 153–160.

Corbetta, P. (2014). Metodologia e tecniche della ricerca sociale. Il Mulino.

Creswell, J. W., & Inoue, M. (2025). A process for conducting mixed methods data analysis. Journal of General and Family Medicine, 26(1), 4–11.

Destrebecq, A., Ferrara, P., Frattini, L., et al. (2018). The Italian version of the Opening Minds Stigma Scale for Healthcare Providers: Validation and study on a sample of bachelor students. Community Mental Health Journal, 54(1), 66–72.

Elliott, K., Haworth, E., Bolnykh, I., et al. (2025). Breast cancer patients with a pre-existing mental illness are less likely to receive guideline-recommended cancer treatment: A systematic review and meta-analysis. The Breast, 79, 103855.

von Elm, E., Altman, D. G., Egger, M., Pocock, S. J., Gøtzsche, P. C., & Vandenbroucke, J. P. (2007). The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: Guidelines for reporting observational studies. BMJ, 335(7624), 806–808.

Fantuzzi, C., Bagozzi, D., Accardo, R., D'Ambrosi, G., & Sanson, G. (2025). Factors influencing stigma toward mental disorders among healthcare workers: An observational study. Perspectives in Psychiatric Care, 2025, 3591255.

Firth, J., Siddiqi, N., Koyanagi, A., et al. (2019). The Lancet Psychiatry Commission: A blueprint for protecting physical health in people with mental illness. The Lancet Psychiatry, 6(8), 675–712.

Foye, U., Simpson, A., & Reynolds, L. (2020). "Somebody else's business": The challenge of caring for patients with mental health problems on medical and surgical wards. Journal of Psychiatric and Mental Health Nursing, 27(4), 406–416.

Giandinoto, J. A., Stephenson, J., & Edward, K. L. (2018). General hospital health professionals' attitudes and perceived dangerousness towards patients with comorbid mental and physical health conditions: Systematic review and meta-analysis. International Journal of Mental Health Nursing, 27(3), 942–955.

Grassi, L., & Riba, M. (2020). Cancer and severe mental illness: Bi-directional problems and potential solutions. Psycho-Oncology, 29(10), 1445–1451.

Hallyburton, A. (2022). Diagnostic overshadowing: An evolutionary concept analysis on the misattribution of physical symptoms to pre-existing psychological illnesses. International Journal of Mental Health Nursing, 31(6), 1360–1372.

Ivankova, N. V., Creswell, J. W., & Stick, S. L. (2006). Using mixed-methods sequential explanatory design: From theory to practice. Field Methods, 18(1), 3–20.

Kisely, S., Sadek, J., MacKenzie, A., Lawrence, D., & Campbell, L. A. (2008). Excess cancer mortality in psychiatric patients. Canadian Journal of Psychiatry, 53(11), 753–761.

Kolb, K., Liu, J., & Jackman, K. (2023). Stigma towards patients with mental illness: An online survey of United States nurses. International Journal of Mental Health Nursing, 32(1), 323–336.

Lasalvia, A., D'Agnalo Vallan, M., Bodini, L., & Bonetto, C. (2025). Attitudes of ambulance service staff towards people with mental illness: A cross-sectional survey in the Verona Province, Italy. Psychiatry Research, 343, 116291.

Leahy, D., Donnelly, A., Irwin, K., & D'Alton, P. (2021). Barriers and facilitators to accessing cancer care for people with significant mental health difficulties: A qualitative review and narrative synthesis. Psycho-Oncology, 30(12), 2012–2022.

Pasere, E., O'Hara, D., Ballard, E., Kilgour, C., & Holland, L. (2025). A narrative review of medical and surgical nurses' attitudes and perceptions when caring for patients with a secondary diagnosis of mental illness. Nurse Education Today, 151, 106684.

Poggenpoel, M., Myburgh, C. P. H., & Morare, M. N. (2011). Registered nurses' experiences of interaction with patients with mental health challenges in medical wards in Johannesburg. Journal of Nursing Management, 19(7), 950–958.

Rahimi, S., & Khatooni, M. (2024). Saturation in qualitative research: An evolutionary concept analysis. International Journal of Nursing Studies Advances, 6, 100174.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care, 19(6), 349–357.

Torres, I. N., Pereira, H. P., Moreira, M. B. P., Marina, S., & Ricou, M. (2024). Prevalence of stigma towards mental illness among Portuguese healthcare professionals: A descriptive and comparative study. Frontiers in Psychiatry, 15, 1425301.

Younas, A., Pedersen, M., & Durante, A. (2020). Characteristics of joint displays illustrating data integration in mixed-methods nursing studies. Journal of Advanced Nursing, 76(2), 676–686.