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Article (Accepted version)
(Refereed)

Original citation:
Rojas Vistorte, Angel O. and Silva Ribeiro, Wagner and Jaen, Denisse and Jorge, Miguel R. and Evans-Lacko, Sara and Mari, Jair de Jesus (2018) Stigmatizing attitudes of primary care professionals towards people with mental disorders: a systematic review. International Journal of Psychiatry in Medicine, 53 (4). pp. 317-338. ISSN 0091-2174
DOI: 10.1177/0091217418778620

Stigmatizing attitudes of primary care professionals towards people with mental disorders: a systematic review

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Summary

Objective: To examine stigmatizing attitudes towards people with mental disorders among primary care professionals, and to identify potential factors related to stigmatizing attitudes through a systematic review. **Methods**: A systematic literature search was conducted in Medline, Lilacs, IBECS, Index Psicologia, CUMED, MedCarib, Sec. Est. Saúde SP, WHOLIS, Hanseníase, LIS-Localizador de Informação em Saúde, PAHO, CVSO-Regional and Latindex, through the Virtual Health Library portal (http://www.bireme.br website) through to June 2017. The articles included in the review were summarized through a narrative synthesis. **Results**: After applying eligibility criteria, eleven articles, out of 19.109 references identified, were included in the review. Primary care physicians do present stigmatizing attitudes towards patients with mental disorders, and show more negative attitudes towards patients with schizophrenia than towards those with depression. Older and more experience doctors have more stigmatizing attitudes towards people with mental illness compared with younger and less experienced doctors. Health care providers who endorse more stigmatizing attitudes towards mental illness were likely to be more pessimistic about the patient's adherence to treatment. **Conclusions**: Stigmatizing attitudes towards people with mental disorders are common among physicians in primary care settings, particularly among older and more experienced doctors. Stigmatizing attitudes can act as an important barrier for patients to receive the treatment they need. The primary care physicians feel they need better preparation, training and information to deal with and to treat mental illness, such as a user friendly and pragmatic classification system that addresses the high prevalence of mental disorders in primary care and community settings.

Keywords: Stigma, stigmatizing attitudes, primary care, mental disorders.

Introduction

Mental, neurological and substance use disorders (MNSD) exact a high toll, accounting for 13% of the total global burden of disease [(1)]. The burden of disease attributable to MNSD increased by 41% between 1990 and 2010. MNSD accounts for one in every 10 disability adjusted life years (DALYs) [(2)] and affects disproportionally low- and middle-income countries (LMIC)[(2)]. Individuals with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left untreated (e.g., cancer, cardiovascular diseases, diabetes and HIV infection) [(2)].

It is widely known that people with mental disorders commonly present in primary care and that disorders such as depression, alcohol abuse and epilepsy can be treated by primary care professionals [(3)]. For instance, Ansseau et al. (2004) in a survey performed in Belgium found that, in the year prior to the study, 31% of adult patients in primary care services had affective disorders, 19% had some type of anxiety disorder, 18% had some type of somatoform disorder and 10% had disorders related to use of alcohol [(4)], and other studies estimate that 24% of patients who present to primary care physicians have a well-defined ICD-10 mental disorder [(5)]. Scientific evidence shows that, worldwide, 69% of patients with mental disorders in primary care settings present to physicians with physical symptoms and that in many of those patients the physical symptoms or physical illness remain undetected [(5)].

It is recommended that common mental disorders be treated in primary care settings. However, a number of obstacles hinder primary care physicians (PCP´s) ability to identify and to treat mental disorders. Firstly, it has been shown that PCP have limited ability diagnose a mental disorder because the training required for developing this ability is not routinely available in general medical undergraduate courses and medical training [(6)]. Lack of training leads to difficulties in dealing with metal health problems, and to the maintenance of misconceptions about mental disorders [(6, 7)]. Another important obstacle is the stigma or prejudice that primary care providers may have in relation to patients with mental disorders [(8-13)].

Stigma is defined as a process involving labeling, separation, stereotype endorsement, prejudice and discrimination in a context in which social, economic or political power is exercised to the detriment of members of a social group [14]. It comprises three related dimensions, which, when combined are a powerful driver of social exclusion: a) lack of knowledge (ignorance and misinformation); b) negative attitudes (prejudice); and c) excluding or avoiding behavior's (discrimination) [12, 15-18].
Stigmatizing attitudes may influence how primary care physicians diagnose and treat individuals with mental disorders [19]. Thus, although individuals with mental disorders may seek treatment more frequently from primary care than from specialized services, in part to avoid the labeling related to psychiatric treatment, they may also face stigma in primary care [20].
Health professionals who work in primary health care services and support stigmatizing attitudes toward people with mental disorders are more pessimistic about their adherence to treatment, both for mental illness and physical illness. Stigma can lead professionals to make clinical decisions based on mistaken assumptions or against clinical standards or guidelines [13]. In this context, unreceptive attitudes of professionals who perpetuate stigmatizing beliefs tend to distance people with mental disorders even more from the health care they need [20, 21].
The main aim of this study was examined stigmatizing attitudes towards people with mental disorders among primary care physicians, and to identify potential factors related to stigmatizing attitudes through a systematic review.

Methods and Procedures

We performed a systematic review of the scientific literature through the Biblioteca Virtual em Saúde (Virtual Health Library) – BVS. The BVS automatically runs searches in the following databases: Medline, Lilacs, PubMed, IBECS, Lilacs, Index Psicologia – Periódicos técnicos-científicos, CUMED, CidSaúde-Cidades saudáveis, MedCarib, BDENF-Enfermagem, Sec. Est. Saúde SP, WHOLIS, BBO-Odontologia, Hanseníase, HomeoIndex-Homeopatia, LIS-Localizador de Informação em Saúde, PAHO, CVSO-Regional, Latindex. Additionally, reference lists of included studies and reviews were checked for potentially relevant articles not identified through the

electronic search. We used the following search terms: stigma-related terms AND primary care AND mental health-related terms as follows: "((tw:(stigma*)) OR (tw:(discriminat*)) OR (tw:(prejudice*)) OR (tw:(social distance*)) OR (tw:(stereotyp*)) OR (tw:(attitude*)) OR (tw:(behav*))) AND (tw:(primary care)) AND ((tw:(mental disorder*)) OR (tw:(mental illness*)) OR (tw:(mental disease*)) OR (tw:(mental disabilit*)) OR (tw:(psychiatr* disorder*)) OR (tw:(psychiatry* illness*)) OR (tw:(psychiatry* disease*)) OR (tw:(psychiatry* diagnos*)))".

Titles and abstracts were screened and full reports of potentially relevant studies were obtained. Two authors (AORV and DJV) independently assessed the reports for eligibility, with discrepancies resolved by discussion with a third author (WSR).

We included quantitative studies which assessed stigmatizing attitudes towards mental health problems, mental health symptoms or mental disorders, among primary care physicians in English, Spanish and Portuguese. Articles were excluded based on the following exclusion criteria: 1) if they referred to non-data-based studies (e.g., editorials, commentaries, opinion papers and review papers); and 2) if stigmatizing attitudes were assessed among non-physician primary care professionals, such as nurses, technicians, social workers and other professionals, among mental health professionals, or in the general population. Data on study design, sample characteristics and findings were extracted independently by two authors (AORV and DJV). Because of heterogeneity between studies, which hindered a statistical synthesis of their results, we summarized evidence from articles included in the review through a narrative synthesis [22].

Results

The database search identified 19.109 non-duplicate references. After reviewing titles and abstracts, 15 articles were identified as potentially relevant and were assessed against eligibility criteria. Eleven studies fulfilled inclusion criteria (**Figure 1**) and are summarized in **Table 1**.

All the eleven studies included in the review used a cross-sectional design to assess stigmatizing attitudes towards mental disorders through questionnaires developed by the authors in six studies and one study using a standardized scale. Two studies were conducted in Brazil [23, 24]; two in the USA [19, 25], one in Australia [10], one in

Hong Kong [26], one in Spain [27], one from Finland [28], one from USA and Canada [29], one from Israel [30] and one from Switzerland [31].

Three studies included in the review assessed attitudes towards depression and anxiety among general practitioners working in primary care [23, 29, 30]. All the studies considered that depression is a frequent problem in primary care. One of the studies [23] found that 42% of physicians considered it "difficult to differentiate whether patients are presenting with unhappiness or a clinical depressive disorder that needs treatment"; that 47% of professionals agreed or strongly agreed that most of depressive symptoms "originates from patients' recent misfortunes"; that 46% and 27% of physicians, respectively, considered it to be "heavy going" and "not rewarding" to work with depressed patients. However, 57% of respondents reported feeling "comfortable in dealing with the need of depressive patients". Despite the consideration that depression is a problem that should be treated in primary care, in the study from Israel [30] almost the 50% of the sample stated that the preferential locus for treatment of depression and anxiety are mental health clinics, 80.6% of the physicians agreed that there is under-diagnosis and under-treatment of depression and anxiety in primary care; and 37.3% stated that they have no interest in treating depression and anxiety in primary care. Coinciding with this, in the third study [29] the PCP´s who think their patients feel uncomfortable with their broaching issues about depression see depression as less important in primary care. Moreover, PCP´s are more likely to feel satisfied if their self-efficacy for diagnosing, treating and managing depression is high.

Three articles assessed PCP's views, knowledge's, beliefs and attitudes (including stereotypes and moral attributions) towards alcohol consumption and drugs dependence [24, 27, 28]. Whereas one of the studies [24] found that PCP had the lowest scores, meaning less negative attitudes, towards alcohol addiction and towards marijuana/cocaine dependence, when compared to other health professionals, the other study [27] found that 69.9% of PCP presented skepticism when treating patients with problems caused by alcohol misuse and presented indifference in their work with patients with alcohol-related disorders. The third study [28] found that 87% of PCP´s "have positive attitudes towards discussing alcohol with patients", and that 81% of them "thought that detection and treating of early phase alcohol abusers was appropriate to their everyday work".

Two articles [25, 31] evaluated stigmatizing attitudes toward schizophrenia, by assessing stigma characteristics, physician's needs and expectations about patients' adherence to treatment, and subsequent health decisions (referral to a specialist and refill pain prescription). The first study [25] showed that physicians who stigmatized mental illness were more likely to be pessimistic about the patient's adherence to treatment [25]. In the other study [31] 21% of PCP´s reported no problems when treating patients with schizophrenia, 56% kept treating schizophrenic patients, even though they considered patients´ behavior to be problematic, and 13% preferred to refer patients for considering their behavior to be problematic. The study also showed that the more PCP´s considered the patient´s behavior to be problematic, the more often they referred them to specialists.

Three studies compared PCP's attitudes towards patients with schizophrenia with their attitudes towards patients with depression [10, 19, 26]. PCP's stigmatizing attitudes were greater towards patients with schizophrenia than towards patients with depression. PCP were more willing to treat patients with depression than schizophrenia, and they were less likely to feel comfortable to deal with the needs of patients with schizophrenia than of patients with depression.

Four [10, 24, 26, 27] of the articles included in the review assessed factors that might be associated with physicians' stigmatizing attitudes towards mental disorders. Two studies [24, 26] found a statistically significant association between age and stigmatizing attitudes, meaning that older physicians presented higher moralization towards alcohol-related disorders [24] , and lower willingness to work with patients with alcohol problems [27]. Another study, however, found results in the opposite direction when the younger physicians presented higher levels of stigma than the older one [10]. Alongside with age, training is another factor that might impact PCP´s attitudes and clinical practice. PCP´s with more training in depression, for example, felt significantly more comfortable dealing with depressed patient, when compared to PCP´s with no or little training [29]. Moreover, a major proportion of PCP´s (59.7% indicated lack of knowledge in diagnosis and treatment) referred/appointed lack of training as a major barrier for treating patients with depression and anxiety, and, therefore, referred/appointed the need of training for improving their skills to treat patients with mental health problems (83.6% of the PCP´s) [30]. Also, Stigma was

greater among those providers who were relatively less comfortable with using mental health services themselves [25].

Five [23, 27, 29-31] articles including in their results the impact of the training in the attitudes and clinical practice of the PCP´s. In one of the studies [30] almost the 60% of the sample indicated the lack of knowledge in diagnosis and treatment as barriers to care people with depression and anxiety. On the other hand, those PCP´s with more training in depression experienced significantly less discomfort while addressing in that those with little or no training [29]. The need of more training it's a common conclusion by the PCP´s in order to improved their skills to treat people with mental disorders [23, 27, 31].

When compared the stigmatizing attitudes from PCP´s with mental health professionals or general population one study [10] found that the public rated positive outcomes as more likely and negative outcomes as less likely than did the physicians and psychiatrists for depression patients. Also, regarding patients with schizophrenia, the general population rated positive outcomes as more likely and negative outcomes as less likely than did all three professional groups, and the general population was less likely to believe there would be discrimination against patients than the physicians did.

Discussion

The results of this systematic review show that stigmatizing attitudes towards patients with mental disorders are common among physicians in primary care settings, and that many physicians don't feel comfortable to deal with patients with mental disorders. Stigmatization towards schizophrenia was found to be significantly higher than towards depression [10, 26, 32], and primary care physicians' views were more negative about a patient with schizophrenia than an otherwise identical patient with depression [33]. These findings of primary care providers having more negative views of individuals with schizophrenia are consistent with other studies which considered stigmatizing attitudes among others primary care professionals like nurses, social workers and mental health professionals [34-37].

Our results also show that physicians have more negative attitudes towards mental illness when compared to other professionals and to the general population. Studies comparing such groups found that physicians had the highest levels of stigmatizing

attitudes, followed by other primary care professionals, mental health professionals and the general population [10, 19, 24, 25].

The literature suggests that stigmatizing attitudes among physicians is associated with a lack of adequate training regarding treatment and identification of mental disorders [38-40]. Research has repeatedly identified deficiencies in both the identification and management of depressive illness in general practice [41-44].

There is evidence that physicians stigmatizing attitudes towards mental disorders might be an important barrier for people with mental health problems to receive the treatment they need [19, 25]. Negative attitudes of primary care providers and mental health providers may contribute to disparities in physical healthcare for persons with serious mental illness such as schizophrenia [40, 45-49]. One of the most important negative attitudes was the erroneous attribution of the signs and symptoms of physical illness to concurrent mental disorders, as it may result in physical ailments being undertreated due to the so-called “medical bias” or “diagnostic overshadowing” related to providers´ negative attitudes [50].

As most depressed patients seek treatment in primary care settings, and these patients are frequently undertreated, it is important to identify ways to increase the effectiveness of primary care clinicians in managing depression. Interventions need to consider the context of the primary care setting and consider barriers to treatment including lack of adequate time, training, competing agendas, and lack of adequate reimbursement. Ineffective treatment leads to patient and physician frustration due to lack of progress [51]. Thus, primary health care providers represent a potential target for interventions to reduce disparities in care for individuals with depression, schizophrenia and in clinical care in general [26, 27, 52].

The main limitation of the study was the search strategy, which may have led to publication bias as potential sources of gray literature were not included. However, the search was conducted in the main medical databases , using terms which have been previously used in the literature on stigma, and references of the studies selected were carefully screened to find further studies [53]. Another limitation was the heterogeneity between studies – particularly regarding the assessment of stigma. Such heterogeneity limits the possibility of combining and synthesizing findings of different articles. Additionally, it was not possible to combine studies’ results in a statistical synthesis (meta-analysis) given the heterogeneity in analysis strategies

and results from individual articles. For this reason, we decided to summarized the results of articles included in the review through a narrative synthesis. Another important limitation is that most of the results in the review are based on a single study, which have important implications when interpreting and generalizing our results.

The main conclusion of this review is that stigmatizing attitudes towards people with mental disorders are common among primary care professionals, and that professionals need more training and adequate tools to deal with mental disorders, such as a user friendly and pragmatic classification system that addresses the high prevalence of mental disorders in primary care and community settings [(54)]. The reduction of stigma among health professionals is important to reduce barriers to treatment faced by people with mental disorders and, thus, to increase their access to optimal care, which would lead to improvement in their mental health status and well-being.

Acknowledgments

AORV is receiving a scholarship from CAPES foundation of the Brazilian Ministry of Education for his doctorate training in the Department of Psychiatry, Federal University of São Paulo. DJ is also funded by Capes for her doctorate training. JJM is an I-A Senior Researcher from the National Brazilian Council (CNPq). SE-L and WSR are funded by the European Research Council under the European Union's Seventh Framework Programme (FP7/2007-2013)/ERC grant agreement number [337673].

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