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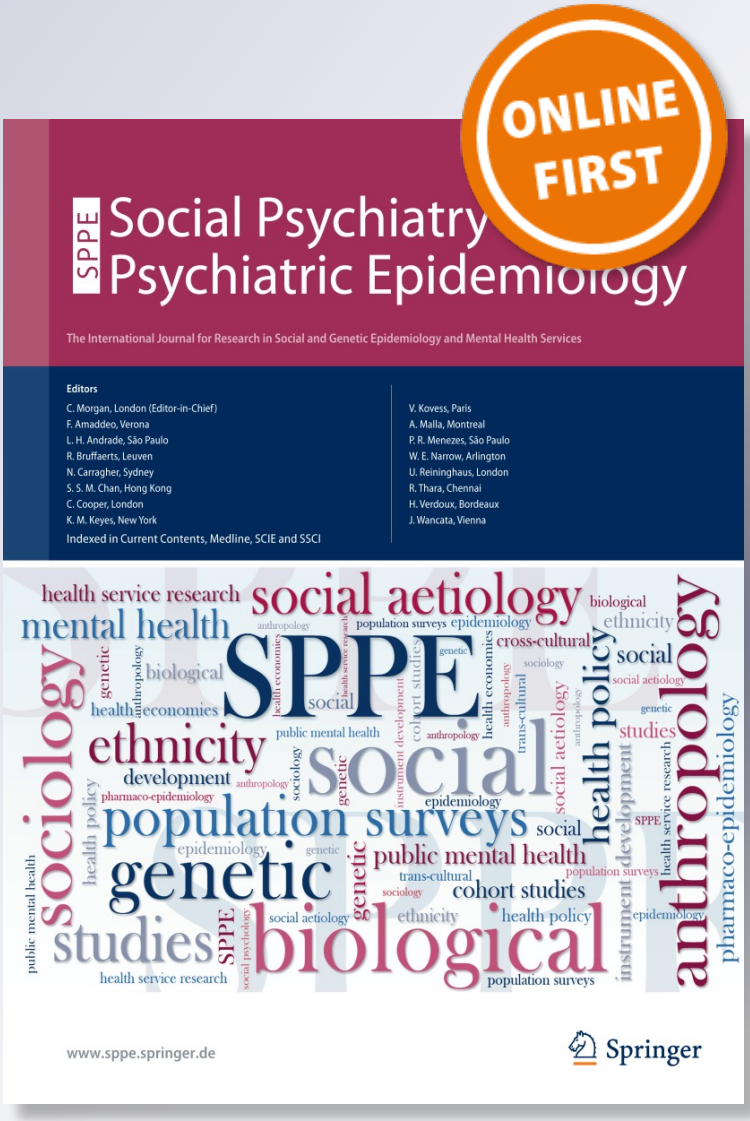

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ORIGINAL PAPER

Differential stigmatizing attitudes of healthcare professionals towards psychiatry and patients with mental health problems: something to worry about? A pilot study

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Abstract
Purpose This study compares stigmatizing attitudes of different healthcare professionals towards psychiatry and patients with mental health problems.
Methods The Mental Illness Clinicians Attitude (MICA) questionnaire is used to assess stigmatizing attitudes in three groups: general practitioners (GPs, $n = 55$), mental healthcare professionals (MHCs, $n = 67$) and forensic psychiatric professionals (FPs, $n = 53$).
Results A modest positive attitude towards psychiatry was found in the three groups ($n = 176$). Significant differences were found on the total MICA-score ($p < 0.001$). GPs scored significantly higher than the FPs and the latter scored significantly higher than the MHCs on all factors of the MICA. Most stigmatizing attitudes were found on professionals' views of health/social care field and mental illness and disclosure. Personal and work experience did not influence stigmatizing attitudes.
Conclusions Although all three groups have a relatively positive attitude using the MICA, there is room for improvement. Bias toward socially acceptable answers cannot be ruled out. Patients' view on stigmatizing attitudes of professionals may be a next step in stigma research in professionals.

Keywords Stigma · Attitudes toward mental illness · Healthcare professionals · Mental health · MICA

Introduction

During the last decade the interest in stigma in mental illness and discriminatory behavior ensuing from it, has increased considerably. Stigmatization affects life domains of people with mental health problems, such as socio-economic status with associated health risks and interpersonal relationships [1–3].

The social network of long-term patients with a serious mental illness is frequently impoverished, reflected by the finding that 76 % of this group name their healthcare professional as the most important person in their lives [4]. Therefore, attitudes of healthcare professionals towards psychiatry and patients with mental health problems are important because they may be a determinant of the quality of care given to people with a mental illness [5–7]. Experiencing stigmatization can seriously undermine the clinical course [8], quality of life and well-being of people with mental illnesses [9]. Diagnostic overshadowing, which is the process by which the physical problems of a patient are overshadowed by their psychiatric diagnosis, may contribute to detrimental effects on physical and mental health [10, 11].

The World Psychiatric Association (WPA) refers to stigma in (mental) healthcare as "iatrogenic stigma". The

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most striking source of stigmatization according to the WPA is the careless use of diagnostic labels [12]. Diagnoses may become harmful when used by non-professionals who are not familiar with the original definition of the diagnosis. Patients and their families experience this 'diagnostic' labeling often as negative and report feeling stigmatized by a lack of interest from healthcare providers [13]. Patients proclaim that providers should be aware of the potentially stigmatizing effects of their own practice. For example, a psychiatric diagnosis is often given along with a negative prognosis such as "you have schizophrenia and you will have many more psychotic episodes" or "you will be ill for the rest of your life", although a significant proportion of patients with schizophrenia achieve a favorable long-term outcome [14]. Also, many non-psychiatric healthcare professionals and many employees continue to call people with schizophrenia 'psychotics' or 'schizophrenics', labeling people by their medical diagnosis [11]. Thus, the attitudes of healthcare professionals may influence self-stigma in patients. Moreover, self-stigma of patients is an important barrier for recovery of mental illness [15, 16]. Nearly one quarter of all stigma experiences reported by patients with a mental illness are related to the (mental) healthcare professionals [2, 17, 18]. Indeed, healthcare professionals stigmatize psychiatric patients as often as the general public [2, 5, 19]. Schulze [2] reported in a review that mental health professionals had a more positive attitude than the general population in six studies, no difference between both groups was detected in nine studies and, professionals had a more negative stigmatizing attitude in seven studies.

In the healthcare system of the Netherlands, most patients first visit their general practitioner (GP) before possible referral to specialized healthcare professionals. The GP is an important factor in the mental healthcare system since 90–95 % of all patients with psychological problems only visits their GP and is not referred to a medical specialist [20, 21]. Importantly, 30–50 % of all psychiatric patients feel discriminated by their GP [21, 22]. Patients often report that they feel not well-understood by their GP and that the GP is eager to refer them to a colleague or mental healthcare instead of a somatic specialist [23, 24]. Lawrie et al. [13] investigated general practitioners' attitude to chronic psychiatric and medical illnesses. They showed that general practitioners are generally more negative about patients with schizophrenia than an identical patient with depression or diabetes.

Thus, the GP plays an important role in patients' life and may influence self-stigma.

Previous studies investigated stigma with items such as civil rights, prognosis, and helpfulness of psychiatric treatment. However, to our knowledge, the attitudes of professionals themselves towards psychiatry and patients with mental health problems (e.g. respect of mental health field compared to other fields of health; disclosure of mental illness to colleagues) were never subject of study. Our interest focuses on the attitudes of general practitioners (GPs), mental health professionals (MHCs) and professionals in forensic psychiatry (FPs) as these disciplines cover the majority of healthcare to patients with a mental illness.

This pilot study aims to investigate the stigmatizing attitudes of GPs, MHCs and FPs towards psychiatry and patients with mental health problems. Previous studies comparing GPs to other mental health professionals show inconsistent results [25–27]. Psychiatrists had a more negative attitude towards treatment outcome compared to GPs [26]. However, more recently in a study of the same research group, GPs were associated with higher scores on the personal stigma scales compared to mental health professionals and the general community [27].

We expect general practitioners to have the most stigmatizing (negative) attitude towards mental health patients as they choose to work as a generalist not being focused on (severe) psychiatric disorders as the other two study groups. The most positive attitude is expected to be found in the group of (general) mental healthcare professionals; having interest in the psychiatric field, having most social contacts with patients with a mental illness (social contact theory) and treating patients who are less violent than in a forensic setting. Attitudes of forensic psychiatric professionals may be influenced by their work with patients who partly live up to the professionals' anticipation of violent behavior and might therefore be more stigmatizing as mental healthcare professionals. Therefore, we are also interested whether this group would show aberrant attitudes from professionals in non-forensic settings. In line with the social contact theory, we expect that work experience in mental health and personal experience with mental illness are related to a less stigmatizing attitude of the health professional.

Methods

Participants and recruitment

In this study, general practitioners (GPs), mental healthcare professionals (MHCs) and forensic psychiatric professionals (FPs) were included. There were no exclusion criteria. All questionnaires were collected between September 2010 and September 2011. Ethical approval was not required as this study includes no patient data. However, all professionals participated voluntarily after being informed about the nature of the study. The study was executed in accordance with the principles of the Declaration of Helsinki.

Amongst the GPs the questionnaires were distributed right before starting a training session on physical (hypertension, obesity and diabetes in general diseases) illnesses. The group consisted of 55 persons who all filled in the form (100 % response). GPs were employed throughout the Northern Netherlands at different institutions (solo and group practices for GPs and mental health institutions).

With regard to the MHC group, the questionnaire was distributed per email within the psychiatric clinic and the outpatient clinic for schizophrenia and related psychotic disorders, mood disorders, and personality disorders. The response was 68 out of 87 (79 % response).

The FP group was addressed by means of email to a forensic institution (Mesdag Forensic Psychiatric Institute, Groningen, The Netherlands). The email was dispersed within the clinic resulting into a response of 53 questionnaires out of 146 (36 % response).

Instrument

The Mental Illness Clinicians Attitude (MICA) questionnaire assesses professionals' attitude towards psychiatry and patients with mental health problems [6]. The MICA scale is a 16-item validated self-report questionnaire. Answers are rated on a 6-point Likert Scale (1 = strongly agree; 6 = strongly disagree). The MICA score ranges from 16 to 96 with higher scores indicating more stigmatizing attitudes. The MICA consists of five factors: views of health/social care field and mental illness; knowledge of mental illness; disclosure; distinguishing mental and physical healthcare; patient care for people with mental illness. Gabbidon et al. [7] reported that some items loaded on two factors. We chose to include the item in the factor on which the highest factor loading was demonstrated.

The MICA questionnaire has been translated from English to Dutch (forward–backward method). The Dutch version of the MICA had a Cronbach Alpha of 0.73 and showed good face validity.

We consider a score of ≤ 3 (indicating somewhat (dis)-agree) as an answer indicating a (moderately) positive attitude. This indicates that a mean score till 48 (16 items $\times$ 3) would involve a moderately positive attitude towards psychiatry and patients with mental health problems with room for improvement. A mean score of 32 (16 items $\times$ 2) indicates a positive attitude while the maximum score of 16 indicates a very positive attitude with little or no room for improvement.

Additionally, sociodemographic information was collected (gender, age, level of education, work experience in general, work experience in mental healthcare, and personal experience with mental health problems (with and without treatment).

Four participants had a missing value on one item and one participant on two items on the MICA questionnaire. These data were imputed by the mean response of the participant to the other items. One participant was excluded due to missing data on 8 items.

Data analysis

All data were analyzed using the statistical analysis program SPSS (20th version). Sociodemographic characteristics were tested using Chi square and *t* tests. One-way ANOVA was used to compare the total MICA score of the three groups. A Multivariate ANOVA was used to compare the five factors (dependent variables) between groups (independent variable). Bonferroni post hoc analyses were executed to study the significant differences of the ANOVA and MANOVA in detail.

Additionally, in case of differences in sociodemographic characteristics, we performed regression analyses on MICA score with group and differing sociodemographic variables between groups as predictors (because of categorical variables; method ENTER).

Also, on the whole study population ($n = 176$) two ANOVA's were performed with total MICA score as dependent variable and (1) personal experience with mental illness as independent variable and (2) having close family (i.e. parent, sibling, child or partner) with a mental illness as independent variable. To explore whether the MICA score and work experience in mental health (in years) were associated, we performed Pearson correlations within the study groups as significant differences were detected on work experience in study groups at baseline.

Results

In Table 1 the demographic characteristics are presented. The sample of the MHC group consisted of nurses, psychologists, psychiatrists (in training) and secretaries, of which 43 % had an academic degree. The FP group consisted mainly of nurses, and some psychologists and psychiatrists. Of these responders, 15 % had an academic degree. The GP group consisted of GPs and GP residents. All three samples were representative for their professional group regarding age, gender, and work experience as compared to the total population of the institution. Additionally, national data about mental health professionals and general practitioners show that the MHC sample, FP sample [28] and GP sample [29] are representative with regard to age and gender (there are no data on work experience). With regard to education, the FP and GP groups were representative. In contrast, the MHC group was not representative as many psychiatrists were included

Table 1 Demographic characteristics of GP group, MHC group and FP group in a study on stigmatizing attitudes of healthcare professionals ($N = 176$)

	GP $N = 55$	MHC $N = 67$	FP $N = 53$	P value
Mean age in years (SD)	46 (12.2)	45 (9.2)	44 (10.0)	0.762
Gender: % female (*n*/*n* total)	29 (16/55)	57 (39/68)	43 (21/49)	0.007*
Educational level: % (*n*/*n* total)				
Academic	100 (55/55)	50 (28/56)	18 (9/51)	
Non-academic	0 (0/55)	50 (28/56)	82 (42/51)	0.001**
Work experience in years: Mean (SD)				
Mental health area	0.5 (1)	16 (10)	15 (9)	0.001**
Total in any health area	19 (12)	21 (10)	22 (12)	0.521
Personally knowing someone with mental illness (%)	38	46	36	0.467
Personal experience with mental health problems (%)	28	39	25	0.212

GP general practitioner, *MHC* mental healthcare professional, *FP* forensic psychiatric professional

* Significant at $p < 0.05$,
** Significant at $p < 0.001$

(in general practice 15 % had an academic degree versus 43 % in our sample).

Of all professionals, 31 % indicated to have personal experience with mental health problems, 7 % of them did not seek professional help for their problem.

Stigmatizing attitude

The total MICA score differed significantly between groups. The GPs had the highest score indicating a more stigmatizing attitude, the FP group scored in between, and the MHC group had the lowest stigmatizing attitude. With regard to the five factors of the MICA, a multivariate analysis showed that groups differ significantly on all factors (F (10, 338) = 7.75; $p < 0.001$). Most stigmatizing attitudes were found on professionals' views of health/social care field and mental illness (GPs > FPs > MHCs) and disclosure (GPs > FPs and MHCs). The results of the analyses are shown in detail in Table 2.

We consider the attitude of the MHC as positive, the GPs as moderately positive and the FPs with an attitude between moderately positive and positive. The regression analysis with group, gender, educational level and work experience in the mental health area as predictors showed that group was the only significant predictor of total MICA score (see Table 3).

Relation between stigmatizing attitude and personal and work experience

Personal experience of mental illness, either having personal experience ($p < 0.177$) or knowing others (family) ($p < 0.364$), was not associated with more or less stigmatization in the total sample. Work experience in mental health was also not significantly associated with stigmatizing attitudes. Pearson correlation between work experience in mental health and the MICA score within groups revealed no significant correlations (MHCs: $p < 0.691$, FPs: $p < 0.186$; GPs: $p < 0.232$).

Highest stigmatizing attitudes

At item level, all three groups had the highest scores on the same three statements. The items with the highest MICA scores in the whole study population were: the public does not need to be protected from people with a severe mental illness (item 12; M: 3.7; SD: 1.3); working in the mental

Table 2 MICA scores on total and 5 factors in GP, MHC and FP group

	GP ($n = 55$) (CI 95 %)	MHC ($n = 67$) (CI 95 %)	FP ($n = 53$) (CI 95 %)	F (df)	P value
MICA total	44.0 (42.2–45.8)	34.1 (32.5–35.7)	38.0 (36.1–39.8)	33.32 (2,172)	<0.001*
Factor 1: Views of health/social care field and mental illness (4 items)	13.2 (12.6–13.9)	10.2 (9.6–10.8)	11.7 (11.0–12.4)	23.23 (2,172)	<0.001[a,b,c]
Factor 2: Knowledge of mental illness (4 items)	11.3 (10.6–12.1)	8.2 (7.6–8.8)	10.1 (9.2–11.0)	18.76 (2,172)	<0.001[a,b]
Factor 3: Disclosure (2 items)	6.8 (6.1–7.4)	5.0 (4.7–5.4)	5.0 (4.5–5.6)	14.29 (2,172)	<0.001[b,c]
Factor 4: Distinguishing mental and physical health (4 items)	9.0 (8.5–9.5)	7.7 (7.2–8.2)	7.7 (7.0–8.4)	7.38 (2,172)	<0.001[b,c]
Factor 5: Patient care for people with mental illness (2 items)	3.7 (3.3–4.0)	2.9 (2.7–3.2)	3.4 (3.0–3.8)	4.88 (2,172)	0.009[b]

* Bonferroni post hoc analyses demonstrated that MHC < FP ($p = 0.006$); MHC < GP ($P < 0.001$); FP < GP ($p < 0.001$)

[a] MHC < FP ($p < 0.05$), [b] MHC < GP ($p < 0.05$), [c] FP < GP ($p < 0.05$)

Table 3 Regression analysis with group and demographic characteristics as predictors of stigmatizing attitudes of healthcare professionals towards psychiatry and psychiatric patients

	B	Standard error	Beta	*P* value
Constant	29.93	3.25		
Group	4.75	0.791	0.520	<0.0001
Gender	−0.44	1.06	−0.029	0.68
Work experience in mental health	−0.08	0.06	−0.106	0.25
Education	0.09	1.19	0.006	0.94

$R^2 = 0.35$

health field is just as respectable as other fields of health and social care (item 3; M: 3.7; SD: 1.1); if I had a mental illness, I would never admit this to my colleagues for fear of being treated differently (item 7; M: 3.1; SD: 1.2). Item 3 and 12 are reversed scored which results in: the public has to be protected from people with SMI and the mental health field is seen as less respectable.

Discussion

In this study, we investigated stigmatizing attitudes among general practitioners, mental healthcare professionals and forensic psychiatric professionals. All three groups have a moderately positive attitude towards psychiatry and patients with mental health problems as examined with the MICA. Consistent with our hypothesis, the GPs scored significantly higher than the FPs and the latter scored significantly higher than the MHCs on all factors of the MICA. Most stigmatizing attitudes were found on the factors professionals' views of health/social care field and mental illness and disclosure. Personal and work experience in mental health did not influence stigmatizing attitudes.

The results of the mental health professionals in the current study are comparable with the results in medical students in the studies of Kassam et al. [6] and Gabbidon et al. [7]. A relatively more stigmatizing attitude of the GP group is also in line with earlier findings [19, 23, 27, 30]. To the best of our knowledge, our study is the first that investigated attitudes of professionals in the forensic area.

Although a moderately positive attitude is found, a study including service user professionals reported more stigma in treatment teams towards patients than their colleagues [31]. Also, service user professionals perceive more discrimination than clinicians. This may implicate that there is a discrepancy between the self-reported attitude of the professionals and the perception by others such as service user professionals. Directly asking service users whether they perceive any stigmatization in mental healthcare is assessed in the Discrimination and Stigma Scale [32].

Burn out of professionals might also influence stigmatizing attitudes. Bayar [33] states that burnout is caused by 'physician bias' i.e. having a pessimistic view on recovery due to treating people who are unwell and stop seeing people who have recovered. Lauber [34] suggests having regular supervision to prevent burnout. Additionally, Bayar suggests that educational programs supporting recovery notions of mental illness might also have beneficial effects.

To get more insight into the attitudes, we examined the factors and items revealing the most stigmatizing attitudes of professionals. First, professionals had the highest score on the factor 'disclosure'. They indicated in the MICA questionnaire that they would hardly admit having a mental illness to their colleagues i.e. representing a stigmatizing attitude. This may be an expression of anticipated rejection of having a mental illness amongst professionals in the (mental) health field. Thus, knowledge and familiarity with a mental illness may not imply that the fear of stigma decreases. Moreover, West [35] emphasizes that most studies on stigma focus on the broader label of mental illness as though various disorders are interchangeable. Thus, having no stigmatizing attitude towards people with a depressive disorder will not automatically lead (generalize) to having no stigmatizing attitude to people with schizophrenia. Future research should also focus on professionals' attitudes in different patient groups.

Of note, 26–38 % of the participants indicated that they had personal experience with a mental illness. This is in line with the findings in the general population [36].

In addition, the professionals scored high on the factor 'views of health/social care field and mental illness'. We will highlight two items of this factor. They indicated that 'psychiatry might be seen as less respectable compared to other fields of health and social care'. This is in line with findings of Mahli et al. [37], in which psychiatry was regarded by medical students as distinctly less 'attractive' than other career options and as lacking a scientific foundation. Additionally, medical students who express their interest in psychiatry risk being perceived as 'odd, peculiar or neurotic'. Also, their choice to enter psychiatric training is being criticized and discouraged by family [38].

The second item in this factor on which professionals had the highest stigmatizing attitude was protection of the public against people with a (severe) mental illness. Short [39] showed that the majority of schizophrenia patients do not engage in criminal violence, but a diagnosis of schizophrenia is significantly associated with the risk of criminal and family violence in comparison to the general community. However, people with a mental illness are more often victim of violent behavior than initiator [40, 41].

Mental healthcare professionals in the forensic psychiatric field may be biased through their work within a system where patients are more often aggressive. For these aggressive incidents the public should indeed be protected. Still, the GPs score higher on this subject than the FPs. Assessing knowledge of professionals on mental health would contribute to more detailed insight in the source of stigmatizing attitudes.

In our study, we did use the MICA. Gabbidon et al. [7] showed good readability and low rates of missing data in medical students using the MICA. They suggested examining the suitability of the MICA in other study groups. In our study, the MICA was suitable for mental healthcare professionals, forensic psychiatric professionals and general practitioners. However, the MICA should also be validated in health professionals.

Additionally, this is the first study that examined the five factors of the MICA in three different healthcare sectors. Scores on the factors are consistent irrespective of the healthcare discipline i.e. all professionals scored highest on the first factor 'professionals' views of health/social care field and mental illness'.

Implications

What are the opportunities to decrease stigmatizing attitudes? Findings in the National Campaign (Time to Change) in England show that the celebrities and average citizens opening up about their own psychological problems contribute to destigmatization [42, 43]. The overall message in this campaign is that anyone can get a mental illness and that having one is common. So, making the public aware and familiar with these kinds of illnesses will improve the attitude towards mentally ill patients. Notably, mass social contact interventions use social contact as one of the most effective strategies to reduce stigma [44]. However, this might not work for mental health professionals having sufficient knowledge about mental disorders and social contact. This is supported by a study from Henderson [43] which demonstrated that experiences of discrimination from mental health professionals did not change significantly (reported by about one-third of participants at baseline and after 1 year) in England's Time to Change anti-stigma campaign.

In line with the campaign for the general public, it might be helpful to reduce stigma when also professionals in (mental) healthcare would open up about their personal experiences towards colleagues especially when it influences their daily functioning at work. Additionally, increased awareness of stigma in (mental) healthcare in general and more specifically to what extent the professional has a stigmatizing attitude him/herself towards mental illness might contribute to reduce stigma within (mental) healthcare. In daily practice, professionals might not be sufficiently aware of the fact that the prevalence of mental illness in the general population is comparable to the prevalence amongst colleagues in any health profession. Educating healthcare professionals on the prevalence of mental health issues amongst their own group as well as the impact of denying mental health issues may improve attitudes toward mental health problems.

Education should also focus on the effects of stigmatizing behaviour of professionals on people with a mental illness. Pinfold [17] studied the effect of educational interventions in UK secondary schools and in the police force. Both studies emphasize that educational interventions were useful. Just one study investigated the effect of educational interventions with regard to stigmatizing attitudes of mental health professionals [33]. This study found a positive effect of education on the stigmatizing attitude of mental health professionals. Future research should focus on how to offer effective educational programs to MHCs on stigma. Notably, a meta-analysis on the effectiveness of educational interventions showed that programs for reducing stigma were effective on improving personal stigma of patients [45]; however, the effect sizes were small. In social contact the focus should be on increasing self-esteem of patients. Van Zelst [46] demonstrated that patients having more self-esteem do suffer less from stigma (stereotype awareness).

Limitation of this study was the lack of homogeneity between groups with regard to gender, educational level, and work experience. However, we used these variables as covariates in the regression analysis and they did not influence the MICA scores. Another limitation was the use of different recruitment procedures and response rates per group, possibly introducing sources of bias.

Although the original English version is checked for socially accepted answers [6], social desirability cannot be ruled out influencing responses to the questionnaire.

Future studies may investigate patients' opinions about stigmatizing attitudes of healthcare professionals, along with ratings of the corresponding professionals as well as the influence on their recovery process.

Conclusions

Attitudes of healthcare professionals may be detrimental for patients in mental healthcare. Although all three groups have a relatively positive attitude using the MICA, there is room for improvement. Most stigmatizing attitudes were found on the factors 'professionals' views of health/social care field and mental illness' and 'disclosure'. Stigmatizing attitudes differed significantly between mental health workers, forensic psychiatric workers and general practitioners. GPs

had the most negative attitude. Socially accepted answers cannot be ruled out. Patients' view on stigmatizing attitudes of professionals may give more insight.

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Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

Ethical standards This manuscript does not contain patient data.

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