Stigma and Discrimination in Behavioral and Physical Healthcare Settings

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While most health professionals enter the healthcare field with good intentions (Burks, Youll, & Durtschi, 2012; Wakefield, 1993), it is also true that they endorse stereotypes and discriminate against people with mental illnesses and substance abuse problems. Indeed, people with mental illnesses and their families often report stigma and discrimination in their interactions within the healthcare system (Holzinger, Beck, Munk, Weithaas, & Angermeyer, 2003; Pinfold, Byrne, & Toulmin, 2005). Mental health professionals, aware of stigma in the community, have been at forefront of public stigma reduction programs (Crisp, Gelder, Goddard, & Meltzer, 2005). However, evidence of negative attitudes and behaviors toward people with mental illnesses among healthcare workers demonstrates the need to implement strategies to reduce stigma within the healthcare field (Wahl & Aroesty-Cohen, 2010).

This review summarizes the current knowledge about how stigma manifests in healthcare settings, and how it affects the lives of people with mental illnesses and substance abuse problems. The material is drawn from several comprehensive reviews that cover various aspects of this issue. The first section provides an overview of the attitudes, beliefs, and behaviors that lead to consumer dissatisfaction and inadequate care, followed by a description of the stigma associated with the interface between mental illness and physical healthcare. The remaining section describes professional and institutional aspects of healthcare environments that contribute to difficulties in providing adequate care.

Attitudes, Beliefs, and Behaviors

Existing research on healthcare professionals' attitudes toward people with mental illnesses and substance use problems reveals contrary trends, with most studies indicating positive and negative attitudes (Schulze, 2007; Wahl & Aroesty-Cohen, 2010). Surveys find healthcare professionals endorse blame (Ross & Goldner, 2009), dangerousness, and unpredictability (Kingdon, Sharma, & Hart, 2004; Magliano, Fiorillo, De Rosa, Malangone, & Maj, 2004). Nurses and emergency room staff report experiencing fear when treating this population (Ross & Goldner, 2009; Clarke, Usick, Sanderson, Giles-Smith, & Baker, 2014). Mental health professionals have shown a tendency to view people with mental illness more negatively than positively (Lauber, Anthony, Ajdacic-Gross, & Rössler, 2004; Nordt, Rossler, & Lauber, 2006), characterizing them, for example, as manipulative (Deans & Meocevic, 2006) and lacking willpower (Domingo & Baer, 2003), or disturbing, ineffective, and difficult to communicate with (Servais & Saunders, 2007). Healthcare professionals in general are also likely to endorse social distance at rates similar to the general public (Lauber et al., 2004; Reavley, Mackinnon, Morgan, & Jorm, 2014). On the positive side, studies have found that mental health professionals promote community-based interventions over institutions (Kingdon et al., 2004; Lauber et al., 2004), and endorse civil rights (Magliano,et al., 2004; Zogg, Lauber, Ajdacic-Gross, & Rössler, 2003). There are mainly positive attitudes about treatment efficacy among mental healthcare professionals (Schulze, 2007). However, people with mental illness report dissatisfaction with treatment options (e.g. medications over psychotherapy) and the often visible and dangerous side effects of medication (Henderson et al., 2014; Schulze & Angermeyer, 2003; Thornicroft, Rose, & Kassam, 2007). Psychiatrists might also have similar concerns about medications as one study indicated that they would be reluctant to use anti-psychotics themselves (Rettenbacher, Burns, Kemmler, & Fleischhacker, 2004).

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Although treatment is thought to be beneficial, on the whole, professionals seem to be pessimistic about recovery, with as many as half failing to endorse recovery as an outcome for serious mental illness (Magliano et al., 2004). Hugo (2001) compared attitudes about recovery for different disorders and found healthcare professionals were more pessimistic about recovery and long-term outcomes for people with schizophrenia than for people with depression. Some have suggested that healthcare professionals' belief in the biomedical model of mental illness, which has been shown to increase stigma in the public (Henderson et al., 2014; Schomerus et al., 2012), should be given more consideration by researchers because it might contribute to negative attitudes about recovery (Henderson et al., 2014).

Healthcare professionals' attitudes toward people with personality disorder, substance abuse and people who self-harm are especially damaging. People with borderline personality disorder are often seen as manipulative (Deans & Meocevic, 2006; Schulze, 2007), undeserving, annoying, and difficult (Lewis & Appleby, 1988; Thornicroft et al., 2007), leading some mental health professionals to exclude this population from treatment (Henderson et al., 2014). People who self-harm reported feeling punished by emergency room professionals (Thornicroft et al., 2007), and judged harshly by nurses (Ross & Goldner, 2009. Nurses and emergency room staff tend to resent diverting care to people who self-harm, endorsing attitudes of anger and hostility toward them (Ross & Goldner, 2009; Clarke et al., 2014). People with substance use problems were found to be stigmatized more highly than people with other mental disorders, with notably higher stigma directed at those with drug addiction (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013).

Several studies have compared the attitudes of healthcare professionals between disciplines. Findings suggest that psychiatrists are more pessimistic about mental illness compared with general practitioners, clinical psychologists, and mental health nurses (Caldwell & Jorm, 2001). However, service consumers report higher stigma when interacting with general healthcare professionals than mental healthcare professionals, with attitudes among emergency room staff considered especially harmful (Mazeh, Melamed, & Barak, 2003; Thornicroft et al., 2007). A recent study in Australia found general practitioners more stigmatizing than psychiatrists, clinical psychologists, or members of the general public (Reavley, et al., 2014).

Attitudes and beliefs about mental illness seem to influence behaviors that contribute to lower quality of care in this population (Corrigan, Druss, & Perlick, 2014; Thornicroft et al., 2007; Schulze & Angermeyer, 2003). Some mental health professionals choose not to disclose diagnoses (Schulze, 2007; Ücok, Polat, Sartorius, Erkoc, & Atakli, 2004), and offer limited information about the illness and treatment to service consumers (Corrigan, Druss, et al., 2014; Schulze, 2007; Thornicroft et al., 2007). People with mental illness report that healthcare professionals tend to focus on characteristics of their illness rather than focusing on them as a person (Schulze & Angermeyer, 2003). As such, it has been observed that psychiatrists rarely engage people with mental illness in such real-life issues as finance, accommodations, and leisure (Killian et al., 2003; Schulze & Angermeyer, 2003). Other research indicates that healthcare professionals in general often engage in over-protective behaviors meant to reduce stress. These behaviors are considered by consumers to be paternalistic, dehumanizing, and disrespectful (Henderson et al., 2014 Thornicroft et al., 2007). Healthcare professionals also tend to communicate low expectations and overemphasize negative outcomes. In fact, they often fail to encourage personal goal achievement (e.g., employment, housing), lifestyle interventions (e.g., smoking cessation, dietary management) and self-determination (medical advance

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directives) (Henderson et al., 2014; Thornicroft et al., 2007; Foti, Bartels, Merriman, Fletcher, & van Citters, 2005).

Schulze (2007) explains that in contrast to psychiatrists' support for community healthcare and maintaining civil rights, they are also found to support involuntary treatment and commitment (Lepping, Steinert, Gebhardt, & Rottgers, 2004; Nordt et al., 2006; Zogg et al., 2003). In fact, people with mental illnesses report treatment was often delivered in a coercive way, and they feared coercion when dealing with the medical community (Thornicroft, et al., 2007). In institutional settings, Henderson et al. (2014) report that people with a mental illness in healthcare facilities are often subject to restrictive and controlling behavior (e.g., limiting opposite sex relationships, contact with children, and leaving the facility) (Ellsworth, 1965).

The Interface Between Behavioral and Physical Healthcare

Important aspects relative to understanding discrimination in general healthcare settings for people with mental illness are (i) the health disparities experienced by this group and (ii) their interactions with healthcare professionals. A review of the literature shows extremely high morbidity rates (World Health Organization, 2001), and mortality rates at 15 to 30 years younger than others (Saha, Chant, & McGrath, 2007). Multiple lifestyle factors contribute to these disparities (Druss, Zhao, von Esenwein, Morrato, & Marcus, 2011), but research suggests that stigmatizing attitudes held by primary care providers might also be a factor (Jones, Howard, & Thornicroft, 2008). Primary care providers often fail to offer routine services, or do not adhere to standards of practice (Corrigan, Mittal et al., 2014). Compared to people without mental illness, research shows that people with mental illness are less likely to be given medical screenings (Koroukian, Bakaki, Golchin, Tyler, & Loue, 2012), offered routine procedures such as cardiac catheterization (Druss, Bradford, Rosenheck, Radford, & Krumholz, 2000), be referred to specialists, or have prescriptions refilled (Corrigan, Mittal et al., 2014).

Interpersonal and organizational aspects of medical care might also contribute to the disparities described above. Diagnostic overshadowing has been applied to situations in which medical professionals mistrust or fail to respond to reports of physical symptoms, attributing them rather to the person's mental illness presentation (Jones et al., 2008; Henderson et al., 2014). Such behavior by physical and mental healthcare professionals can delay care, leading to more serious medical problems, and higher mortality rates (Jones et al., 2008; Henderson et al., 2014). Ross and Goldner (2009) describe in general healthcare a "conceptual fragmentation" that places mental health needs at the lowest priority. For example, nurses in general healthcare report providing care in a task-oriented manner, tending to psychiatric needs only if time allowed, or when all other needs are met. An example of how organizational policies might contribute is exemplified by the frustration emergency room staff reported concerning the low priority placed on psychiatric emergencies as a policy in some emergency care centers (Summers & Happell, 2003).

Professional and Environmental Aspects

Professional and environmental aspects of the healthcare workplace can also contribute to perpetuating stereotypes and interfering with quality care. Take for instance the effect of contact with people with a mental illness in healthcare settings. There is robust evidence that contact with a marginalized group is an effective means to reduce stigma (Allport, 1954; Corrigan,

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Morris, Michaels, Rafacz, & Rüsch, 2012; Pettigrew & Tropp, 2006). The nature of contact in healthcare environments puts practitioners regularly in contact with people with severe and chronic symptoms that might have a paradoxical effect that actually perpetuates stereotypic assumptions (Henderson et al., 2014). In addition, contact theory (Allport, 1954) outlines four conditions for optimal contact including equal status between the groups. This condition is typically violated by the inherent imbalance that often exists between healthcare professionals and consumers, possibly attenuating the positive effects of contact (Bell, Johns, & Chen, 2006; Henderson et al., 2014; Hinshaw & Cicchetti, 2000). However, the negative effect of contact among some healthcare practitioners seems to decrease with increased experience and age (Henderson, et al., 2014).

Experience and age also has been associated with decreased burnout. (Henderson et al., 2014). Burnout, the result of chronic job stress, is characterized by exhaustion, a sense of ineffectiveness, and detachment and cynicism toward work (Rössler, 2012). Burnout has been linked to negative attitudes and reduced quality of care by mental health professionals. Rössler (2012) and others have described several aspects of the work environment that limit the provision of adequate care, and eventually leads to burnout, including non-supportive environments, limited resources, inadequate facilities, and the stigma directed at mental healthcare professionals. Healthcare professionals report that these negative characteristics affect the quality of care they provide (Ross & Goldner, 2009; van Boekel et al., 2013). For example, nurses reported lack of resources and infrastructure compromised their safety, which exacerbated fear of caring for people with mental illnesses and resulted in delaying or avoiding care (Ross & Goldner, 2009). In contrast, substance abuse specialists with more organizational support, supervision, and consultation with experts have been shown to have more positive attitudes toward people with substance use problems (van Boekel et al. 2013).

Stigma may also extend to providers of mental health care, and this might exacerbate public stigma as well as influencing attitudes toward seeking care. In reviewing this topic, Sartorius et al. (2010) explain how psychiatrists and the practice of psychiatry are viewed by different groups. The public view is that psychiatry is ineffective and harmful, and that psychiatrists are low-status physicians who rely too much on medication. The media portrays psychiatry as a discipline without true scholarship, depicting psychiatrists as mad doctors, as super healers, or as exploitative practitioners. Medical students and others in the medical field view psychiatry as having low status, which might discourage promising students from pursuing a mental health career, and drive talented professionals away from the discipline (Gaebel et al., 2011; Link & Phelan, 2001).

Several reviews indicate that healthcare professionals should be more attuned to the cultural and racial differences of people who present with mental health concerns (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006; Giacco, Matanov, & Priebe, 2014). Schraufnagel and colleagues (2006) explain that although there is limited research in this area (US Department of Health and Human Services, 2001), it remains clear that ethnic and racial minorities do not access mental healthcare at the rate of Caucasians, and when they do, care is often inadequate (SAMHSA, 1999). For example, Schraufnagel et al. (2006) reported that compared to Caucasians, medication was prescribed at lower doses and shorter duration for people of Asian descent (Cornwell & Hull, 1998) and African Americans were prescribed outmoded tricyclics more often for depression (Melfi, Croghan, Hanna, & Robinson, 2000) There are a number of factors that seem to reduce access to good quality care, and others that might increase rates of treatment for common mental disorders for both ethnic and racial minorities and immigrants.

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Language barriers and provider misunderstanding of cultural ideas about treatment and conceptualizations of mental illness, seem to obstruct quality care (Schraufnagel et al., 2006; Giacco et al., 2014). Integrated healthcare has been recognized to increase participation in mental health treatment for these groups (Schraufnagel et al., 2006; Giacco et al., 2014). Although most healthcare professionals agree that cultural competency training is important, it remains limited in healthcare settings (Giacco et al., 2014). A greater focus on increasing awareness of cultural norms regarding mental illness and treatment could increase minority engagement in treatment and promote higher quality care among healthcare professionals (Giacco et al., 2014).

Overwhelmingly, the literature emphasizes the need for formal mental healthcare training to better prepare healthcare professionals to care for people presenting with mental health issues. For example, lack of knowledge about mental illness treatment in primary care settings could lead to misdiagnosis and improper treatment regimens (Wang, Demler, & Kessler, 2002). Nurses report lacking necessary skills to care for people with mental illnesses, often leading to fear, misunderstanding, and avoidance (Ross & Goldner, 2009). Studies found greater perceived efficacy in assessing and treating mental health needs to be associated with more positive attitudes among emergency room staff (Clarke et al., 2014). Training can be effective. Studies have demonstrated that training improved attitudes toward people with borderline personality disorder and those who self-harm, with stable effects over time (Henderson et al., 2014). It has been suggested that cross-disciplinary training about mental illnesses and effective treatments in medical school could have long term significance for increased provider efficacy and consumer satisfaction (Henderson et al., 2014; Weinerman et al., 2011).

Conclusion

This paper provides a summary of the difficulties people with mental illnesses and substance abuse have in their interactions with behavioral and general healthcare providers. Overall, negative attitudes and behaviors toward these populations exist in all aspects of healthcare. Improving the contextual factors that lead to healthcare worker dissatisfaction, and removing barriers that prevent providing high quality care might be an important step toward improving attitudes and increasing care seeking (van der Kluit & Goossens, 2011). Disparities in healthcare for people with mental illness who present with physical health concerns seems to be an important target for intervention (Corrigan, Druss et al, 2014; Corrigan, Mittal et al., 2014), as does formal training in mental health issues for medical professionals (Weinerman et al., 2011). Moving forward, more research needs to be done to unpack the underlying mechanisms and practical solutions that would improve professional engagement and increase treatment seeking and satisfaction with care.

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