Patient and Health Care Professional Perspectives on Stigma in Integrated Behavioral Health: Barriers and Recommendations

Sean M. Phelan, PhD, MPH[1]
Manisha Salinas, DrPH[2]
Tyson Pankey, PhD, MPH[3]
Gabrielle Cummings[4]
Jay-Sheree P. Allen, MD[5]
Anne Waniger, MD[6]
Nathaniel E. Miller, MD[5]
Jocelyn Lebow, PhD, LP[7,8]
John F. Dovidio, PhD[9,10]
Michelle van Ryn, PhD, MPH[10]
Chyke A. Doubeni, MD[11]

[1]Department of Family Medicine, Division of Health Care Delivery Research, Robert D. & Patricia E. Kern Center for the Science of Healthcare Delivery, Mayo Clinic, Rochester, Minnesota

[2]Center for Health Equity and Community Engaged Research, Mayo Clinic, Jacksonville, Florida

[3]Department of Psychiatry & Behavioral Sciences, Duke University School of Medicine, Durham, North Carolina

[4]Alix School of Medicine, Mayo Clinic, Rochester, Minnesota

[5]Department of Family Medicine, Mayo Clinic, Rochester, Minnesota

[6]Department of Psychiatry, Mayo Clinic, Rochester, Minnesota

[7]Department of Psychiatry and Psychology, Mayo Clinic, Rochester, Minnesota

[8]Department of Pediatrics and Adolescent Medicine, Mayo Clinic, Rochester, Minnesota

[9]Department of Psychology, Yale University, New Haven, Connecticut

[10]Diversity Science, Inc, Portland, Oregon

[11]Department of Family Medicine, Center for Health Equity and Community Engaged Research, Mayo Clinic, Phoenix, Arizona

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CORRESPONDING AUTHOR

Sean M. Phelan
200 First St SW
Rochester, MN 55905
Phelan.sean@mayo.edu

ABSTRACT

PURPOSE Stigma related to mental health is well documented and a major barrier to using mental and physical health care. Integrated behavioral health (IBH) in primary care, in which behavioral/mental health care services are located within a primary care setting, may reduce the experience of stigma. The purpose of this study was to assess the opinions of patients and health care professionals about mental illness stigma as a barrier to engagement with IBH and to gain insight into strategies to reduce stigma, encourage discussion of mental health, and increase uptake of IBH care.

METHODS We conducted semistructured interviews with 16 patients referred to IBH in a prior year and 15 health care professionals (12 primary care physicians and 3 psychologists). Interviews were transcribed and inductively coded separately by 2 coders for common themes and subthemes under the topic headings of barriers, facilitators, and recommendations.

RESULTS We identified 10 converging themes from interviews with patients and the health care professionals, representing important complementary perspectives, with respect to barriers, facilitators, and recommendations. Barriers included professionals, families, and the public as sources of stigma, as well as self-stigma or avoidance, or internalizing negative stereotypes. Facilitators and recommendations included normalizing discussion of mental health and mental health care–seeking action, using patient-centered and empathetic communication strategies, sharing by health care professionals of their own experiences, and tailoring the discussion of mental health to patients' preferred understanding.

CONCLUSIONS Health care professionals can help reduce perceptions of stigma by having conversations with patients that normalize mental health discussion, use patient-centered communication, promote professional self-disclosure, and are tailored to patients' preferred understanding.

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INTRODUCTION

The well-documented stigma of mental illness is a barrier to patients seeking and benefitting from mental and physical health care. Stigma is the societal labeling, stereotyping, and rejecting of or discriminating against people with a trait that is considered to be undesirable.[1-7] Throughout history and today, people with mental and behavioral health disorders have been labeled as dangerous, volatile, weak, frail, and unintelligent or lacking in self-control.[8] These stereotypes contribute to systematic discrimination and have multiple adverse effects that compromise the quality of medical care.[9-13] Mental illness stigma persists today and affects the way people, including health care professionals, interact with individuals having mental health disorders.[11,14] Patients with mental illness may avoid needed care because they anticipate being stigmatized by others or have internalized stigma.[14,15] Understanding mental illness stigma from the perspectives of both patients and health care professionals is therefore a critical step in reducing its impact on medical care.

Integrated behavioral health (IBH) in primary care, whereby psychotherapeutic and psychiatric medication interventions are provided within the primary care setting, represents a promising approach to overcoming barriers to care associated with mental illness stigma.[16-18] Integrating mental health care into the primary care setting may decrease stigma by framing mental health care as a part of whole-body wellness and reducing the need for patients to make and keep referral appointments

with specialty mental health professionals outside primary care settings.[16] Removing the possibility of being seen seeking care at a specialty mental health clinic or thinking about oneself as needing such care may also reduce stigma.[19] Nevertheless, stigma continues to prevent patients from initiating and continuing with mental health care even within IBH settings, suggesting that barriers remain.[16,20] Furthermore, primary care clinicians may not have the training and experience to recognize and avoid stigmatizing behavior, and thus may particularly benefit from specific strategies to reduce stigma or its impact on patients.

In this study, we sought to develop a better understanding of mental illness stigma as a barrier to engagement with IBH and to identify strategies to reduce stigma's impact, using interviews with both patients and health care professionals in an IBH primary care practice. Our aim was to elucidate best practices and patient preferences to help health care professionals identify strategies to reduce stigma.

METHODS

Participants

We obtained the patient perspective from 16 adult patients whose medical records indicated they had been referred to an IBH appointment in the past year (12 women, 4 men; mean [SD] age = 49.0 [18.4] years). The reason for referral was not recorded, but people seeking care for anxiety disorders, depressive disorders, and adjustment disorders made up 84% of this practice's patients.[21] Of the 16 patients referred to IBH, 10 completed at least 1 visit and 6 did not. The study methods were approved by the Mayo Clinic Institutional Review Board.

We obtained the professional perspective from 15 health care professionals (9 family medicine physicians, 3 internal medicine physicians, and 3 IBH psychologists) who practiced in a large integrated primary care and behavioral health practice in the upper midwestern United States. They were nearly equally split by sex (7 women, 8 men).

Procedures

We used phenomenological methods, which aim to understand and interpret lived experiences,[22] to guide the study. A semistructured interview guide was developed for health care professional and patient interviews with probing questions related to mental illness stigma (Supplemental Table 1). Mental health stigma was not explicitly defined for interviewees to encourage them to share their individual perspective on bias. Health care professionals were asked to describe their experiences discussing mental health and mental health care with their patients, as well as strategies they recommend for having an effective, nonstigmatizing discussion with patients about mental health. Patients were asked to describe their experiences seeking, discussing, being offered, and participating in IBH care. They were also asked for their recommendations on strategies to help overcome stigma as a barrier to communication about mental health.

Participants were recruited via e-mail or a patient portal message. Individual video interviews were conducted using Zoom video conferencing software (Zoom Video Communications, Inc), and all audio and video were recorded. Interviews were conducted by study investigators trained in qualitative and mixed methods research (M.S. and S.M.P.) and lasted from 30 to 60 minutes. All recordings were initially transcribed by Otter.ai automated transcription software (Otter.ai, Inc) and then carefully reviewed by 1 of 4 research assistants to correct transcription errors.

Data Analysis

Two coders (S.M.P. and M.S.) reviewed deidentified transcripts independently. Health care professional and patient interviews were coded separately. We first used open inductive coding to group specific transcript passages, and then used axial coding to refine, categorize, and identify patterns across the data.[23,24] Categories were collapsed and selectively coded to develop major themes and subthemes separately in professional interviews and in patient interviews. Coders met at regular intervals to discuss concerns or discrepancies to mutual consensus. A subset of transcripts were re-reviewed and recoded.

RESULTS

Interview discussions focused primarily on barriers, facilitators, and recommendations to overcome stigma. Barriers were the factors whereby stigma prevented access to effective care. Facilitators were the factors that helped reduce the impact of stigma on care. Recommendations were the strategies provided by both health care professionals and patients to reduce stigma or its impact on care. Because of their conceptual overlap, facilitators and recommendations are presented together. We identified 10 themes and 4 subthemes (Supplemental Table 2). Supplemental Tables 3 and 4 contain direct quotes from transcripts referred to in the text below.

Barriers

Professionals as a Source of Stigma

Patients and health care professionals alike described situations wherein the primary care professional was a direct source of mental illness stigma.

Patient perspective. Patients described the tendency of some primary care professionals to overly medicalize mental health concerns, which caused patients to feel as though their experiences were either abnormal or more severe than they perceived. For example, patients described professionals jumping to conclusions and being told that they needed treatment without a process of shared decision making (Supplemental Table 3, quotes 1 and 2). Some patients also described the experience of having a primary care professional ignore or dismiss their concerns and preferences regarding mental health treatment. In some instances, patients

perceived their professionals as having a fixed opinion on a course of treatment that did not reflect the patients' personal preferences and values (quotes 3 and 4).

Other patients identified primary care professionals as a source of stigma because they feared that their professional's beliefs about them might change if they discussed mental health. For example, some patients worried about being viewed by their primary care professional in terms of negative group stereotypes and subsequently losing control over their own care because of this negative impression (quote 5).

Professional perspective. Health care professionals also named primary care professionals as a source of mental illness stigma. For example, they reported a tendency for some clinic staff to make insensitive comments or express bias toward patients with mental health concerns. This situation was exacerbated when professionals were covering for a colleague and did not have rapport with a new patient (Supplemental Table 3, quotes 6 and 7). Professionals also reported feeling undertrained to adequately provide care to patients with substance use concerns. They indicated that substance use and addiction remain highly stigmatized among clinicians in primary care settings (quotes 8 and 9). Professionals also discussed patients' fear of being stigmatized by clinicians who sought additional information that patients did not want to disclose (quote 10).

Stigma From Interpersonal Network

Patient perspective. Several patients commented on stigma stemming from members within their own communities or social networks. Some described experiences of teachers or other trusted individuals dismissing their mental health symptoms as unimportant (Supplemental Table 3, quote 11). Others described how employers or coworkers had stopped speaking to them after they disclosed that they were seeking or receiving mental health care services (quotes 12 and 13).

Professional perspective. Several health care professionals identified patients' families as a major source of stigma. They described how family members seemed to find it more difficult to support their relatives through mental health conditions compared with physical health conditions. A specific comparison was drawn to the transparency of disclosing physical ailments such as diabetes to family, in stark contrast to the stigmatization and stereotyping of individuals with anxiety (Supplemental Table 3, quote 14). One professional shared that family stigma appeared to affect men more than women, in part, because mental health symptoms may be perceived more by others as a sign of weakness (quote 15).

Self-Stigma

Health care professionals discussed patients' own self-stigma as a major barrier to patients discussing their mental health. Several perceived that patients find it difficult to acknowledge they need help with a mental health concern or believe that needing help is an indicator of personal weakness or failure (Supplemental Table 3, quotes 16 and 17). Professionals explained how some patients insist that they can manage their mental health on their own and do not need additional support (quotes 18 and 19). Others described patients' beliefs or insistence that their mental health symptoms were directly related to a physical condition, which in turn acted as a barrier to mental health treatment (quotes 20 and 21).

Facilitators and Recommendations

Many of the facilitators identified are elements of high-quality patient-centered practice generally and are not specific to stigma. Because they were identified as stigma reducing by participants, however, we include them to provide a more complete picture of tools that can be developed or strengthened to reduce the impact of stigma.

Patient-Centered Communication

Patient perspective. Patients described how a professional's communication skills, such as expressing empathy and building rapport, helped them feel more comfortable discussing mental health. Patients specifically noted how active listening empowered them to share more details without fear of judgment (Supplemental Table 4, quotes 1-3). They commented that the help they received was more effective when their professionals conversed with empathy and understanding. For example, one patient observed that emphasizing a patient's strengths before detailing areas of needed improvement was beneficial (quote 4). Another patient talked about how their professional helped them focus on their goals and deep values as a parent (quote 5). One patient described how the use of a shared document with annotations of salient points can be helpful in opening communication (quote 6).

Professional perspective. Several health care professionals described strategies for maintaining open dialog. One emphasized the importance of closing the medical record and connecting with the patient as opposed to splitting attention between them (Supplemental Table 4, quote 7). One noted techniques common to motivational interviewing to be helpful (quote 8). Two others emphasized speaking with empathy and understanding (quotes 9 and 10). Shared decision making was also named as a strategy. One professional described her philosophy on transparency in patient notes to engage patients in decisions about their care (quote 11).

Build Trust and Rapport

One health care professional noted that longevity of the patient-clinician relationship and rapport were crucial components of an open dialog about mental health (Supplemental Table 4, quote 12). This participant went on to say that their supportive, long-term relationships with patients made them less prone to seeing patients in terms of stereotypes (quote 13). Others described the importance of being genuine and finding elements of the patient's history that humanize them to facilitate a meaningful and trusting connection (quotes 14 and 15).

Message Framing

Health care professionals discussed the importance of flexibility in approaching mental health discussions with patients. One strategy that emerged was observing the patient's response to the discussion and being ready to shift into a different way of framing the issue if patients responded negatively (Supplemental Table 4, quote 16). One professional explained that when training future clinicians, it is important to teach them that different strategies might be more effective based on a patient's cultural background (quote 17).

Normalization

Patient perspective. Some patients explained that it felt easier to discuss their mental health within clinics that actively normalized and regularly discussed mental health concerns with patients (Supplemental Table 4, quotes 18 and 19). One said that the more clinicians bring mental health care up, the more normal it feels (quotes 20 and 21). A patient described clinician self-disclosure as a form of empathetic communication and felt more confident that their clinician understood firsthand the struggles and effects of medication (quote 22).

Professional perspective. Health care professionals shared that stigma seems to be decreasing, and that normalizing mood disorders and other common mental health conditions within the general public seems to reduce the impact of stigma. They indicated that this shift seemed particularly true among women and younger patients (Supplemental Table 4, quotes 23-26). Patients and health care professionals described how normalizing mental health conditions within the clinic also reduced the impact of stigma. Some professionals felt that the IBH model contributed to normalization of mental health concerns by helping patients view mental health care as an essential component of comprehensive medical care, rather than separate from routine care (quotes 27-29). Some professionals emphasized the important integration between mental and physical health by telling patients that their health care will be most effective if it includes mental health care (quotes 30-32).

Several participants felt that self-disclosure of health care professionals' own past struggles with mental health could help normalize mental health issues. Although not all professionals said that this was something they had done or would feel comfortable doing, several recommended self-disclosure to help patients with their ease of sharing their own concerns (quotes 33 and 34).

DISCUSSION

We conducted semistructured interviews with 16 patients and 15 health care professionals to explore the impact of stigma on mental health assessment and treatment within a primary care practice using the IBH model. The interviews focused on the overarching categories of barriers, facilitators, and recommendations; from these categories, we identified 10 themes and 4 subthemes that can help inform strategies for reducing stigma and its impact.

Key Findings and Implications

The overmedicalization of mental health symptoms by primary care professionals emerged as a major contributor to mental illness–related stigma and a barrier to IBH care. Overmedicalization caused some patients to feel as though their mental health symptoms were more serious than they had previously perceived them to be. Existing literature suggests that the medicalization of mental health concerns may reduce stigma for some patients by more accurately linking mental health symptoms to an underlying physiologic cause rather than a personal deficit.[25] There is evidence, however, that medicalization and the increased growth in pharmaceutical treatments for mental health disorders have not substantially reduced mental illness stigma.[26] Some research suggests that medicalization may increase some patients' fears that their symptoms could be difficult to alleviate.[27] Another, related theme was patients' fear of "losing control of treatment" if they discussed mental health concerns. Results of the National Survey on Drug Use and Health corroborate this finding, showing that more than 16% of US adults endorsed a fear of being committed to a psychiatric facility against their will or of being forced to take medication for a mental health condition.[28]

The variable impact of medicalization suggests that primary care professionals may benefit from using this strategy flexibly with patients, based on patients' needs and perspectives toward mental and behavioral health. For some patients, explaining mental health disorders as a biologic condition may help to reduce stigma; however, for others, medicalizing their mental or behavioral health symptoms may increase fear and reduce engagement. Additionally, clinicians may benefit from describing the occurrence of mental and behavioral health symptoms as normal and commonplace among the general patient population, considering that 1 out of every 5 US adults will have depression at some time in their life.[29] Presenting mental and behavioral health as an important component of whole-person health care may increase patients' comfort and engagement in discussion of, and potential referral to, IBH treatment. This framing may be particularly useful considering how patient participants often felt that meeting with a mental health professional within the primary care setting was less threatening than going to a mental health specialty clinic.

Patients also endorsed self-stigma as a major barrier to IBH care. This finding is consistent with existing evidence indicating that an individual's own stereotyped beliefs about mental health conditions negatively affect their help-seeking behaviors.[30] Health care professionals highlighted their own self-disclosure as a way to normalize mental health concerns and reduce self-stigma among patients. Such disclosure may help counter stereotypical beliefs about mental health conditions because much of the general public has positive views of health care professionals.[31] Although clinician self-disclosure is often not feasible, the principle of making efforts to counter patients' preconceptions of mental health conditions as a personal indicator of weakness or failure and help validate patients' feelings and build trust is important. When self-disclosure is not applicable

or appropriate, clinicians may seek alternative ways to help destigmatize mental health concerns among their patients.[31]

Strengths and Limitations

This study provides a first-person account of patient and health care professional opinions about how mental illness stigma operates in a primary care setting, as well as examples of strategies to reduce stigma by those most affected by it. Limitations to the study include the representativeness of the opinions expressed by patients and health care professionals of a single integrated practice using the IBH model to the general population. The data were analyzed rigorously, however, and our findings are supported by extant research literature on stigma.

Conclusions

Health care professionals' flexibility to dynamically reframe conversations with patients may help address the stigma surrounding mental illness. In some cases, their empathy and self-disclosure can help build trust to reduce patient-perceived stigma, although more research is needed to understand the implications of self-disclosure in primary care settings. Our findings may help inform primary care clinicians about ways to reduce stigma as a barrier to patients engaging with IBH and improve use of this important resource for mental health care. They might consider which strategies presented here seem feasible for them and test these strategies to see how patients respond.

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Key words: integrated behavioral health; mental health; mental health services delivery; stigma; primary care; health services accessibility; barriers; physician-patient relations; attitude of health personnel; patient acceptance of health care; patient-centered care; communication

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Supplemental materials

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