SHAPING PERSPECTIVES: THE IMPACT OF SOCIO-DEMOGRAPHIC FACTORS ON HEALTHCARE PROFESSIONALS' ATTITUDES TOWARDS MENTAL ILLNESS.

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ABSTRACT
Mental health stigma attitude remains a pervasive barrier to effective care, often shaped by the socio-demographic and professional characteristics of healthcare professionals (HPs). While self-stigma and public stigma are well-documented, structural stigma reflected in discriminatory policies and systemic barriers remains underexplored especially among healthcare professionals, with existing studies yielding mixed findings. This study examines the nuanced impact of gender, marital status, cultural and religious affiliation on HPs' attitudes toward individuals with mental illness, with a particular focus on dimensions of Authoritativeness, Benevolence, Social Restrictiveness, and Community Mental Health Ideology (CMHI).
Employing a cross-sectional design, we surveyed 289 sample of HPs using validated Community Attitude toward Mental Illness (CAMI) scale to assess their attitudes and biases. Findings from multiple analysis of variance revealed significant variations in attitudes based on gender, with male HPs demonstrating higher authoritarian tendencies and restrictive views. Religious and cultural influences also emerged as pivotal factors, shaping both benevolent and stigmatizing attitudes.
Based on these insights, we propose evidence-based training programs aimed at fostering more inclusive, empathetic, and community-integrative attitudes among HPs. Specifically, gender-responsive interventions should encourage male HPs to adopt more autonomy-supportive practices, while culturally and religiously sensitive training should challenge stigmatizing beliefs rooted in traditional norms. Furthermore, promoting intergroup dialogue and strengthening community-based mental health strategies can enhance CMHI-related attitudes, ultimately improving patient outcomes.

Keywords: *Attitude toward Mental Illness, Authoritativeness, Benevolence, Social Restrictiveness, and Community Mental Health Ideology*

INTRODUCTION
Mental illness remains a significant public health concern worldwide, affecting approximately 1 in 8 people globally (World Health Organization [WHO], 2022). Despite advancements in mental health awareness, research, advocacy and treatment, Freeman (2022) acknowledged that mental health around the world remains poor, service insufficient and for some abusive. In the words of Freeman (2022), this becomes focus of the WHO (2022) to create compelling and new understanding as to why change is urgently needed. Consequently, one of the major areas to consider for change is the area of stigma and negative attitudes towards mental illness. Corrigan et al. (2014) conceptualized stigma as a complex social process of labeling, devaluation and discrimination of person in a series of combination that may involve cognitive, emotional and behavioural aspect. Since stigmatization can occur on multiple levels simultaneously that may involve; self (self-stigma), public (interpersonal) and systemic (structural), studies have empirically concluded that only powerful social groups can stigmatize (Link, 2001; Corrigan et al. 2014, Livingston, 2013).

The healthcare system, in particular, is often overlooked in discussions of structural stigma and negative attitude towards mental illness, possibly due to the assumption that healthcare providers are adequately trained to approach mental illness without bias. Additionally, they are generally perceived by the public as the primary custodians of mental health solutions, leading to an implicit expectation that stigma or negative attitudes should not originate from such professionals (Knaak et al., 2017). However, evidence suggests that healthcare providers are not immune to stigma, and their attitudes can significantly influence the quality of care patients with mental illness receive (Henderson et al., 2020). In many African contexts, where mental health services are often

considered a last resort after traditional or religious interventions have failed, healthcare providers play a crucial role in determining access to appropriate treatment (Gureje et al., 2005). Moreover, general hospital practitioners frequently serve as the first point of contact for individuals experiencing mental health issues, largely due to the interconnected nature of physical and mental health (Patel et al., 2018). This positioning allows them to identify early signs of mental health conditions during consultations for physical illnesses, making their perspectives and attitudes toward mental illness particularly critical in shaping patient outcomes.

While self-stigma and public stigma have been extensively studied, structural stigma—manifested in discriminatory or exclusionary policies, laws, and systemic barriers—has received comparatively less attention (Hatzenbuehler & Link, 2014; Hansson et a. 2013) and the findings of available published studies have reported mixed findings which may be attributed to their geographical differences. For instance, in the United States, a comparative study between mental health professionals and the general public found that mental health professionals exhibited more positive attitudes (Stuber et al. 2014). This aligns with the expectation that specialized training and direct clinical experience foster more informed and compassionate perspectives. Similarly, a study conducted among nurses in Finland reported generally favorable attitudes toward individuals with mental illness (Ihalainen-Tamlander et al., 2016). However, these findings are not universal. In Palestine, research on mental health professionals revealed a more complex picture, indicating a mix of both positive and negative attitudes toward people with mental illness (Ahmead, Rahhal & Baker, 2010). This suggests that cultural and systemic factors may influence professionals' views, despite their medical training. A survey of medical students in Qatar revealed troubling misconceptions, with many students believing that mental illness is a form of divine punishment that individuals with mental illness should not marry, and that having a family member with mental illness would bring shame (Zolezzi et al., 2017).

Further studies from Kuwait have reinforced the persistence of stigmatizing attitudes among healthcare professionals (Al-Awadhi et al., 2017). These attitudes, particularly when held by those expected to provide care, can have serious consequences, including delayed help-seeking, inadequate treatment, and worsening health outcomes for individuals experiencing mental illness. Recent research from Saudi Arabia and Jordan underscores this issue, revealing high levels of stigma among tertiary hospital physicians and general healthcare providers (Saad et al., 2019; Dalky et al., 2020). Thus, stigmatizing attitudes have far reaching outcomes in persons with mental illness and the studies with HPs are scanty and not conclusive especially in African countries.

The variations in findings across regions and professional groups highlight the multifaceted nature of stigma in healthcare settings. While some professionals demonstrate awareness and empathy, others may unconsciously perpetuate discriminatory attitudes, influenced by cultural norms, religious beliefs, and systemic biases. Given the crucial role of healthcare providers in mental health advocacy, treatment, and policy implementation, addressing these attitudes is essential for fostering a more inclusive and supportive healthcare environment for individuals with mental illness.

Healthcare professionals (HCPs), as primary and formal caregivers, play a crucial role in shaping patients' experiences and treatment outcomes. However, their attitudes towards mental illness are not uniform and are often shaped by a range of socio-demographic factors, including age, gender, education, cultural and religious background, and professional experience (Ahad, Sanchez-Gonzalez, & Junquera, 2023). Research suggests that healthcare professionals' beliefs about mental illness can significantly influence their willingness to provide compassionate care, recommend evidence-based treatments, and advocate for mental health policies (Knaak et al., 2017). For instance, some studies have acknowledged anticipated stigma from healthcare providers as a significant factor in people’s reluctance to seek help for mental illness (Corrigan et al., 2014; Hamilton et al., 2016). In confirmation that healthcare providers stigmatizes their patient,

Abbey et al., (2012) reported that almost 80 percent of psychiatrist reported first-hand expression of discrimination towards a patient while other medical providers observed reported over 50 percent discrimination against a patient from psychiatry. Furthermore, cultural and religious beliefs can shape perceptions of mental illness, often determining whether it is viewed as a medical condition or a moral failing (Angermeyer & Dietrich, 2006). These biases may lead to disparities in diagnosis, treatment, and patient engagement, ultimately affecting mental health outcomes.

The complex interplay between socio-demographic factors and healthcare professionals' attitudes towards mental illness plays a crucial role in shaping the quality and accessibility of mental health care. Understanding these attitudes is paramount, given the increasing recognition of mental health issues as integral components of overall health. Factors such as age, gender, socioeconomic status, and educational background significantly influence how professionals perceive and interact with individuals suffering from mental health disorders. For instance, differing levels of training and exposure to mental health contexts can engender varying degrees of authoritativeness, benevolence, and social restrictiveness among healthcare providers. Moreover, these attitudes not only affect the therapeutic alliance but also impact community mental health integration, shaping societal perceptions of mental illness.

Given that this study focuses on structural stigma and negative attitudes within the healthcare system, the Community Attitudes toward Mental Illness (CAMI) Scale was deemed the most appropriate instrument for assessment. The CAMI scale, originally developed to measure community perceptions of mental illness, provides a comprehensive framework for understanding attitudes and stigma within broader societal structures, including healthcare settings (Taylor & Dear, 1981). According to Taylor & Dear (1981), CAMI measures community attitudes and stigma to mental illness through four dimensions, including: authoritativeness (defined as a standpoint which views mentally ill persons as inferior and requiring coercive action against); benevolence (defined as a standpoint characterized by a sympathetic view of people with mental illnesses); social restrictiveness (defined as a perspective which believes that persons with mental illnesses should be avoided because they present a form of threat to the community); and Community Mental Health Integration (CMHI, defined as the viewpoint which is accepting of people with mental illnesses, and mental health services in the community). In other words, authoritativeness pertains to the perception of mental illness as a serious condition necessitating strict management, which may inadvertently foster an authoritarian approach in patient care. Conversely, benevolence reflects a more compassionate stance, promoting supportive interactions that encourage recovery and integration within society. However, social restrictiveness often surfaces as a consequence of stigma, leading to isolation and diminished opportunities for social engagement. Lastly, the dimension of community mental health integration emphasizes the importance of incorporating mental health services within community settings, which can significantly alter healthcare professionals' attitudes by fostering an environment of acceptance and normalization. By examining these dimensions, it becomes evident that socio-demographic factors play a crucial role in shaping attitudes toward mental illness among professionals in the healthcare sector.

Understanding the socio-demographic determinants of healthcare professionals' attitudes toward mental illness is essential for developing targeted interventions aimed at reducing stigma and improving mental health service delivery (Ghuloum et al., 2022). By examining how factors such as gender, age, religion, ethnicity, years of experience, and cultural orientation shape the dimensions of the community attitude towards mental illness, this study seeks to contribute to the growing body of literature that advocates for evidence-based anti-stigma and negative attitude initiatives within healthcare settings. Addressing these disparities can lead to a more inclusive and effective mental healthcare system, ensuring that individuals with mental illness receive the support and treatment they deserve. Thus, this study aims to provide answer to the research

question that enquire whether socio-demographic variables significantly influence HPs' attitudes towards people with mental health issues.

METHODS

Research Design

This study adopted a quantitative cross-sectional survey design, which allowed for the collection of data from healthcare professionals at a single point in time. This design is particularly useful for examining relationships between socio-demographic factors and attitudes toward mental illness without inferring causality (Spector, 2019). By capturing data across different age groups and professional backgrounds simultaneously, the study provided a broad and comparative understanding of attitudinal differences within the healthcare sector.

Sampling Method

A purposive sampling method was employed to ensure that the study targeted healthcare professionals with relevant exposure to mental health issues. Specifically, participants were recruited from attendees of the World Mental Health Day Conference (2022), organized by the Department of Clinical Psychology at the Federal Medical Centre, Abeokuta. Purposive sampling was chosen because it allows researchers to focus on individuals with direct experience and insights into mental health service delivery. This approach ensured that the collected data reflected perspectives from professionals actively engaged in mental health discussions.

Data Collection Procedure

Data was collected through an electronic survey hosted on Google Forms. The survey link was distributed to conference attendees, and participation was voluntary. Informed consent was obtained digitally—participants indicated their consent by submitting their responses along with their email addresses, ensuring ethical compliance and participant accountability.

Participants

The study sample consisted of 289 healthcare professionals who attended the World Mental Health Day Conference (2022) organized by the Department of Clinical Psychology at the Federal Medical Centre, Abeokuta. For the purpose of this research, healthcare professionals (HPs) are defined as individuals who apply scientific knowledge in the care and treatment of persons with illnesses. The participants represented a diverse group, including nurses, doctors, social workers, clinical psychologists, and medical students.

Demographic distribution of the participants

i. Gender and Age Distribution

The sample included 142 males (49%) and 147 females (51%), with ages ranging from 18 to 72 years. The mean age was 37.58 years (SD = 11.70), reflecting a broad representation of professionals across different career stages.

ii. Ethnicity and Religion

The majority of the participants were of Yoruba ethnicity (n = 182, 63%), followed by other ethnic groups (n = 55, 19%), Igbo ethnicity (n = 42, 15%), and Hausa ethnicity (n = 10, 3%). Religious affiliation varied among participants, with the majority identifying as Christians (n = 230, 79%), followed by Muslims (n = 52, 18%). A small proportion identified with other religions (n = 5, 2%), and traditional religious practices (n = 2, 1%).

iii. Educational Qualification

A large proportion of the participants held postgraduate degrees (n = 156, 54%), while first-degree holders, diploma, and certificate holders constituted 42% (n = 122). A small fraction were undergraduate students (n = 11, 4%).

iv. Marital Status

More than half of the participants were married (n = 163, 57%), while 114 participants (40%) were single. A smaller proportion were separated or divorced (n = 8, 3%), and 4 participants (1%) were widowed.

v. Employment Status

Regarding employment type, 95 participants (33%) were government-employed, while 79 participants (27%) worked in private institutions or companies. Self-employed (private practices) individuals accounted for 74 participants (26%), and 41 participants (14%) were either unemployed or clinical/medical students.

Instruments

The instruments utilised in this research included self-constructed items for obtaining demographic information among participants, alongside the Community Attitudes of Mental Illness (CAMI) scale. Prior to this instrument, demographic information was obtained from participants concerning: Sex; Age; Ethnicity; Religion; Highest educational qualification; marital status; Nature of occupation and employment status.

Community Attitudes toward Mental Illness (CAMI) Scale

The Community Attitudes toward the Mental Illness (CAMI) scale, developed by Taylor and Dear (1981), is a widely used instrument for assessing attitudes and stigma toward mental health issues. Several versions of the CAMI scale exist, including the CAMI-40 (40 items), CAMI-10 (10 items), and CAMI-BR. For this study, the CAMI-40 was selected due to its ability to comprehensively capture various aspects of attitudes and stigma toward mental illness and its higher reliability compared to other versions. The scale utilizes a five-point Likert response format, ranging from strongly agree (5) to strongly disagree (1). Negatively worded items were reverse-scored, where strongly agree received a score of 1, and strongly disagree received a score of 5. Previous studies have reported the internal consistency of the CAMI-40 to range from 0.59 to 0.80 across its subscales (Sanabria-Mazo et al., 2023). In the present study, the internal consistency of the CAMI-40 was within the range of 0.55 to 0.78 for its subscales, indicating an acceptable level of reliability.

Statistical analysis

The data analysis for this study involved both descriptive and inferential statistical methods. Descriptive statistics such as frequencies, percentages, mean, and standard deviation were used to summarize and provide a clear overview of the dataset. For inferential analysis, Multivariate Analysis of Variance (MANOVA) was employed. This statistical technique was chosen because the dependent variable (attitudes toward mental illness) is a multidimensional construct measured on an interval scale, while the independent variables consist of categorical responses measured on a nominal scale. MANOVA allows for the examination of multiple dependent variables simultaneously, making it an appropriate choice for detecting differences across groups while controlling for Type I error (Tabachnick & Fidell, 2019). Additionally, post hoc tests and independent samples t-tests were conducted where necessary to further explore significant differences between participant categories, providing more insight into the extent and direction of observed effects. These tests ensured a rigorous examination of group differences, enhancing the study's analytical robustness.

RESULTS

The results of this study are presented in the following tables, on the basis of the research question.

Do socio-demographic variables significantly influence HPs' attitudes towards people with mental health issues?

This question was answered using MANOVA as a statistical tool of analysis. Socio-demographic variables included Sex, Ethnicity, Religion, Highest Educational Qualification, Marital Status, and Nature of occupation. The influence of these variables was analysed for each dimension of attitudes towards people with mental health issues. The results are shown in Table 1, with significant factors in bold:

Table 1: MANOVA Table Showing Influence of HPs' Socio-demographic Factors on Attitudes towards People with Mental Health Issues.

Attitudes towards Mental Illness	Socio-demographic Variables	Sum of Squares	Mean Square	F	df	Sig
Authoritativeness	**Sex**	**75.29**	**75.29**	**4.84**	**1**	**.029**
	Ethnicity	59.41	19.80	1.27	3	.284
	Religion	**163.08**	**54.36**	**3.50**	**3**	**.016**
	Highest Educational Qualification	26.25	13.13	0.84	2	.431
	Marital Status	1.82	0.61	0.04	3	.990
	Nature of Occupation	10.47	3.49	0.22	3	.879
Benevolence	Sex	48.10	48.10	2.76	1	.098
	Ethnicity	9.36	3.12	0.18	3	.911
	Religion	**155.26**	**51.75**	**2.96**	**3**	**.033**
	Highest Educational Qualification	14.57	7.29	0.42	2	.659
	Marital Status	5.48	1.83	0.11	3	.957
	Nature of Occupation	29.75	9.92	0.57	3	.637
Social Restrictiveness	Sex	0.51	0.51	0.03	1	.866
	Ethnicity	88.97	29.66	1.66	3	.177
	Religion	134.76	44.92	2.51	3	.060
	Highest Educational Qualification	4.02	2.01	0.11	2	.894
	Marital Status	54.36	18.12	1.01	3	.388
	Nature of Occupation	13.38	4.46	0.25	3	.862
CMHI	Sex	4.56	4.56	0.22	1	.636
	Ethnicity	95.14	31.71	1.56	3	.200
	Religion	**160.58**	**53.53**	**2.63**	**3**	**.050**
	Highest Educational Qualification	51.07	25.53	1.26	2	.287
	Marital Status	**189.64**	**63.21**	**3.11**	**3**	**.027**
	Nature of Occupation	43.83	14.61	0.72	3	.542

*Significant factors are in **bold*** *CMHI = Community Mental Health Integration.*

The results in Table 1 display that socio-demographic factors of sex ($F_{(1, 287)}$ =4.84; p<.05) and religion ($F_{(3, 285)}$ =3.50; p<.05) had significant influence on authoritativeness attitude. Religion alone had a significant influence on benevolent attitude ($F_{(3, 285)}$ =2.96; p<.05). Furthermore, social restrictiveness attitude was not influenced by any of the socio-demographic variables. Community mental health integration was however influenced by both Religion ($F_{(3, 285)}$ =2.63; p<.05) and Marital Status ($F_{(3, 285)}$ =3.11; p<.05).

Tukey's HSD and independent samples t-test were also carried out in order to further investigate how socio-demographic variables influenced the aspects of attitudes towards people with mental health issues. These are presented one by one, in relation to each domain of attitudes towards people with mental health issues.

Authoritativeness (defined as a standpoint which views mentally ill persons as inferior and requiring coercive action against)

Sex and Authoritativeness Attitude

As shown in Table 2, there was a significant difference between male and female HPs on Authoritativeness attitude ($t_{(285)}$ =2.43; p<.05). Male HPs scored significantly higher on authoritativeness (Mean=26.89; SD=4.71) than female HPs (Mean=25.54; SD=4.72):

Table 2: T-test Summary Table Showing Differences in Authoritativeness between Male and Female HPs

Sex	N	Mean	SD	df	t	P
Male	141	26.89	4.71			
				285	2.43	< .05
Female	146	25.54	4.72			

Religion and Authoritativeness

Christian HPs scored significantly higher on authoritativeness (Mean=26.40; SD=4.83) than HPs of "Others" specified religions (Mean=19.80; SD=1.64). Muslim HPs also scored significantly higher on authoritativeness (Mean=25.96; SD=4.23) than HPs of "Others" specified religions (Mean=19.80; SD=1.64). This is demonstrated in Table 3 below:

Table 3: Tukey's HSD Multiple Comparison Table Showing Differences in Authoritativeness between HPs' Religious Groups

DV	Religion	Mean Difference (I – J)				Mean	SD
		Christianity (J1)	Islam (J2)	Traditional (J3)	Others (J4)		
Authoritativeness	1. Christianity (J1)	0.00	0.44	0.40	6.60**	26.40	4.83
	2. Islam (J2)		0.00	0.04	6.16**	25.96	4.23
	3. Traditional (J3)			0.00	6.20	26.00	2.83
	4. Others (J4)				0.00	19.80	1.64

** = p<.01

Benevolence (defined as a standpoint characterized by a sympathetic view of people with mental illnesses)

Religion and Benevolent Attitude

Religion significantly influenced benevolent attitudes to people with mental illness, with Christian HPs having a significantly lower benevolence (Mean=39.13; SD=4.49) than HPs of "Others" specified religions (Mean=45.40; SD=1.82). Similarly, Muslim HPs reported significantly lower Benevolence for people with mental illness (Mean=39.85; SD=4.92) than HPs belonging to "Others" specified religious groups (Mean=45.40; SD=1.82). This is demonstrated in Table 4:

Table 4: Tukey's HSD Multiple Comparison Table Showing Differences in Benevolence between HPs' Religious Groups

DV	Religion	Mean Difference (I – J)				Mean	SD
		Christianity (J1)	Islam (J2)	Traditional (J3)	Others (J4)		
Benevolence	1. Christianity (J1)	0.00	0.68	0.13	6.27**	39.13	4.49
	2. Islam (J2)		0.00	0.02	5.60*	39.85	4.92
	3. Traditional (J3)			0.00	6.40	39.00	0.00
	4. Others (J4)				0.00	45.40	1.82

* = p<.05; *** = p<.001

Community Mental Health Integration (CMHI): defined as the viewpoint which is accepting of people with mental illnesses, and mental health services in the community).

Religion and CMHI Attitude

According to Table 5, HPs who belong to "Others" specified religions scored significantly higher on CMHI attitude (Mean=43.00; SD=3.32) than Christian HPs (Mean=37.00; SD=5.53) and Muslim HPs (Mean=37.37; SD=5.52).

Table 5: Tukey's HSD Multiple Comparison Table Showing Differences in CMHI between HPs' Religious Groups

DV	Religion	Mean Difference (I – J)				Mean	SD
		Christianity (J1)	Islam (J2)	Traditional (J3)	Others (J4)		
CMHI	1. Christianity (J1)	0.00	0.42	1.50	6.00*	37.00	5.53
	2. Islam (J2)		0.00	1.91	5.59*	37.37	5.52
	3. Traditional (J3)			0.00	7.50	35.50	3.54
	4. Others (J4)				0.00	43.00	3.32

CMHI = Community Mental Health Integration * = p<.05

Marital Status and CMHI Attitude

Legally married HPs scored significantly higher on CMHI attitude (Mean=38.31; SD=5.53) than single HPs (Mean=35.65; SD=5.08). Table 6 shows the differences in HPs' CMHI across their marital status categories.

Table 6: Tukey's HSD Multiple Comparison Table Showing Differences in CMHI according to HPs' Marital Status

DV	Marital Status	Mean Difference (I – J)				Mean	SD
		Legally Married (J1)	Separated/Divorced (J2)	Single (J3)	Widowed (J4)		
CMHI	1. Legally Married (J1)	0.00	2.19	2.66***	3.06	38.31	5.53
	2. Separated/Divorced (J2)		0.00	0.47	0.88	36.13	7.32
	3. Single (J3)			0.00	0.40	35.65	5.08
	4. Widowed (J4)				0.00	32.25	4.19

CMHI = Community Mental Health Integration *** = p<.001

DISCUSSION

Authoritativeness reflects a controlling and coercive stance toward individuals with mental health issues. The study found that sex and religion significantly influenced this dimension of attitude. As for sex differences, male HPs scored higher on authoritativeness than females, suggesting that male professionals may be more inclined toward hierarchical or paternalistic approaches to mental illness. This aligns with some previous studies indicating that males are often more likely

to endorse stigmatizing views due to traditional gender roles emphasizing control and authority in caregiving (e.g., Ghuloum et al., 2022). Conversely, female HPs may adopt more empathetic and patient-centered approaches due to societal expectations of caregiving and nurturing behaviors.

In addition, HPs identifying as Christian or Muslim scored significantly higher on Authoritativeness than those from "Other" specified religions. This finding may stem from religious doctrines or cultural interpretations within these faith groups that emphasize control or "discipline" as a means of addressing mental illness. These results suggest the need for culturally sensitive mental health training that considers how religious beliefs may influence professional attitudes. This finding is in tandem with the findings of Zolezzi et al. (2017) whose survey of medical students in Qatar revealed troubling misconceptions, with many students believing that mental illness is a form of divine punishment that individuals with mental illness should not marry, and that having a family member with mental illness would bring shame.

Benevolence reflects a sympathetic and supportive perspective toward individuals with mental illness. In this study, religion emerged as a significant factor, with HPs from "Other" specified religions exhibiting the highest levels of Benevolence compared to Christians and Muslims. This finding suggests that religious minorities or non-mainstream religious groups may foster attitudes that are more accepting of mental illness, possibly due to less stigmatization in their teachings or smaller community sizes promoting empathy. In contrast to this finding, Hlongwane (2023) found a positive attitude towards mental illness was reinforced by mental illness knowledge in a Pentecostal Christian community in South Africa. On the other hand, HPs from dominant religious groups may be influenced by societal stigma or traditional beliefs that perceive mental illness as a moral failing or spiritual issue (Zolezzi et al. 2017). The lower benevolence among Christian and Muslim HPs underscores the need to address stigma rooted in religious and cultural narratives within these groups.

Social Restrictiveness, which measures the extent to which individuals advocate for isolating or limiting the rights of people with mental illness, was not significantly influenced by any socio-demographic variable. This suggests a uniformity in restrictive attitudes across different groups of HPs, indicating that restrictive beliefs may be more deeply ingrained in societal or professional norms rather than shaped by individual socio-demographic factors.

Community Mental Health Integration (CMHI) reflects acceptance of mental health services and the integration of individuals with mental illness into the community. Both religion and marital status significantly influenced CMHI attitudes. Notably, HPs from "Other" (Traditional) specified religions were more accepting of community integration compared to Christian and Muslim HPs. This could be attributed to differences in cultural and religious teachings about inclusivity and the moral obligations toward individuals with disabilities or illnesses. Likewise, legally married HPs exhibited significantly higher CMHI attitudes than single or widowed HPs. Marriage may enhance individuals' exposure to diverse perspectives through spousal interactions or provide a support network that fosters empathy. Single and widowed HPs may have fewer opportunities for such enriching interpersonal experiences, potentially contributing to lower community integration attitudes.

Conclusion

The findings of this study call for a critical examination of the organizational and institutional cultures within healthcare settings that may inadvertently reinforce restrictive attitudes toward individuals with mental illness. These deeply ingrained perspectives, often shaped by workplace norms, professional hierarchies, and societal influences, highlight the pressing need for systemic

interventions that foster more progressive, patient-centered mindsets among healthcare professionals (HPs).

Addressing these challenges requires a multi-pronged approach, particularly in the domains of social restrictiveness, Authoritativeness, and community mental health integration (CMHI). Targeted interventions must go beyond individual awareness and actively reshape the professional and cultural frameworks that influence HPs' attitudes. On this basis, we propose the following training initiatives:

1. Given the observed gender differences in attitudes, training should be designed to encourage male HPs to adopt more empathetic, autonomy-supportive approaches in patient care. Workshops emphasizing compassionate communication, shared decision-making, and the humanization of mental health conditions can help mitigate authoritarian tendencies.
2. Recognizing that stigma is often deeply embedded in cultural and religious beliefs, training modules should incorporate strategies to challenge misconceptions while respecting diverse value systems. By fostering critical reflection and providing alternative, evidence-based perspectives on mental health, HPs can develop more inclusive and benevolent attitudes toward individuals with mental illness.
3. To enhance CMHI-related attitudes, healthcare training should prioritize intergroup dialogue, collaboration with community stakeholders, and exposure to successful community-based mental health models. Emphasizing the tangible benefits of integrated mental healthcare—such as improved patient outcomes, reduced hospitalization rates, and enhanced social reintegration—can shift perspectives and encourage more holistic, community-driven support systems.

By implementing these evidence-informed strategies, healthcare institutions can actively dismantle stigma, reduce social restrictiveness, and cultivate a workforce that is not only clinically competent but also socially attuned and culturally responsive. A shift toward a more inclusive, person-centered mental healthcare paradigm will not only enhance professional practice but also contribute to the broader goal of equitable and compassionate mental health services for all.

Limitations and Future Research Directions

While this study provides valuable insights, it is limited by the scope of socio-demographic variables analyzed. Future research could explore additional factors such as professional experience, exposure to mental health training, or geographic differences. Longitudinal studies are also needed to assess the stability of these attitudes over time and the effectiveness of interventions aimed at reducing stigma.

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