

“PLEASE ADMIRE ME!” WHEN HEALTHCARE PROVIDERS' POSITIVE STEREOTYPES OF ASYLUM SEEKER PATIENTS CONTRIBUTE TO BETTER CONTINUITY OF CARE

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SUMMARY

Background: Among asylum seekers (AS), mental health conditions are highly prevalent. However this population group has poor access to adequate services and frequently incurs discontinuity of mental healthcare. Many factors explain discontinuity of mental healthcare for asylum seekers. The aim of this study is to evaluate if facilitation of care for AS decreases healthcare provider stereotypes of this population and improves their continuity of care.

Subjects and methods: General practitioners (GPs) and mental health professionals (MHPs) were invited to participate in a vignette study, presenting an AS patient manifesting post-traumatic stress symptoms. We randomly manipulated the context of the clinical vignette to create two experimental conditions: facilitated care versus non-facilitated care. In each condition, we measured participants' stereotypes and continuity of care.

Results: There was a significant effect of participant's type of stereotypes on continuity of care ($F=2.87$, $p=0.035$). However, we found no effect of condition (facilitated vs. non facilitated care) on stereotypes ($F=0.11$, $p=0.95$), nor on continuity of care ($F=0.35$, $p=0.55$). Furthermore, there was a significant effect of profession (GPs vs MHPs) on continuity of care ($F=11.43$, $p=0.001$). Participants' number of consultations per week ($F=10.33$, $p=0.002$) and their gender ($F=3.69$, $p=0.030$) both have a significant effect on continuity of care.

Conclusion: Among healthcare providers, we found that “admiration” stereotypes were associated more with continuity of care. Paradoxically, continuity of mental healthcare was better among GPs compared to MHPs. Thus, improvement of continuity of mental healthcare for AS among MHPs should be investigated in further studies.

Key words: general practitioners - mental health professionals - asylum seekers - care facilitation - stereotype content - continuity of mental healthcare

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INTRODUCTION

Since the last few years, Europe has been hosting several thousands of people who have left their country because of human rights violation or military conflicts. Most of these migrants were exposed to stressful experiences during migration, and past traumas are likely to be exacerbated by post-migration environment (prolonged detention, insecure status, loss of community and family ties). This situation makes migrants vulnerable to mental health conditions (Turrini et al. 2017). According to the United Nations High Commissioner for Refugees (UNHCR) and the World Health Organization (WHO) most asylum seekers (AS) and refugees with mental health issues will never receive appropriate services (Silove et al. 2017). Thus, one of the main challenges for such vulnerable group is to provide them accessible, tailored and continuous mental healthcare.

Continuity of care (COC) is considered both by patients and professionals as an essential feature of high quality of care (Biringer et al. 2017). In an influential review, Bachrach defined COC as a: “process involving the orderly, uninterrupted movement of patients among the diverse elements of the service delivery system” (Bachrach 1981).

Several barriers prevent asylum seekers from COC within mental health services. These barriers stem from

different levels: the political (e.g. host policies), the organizational (e.g. fragmentation of services), the patient (e.g. linguistic proficiency, help-seeking behaviours), and also from the healthcare provider (e.g. stereotype, avoidance) (O'Donnell et al. 2016).

We know that stereotypes exist among mental health providers, and that they are likely to impair quality of care, contributing to healthcare disparities (Chapman et al. 2013, Lepière et al. 2014). Stereotypes are considered as a psychological mechanism that economizes on time and effort spent on information processing by simplifying social reality (Fiske et al. 1991). Therefore, stereotypes are more likely to be elicited under certain contextual variables, for instance: when providers are in a situation of overload, uncertainty, unfamiliarity, social and cultural distance with “outgroup” patients (Balsa et al. 2003, Burgess 2010). Providing care to asylum seekers could well be perceived as a highly demanding task, leading providers to stereotypes, particularly when they are not sufficiently supported to treat this population group.

The stereotype content model (SCM) hypothesizes that stereotypes possess two dimensions: “warmth” and “competence” that predict distinct intergroup behaviors (Fiske et al. 2002).

Social groups are perceived as “warm” if they do not compete with the ingroup for the same resources, and

they are considered "competent" if they are high in status. Combinations of perceived warmth and competence result in four types of stereotype: "contemptuous" (low warmth, low competence); "paternalistic" (high warmth, low competence); "ambivalent" (low warmth, high competence), and "admiration" (high warmth, high competence) (Cuddy et al. 2008).

The aim of this paper is to evaluate if facilitation of care for asylum seekers decreases healthcare provider stereotype manifestation, and if the four types of stereotypes impact differently continuity of care.

SUBJECTS AND METHODS

General practitioners (GPs) and mental health professionals (MHPs) were invited by email to participate in a study about their practices when treating migrant patients. GPs were included in the study, as they are often dealing with asylum seekers' mental health issues.

Qualtrics® software was used to design a web survey in which participants were randomly assigned to one of two experimental conditions. All participants dealt with the same clinical vignette of a 20 year-old Iraqi asylum seeker, presenting post-traumatic stress disorder symptoms. However, in one of the two conditions, the vignette contained information on the participant's eligibility to receive support from the asylum facility centre to treat the patient, such as help for: administrative task, payment, transport, interpreter (facilitated care vignette). In the other condition, the vignette did not contained information about additional support to treat the patient (non-facilitated care vignette).

Participants self-reported socio-demographic data, clinical activities, and other relevant variables (Table 1). For each participant, we assessed the two dimensions of the stereotype: warmth (6 items) and competence (6 items). We measured continuity of care based on Bachrach's multidimensional model, circumscribing to 4 relevant dimensions: globality (collaboration with services, comprehensiveness, coordination of care, 3 items), longitudinality (long term follow-up, 3 items), flexibility (adjustment to patient's needs, 3 items) and, communication (information exchange with other health professionals, 2 items). Our dependant variable, continuity of care, consists of the sum of these 4 dimensions. Statistical analyses were performed with IBM SPSS 25®.

Our study has been approved by the Ethics Committee of Saint-Luc Brussel University Hospital (UCL), and conforms to the provisions of the Declaration of Helsinki in 1995 (as revised in Edinburgh in 2000).

RESULTS

Population characteristics are described below in table 1.

Our general model and covariables are presented in table 2. There was a significant effect of participant's type of stereotype on continuity of care ($F=2.87$,

$p=0.035$) as shown in figure 1. However, we found no effect of condition (facilitated vs. non facilitated care) on stereotypes ($F=0.11$, $p=0.95$) nor on continuity of care ($F=0.35$, $p=0.55$). Furthermore, there was a significant effect of profession (GPs vs MHPs) on continuity of care ($F=11.43$, $p=0.001$). Participants' number of consultations per week ($F=10.33$, $p=0.002$) and gender ($F=3.69$, $p=0.030$) have both a significant effect on continuity of care.

Table 1. Population characteristics

Participants characteristics (N=88)	N	%	Mean	SD
Condition (asylum seeker patient vignette)				
facilitated care	42	47.7		
non-facilitated care	46	52.3		
Profession				
general practitioners (GPs)	52	59.1		
mental health professionals (MHPs)	36	40.9		
psychologists	22	25.0		
psychiatrists	14	15.9		
Gender				
men	27	30.7		
women	61	69.3		
Age	88		35.5	11.1
Consultations per week	88		57.7	36.0
Practice type				
solo	10	11.4		
group-medical center	52	59.1		
hospital	26	29.5		
Status				
employee	65	73.9		
independent	23	26.1		
Activity localization				
rural	13	14.8		
semi-urban	20	22.7		
urban	55	62.5		
Ethnicity (non-caucasian)	4	4.5		
Proportion of migrants among patients	88		17.5	25.7
Working time (<50%)	88	6.8		

DISCUSSION

The aim of this research was to evaluate if facilitation of care for asylum seekers (AS) could decrease providers' manifestation of stereotypes and if providers' stereotypes were influencing continuity of healthcare. We found that "admiration" stereotypes (perception of AS as both high in warmth and competence) were associated with more continuity of care. The three others types of stereotypes (i.e. "contemptuous", "paternalistic", and "ambivalent") were associated with less continuity of care. However, in opposition to our

Table 2. General model and covariables

Continuity of care	Sum of mean square	df	Mean square	F	p	Partial η^2
Corrected model	27.942*	17	1.6	3.47	0.000	0.476
Constant	109.4	1	109.4	231.22	0.000	0.781
Condition (facilitated vs non facilitated care)	0.2	1	0.20	0.35	0.558	0.005
Type of stereotype	4.1	3	1.4	2.87	0.035	0.117
Profession	5.4	1	5.4	11.43	0.001	0.150
Gender	1.7	1	1.7	3.69	0.030	0.054
Consultations per week	4.9	1	4.9	10.33	0.002	0.137
Age	0.0	1	0.0	0.03	0.852	0.001
Practice type	1.2	2	0.6	1.22	0.302	0.036
Status	0.7	1	0.7	1.56	0.216	0.023
Activity localization	0.9	2	0.5	0.99	0.378	0.029
Proportion of migrants among patients	1.1	1	1.1	2.27	0.136	0.034
Interaction: Condition x Type of stereotype	0.2	3	0.1	0.11	0.953	0.005
Error	30.8	65	0.5			
Total	2626.6	83				
Total corrected	58.7	82				

*Adjusted $R^2=0.340$

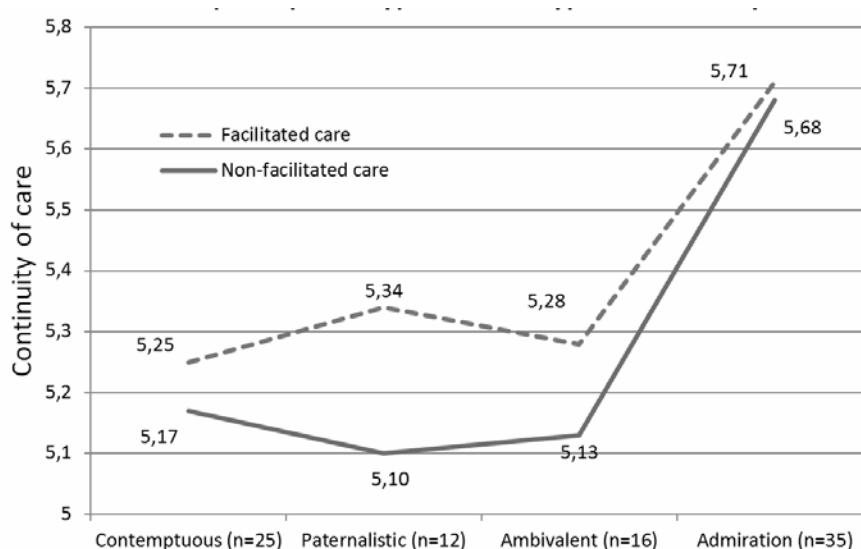


Figure 1. Effect of participant's type of stereotype on continuity of care

hypothesis, the facilitated care condition (providers get support to treat the patient) did not have a significant effect either on stereotype, or on the continuity of care. As stereotypes are more likely to be triggered in overload context, facilitation of care particularly when treating potential demanding situations (i.e. migrants' care) should remain a priority in healthcare organisations, thus to avoid stereotype manifestation and their negative consequences on quality of care (Penner et al. 2014).

Our measure of continuity of care consisted in: globality, longitudinality, flexibility and, communication (Bachrach 1981). Surprisingly, we observed that GPs offered more continuity of care in comparison with MHPs even if the presented vignette was a mental health issue (PTSD). This could be due to our measure

of continuity, which includes the globality dimension (i.e. collaboration with services, comprehensiveness, and coordination of care), which is typically the role of GPs within the healthcare system. Another explanation could be that on the field, most asylum seekers' mental health situations are treated in primary care. This phenomenon is reinforced by a lack of availability of specialised mental health care services. A better articulation between primary care and specialized mental health services should be sustained to avoid over-solicitation within general practice and offer most adapted care to asylum seekers presenting mental health conditions.

We found that women providers were offering more continuity of care than their male colleagues; this could confirm gender different practices when treating vulnerable population groups (Howe 2007).

Regarding limits of the study, our results should be taken with caution due to our limited sample, and representativeness bias (i.e. gender and profession composition, practice type and localization). Finally, most participants in our study could have been participants with an interest in migrants' health. Further research should focus on organisational improvement of continuity of mental healthcare for asylum seekers among MHPs, and enlighten contextual variables that make healthcare providers developing positive stereotypes about their patients thus to improve continuity and quality of care.

CONCLUSION

This study stresses the importance of stereotypes on establishment of continuity of care, which is a fundamental dimension of healthcare quality, particularly for vulnerable groups such as asylum seekers. A part of healthcare providers were showing positive stereotypes ("admiration") with regard to asylum seekers, which generated a better continuity of care. Paradoxically, continuity of mental healthcare was better among GPs. Therefore, improvement of continuity of mental healthcare for asylum seekers among MHPs and a better understanding of how positive stereotypes are elicited should be investigated in further studies.

Acknowledgements: None.

Conflict of interest: None to declare.

Contribution of individual authors:

All authors make substantial contributions to conception and design and or acquisition of data and/or analysis or interpretation of data.

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