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Research Article

Factors Influencing Stigma Toward Mental Disorders Among Healthcare Workers: An Observational Study

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Introduction: The stigma perpetuated by healthcare workers toward people with mental disorders exacerbates both the actual and perceived quality of care, adversely affecting various clinical outcomes.
Objectives: Assess the level of stigma among healthcare professionals and investigate factors that could be predictive.
Methods: This was a cross-sectional study. The OMS-HC-15 scale was used to measure stigma level (ranging from 15 to 75) in 409 healthcare providers. Sociodemographic information, personal data, and professional experiences related to mental disorders were also collected. A linear regression model was used to elucidate the factors that influence the level of stigma.
Results: The median stigma score was 33, in line with previous studies. In bivariate analysis, stigma level was statistically associated ($p < 0.05$) to professional experience with mental disorder (lower level), to the healthcare department in which one was engaged (lower in community services, higher in hospital), and to political orientation (higher among those identified as "right-wing") and religious affiliation (higher among Christians compared to atheists/agnostics). In multivariate analysis, identification as "right-wing" was predictive of higher stigma, while preliminary specific mental health training and working in mental health or primary/community care services predicted lower stigma.
Conclusions: These results highlight the multifaceted nature of attitudes of healthcare workers toward individuals with mental disorders, informing the need for targeted stigma-reduction interventions. Understanding this phenomenon and its implications for healthcare is a crucial step toward enhancing quality of care.

Keywords: healthcare workers; mental health; quality of care; stigma

1. Introduction

People suffering from mental disorders also experience higher rates of physical illness, substantial economic losses, and shorter life expectancy than the general population [1–3]. These outcomes can be worsened by public stigma, encompassing behaviors such as stereotypes and discrimination [4]. Indeed, in social imaginary, people with mental disorders are generally considered unpredictable, violent, and dangerous, leading to preventive social condemnation even in the absence of illicit behaviors or attitudes [5]. Public stigma may persuade people with mental disorders to internalize the acceptance of such stereotypes and discrimination (self-stigma) [6], inducing them to experience their condition with shame and guilt, thus exposing them to isolation and discontinuation of care [7, 8]. A growing body of evidence attests that discriminatory behaviors are often exhibited by healthcare workers [5], who can demonstrate a lack of attention to the basic needs of patients with mental disorders, poor tolerance toward their behaviors, and

a tendency to attribute to mental disorder any emerging sign or symptom [9, 10]. Furthermore, coercive treatments (e.g. physical and pharmacological restraint, isolation, or forced medication) are often implemented [11], even when not necessary [12]. Such practices have a negative impact on quality of care, undermining perceived healing capacity [13] and contributing to the deterioration of clinical outcomes for people with mental disorders [1]. Therefore, it is essential to assess the presence and extent of stigma among healthcare workers [14]. Furthermore, a comprehensive understanding of the dimensions with which stigma manifests must be achieved to implement actions aimed at reducing stigma and improving the quality of mental health practice [5]. As frontline caregivers, healthcare workers play a critical role in shaping the experiences of individuals with mental disorders, influencing their treatment outcomes and overall well-being. This highlights the importance of understanding their attitudes, as these can directly impact the quality of care provided.

In recent years, research has increasingly explored the variables associated with stigma toward mental disorders, especially within the healthcare settings. Sociodemographic characteristics such as age [15] and sex assigned at birth have shown mixed associations with stigmatizing attitudes [16, 17]. Several international initiatives have emphasized the importance of targeted education and training to reduce stigma toward mental disorders among healthcare professionals. The World Health Organization has repeatedly called for the integration of antistigma strategies into mental health policies and professional training, recognizing stigma as a major barrier to care and recovery [18] Educational interventions, particularly those that include direct contact with people with lived experience, have been shown to improve empathy, reduce fear, and promote inclusive practices [15, 19, 20–24]. These findings support the hypothesis that specific training in mental health may be a key modifiable factor in reducing stigma within healthcare settings. Additionally, personal or professional experiences with mental illness—such as having a relative with a mental disorder or working with patients with psychiatric conditions—have been associated with more empathetic attitudes and lower stigma [15, 23]. Other psychosocial factors have also been implicated. Religious beliefs may play a dual role: while some faith-based perspectives foster compassion and support, others may reinforce moralistic or punitive views of mental illness [25–27]. Similarly, political orientation has been linked to stigma levels. Individuals endorsing conservative or authoritarian values tend to report greater stigma toward people with mental illness, whereas liberal or progressive ideologies are more often associated with inclusive attitudes [28, 29]. While this variable has been investigated in general population, its role among healthcare professionals remains unexplored. Finally, clinical role and care setting—including hospital, outpatient, or home care environments, and psychiatric vs. nonpsychiatric departments—may shape stigma expression. Evidence suggests that professionals working in psychiatric contexts or with greater exposure to mental health care report lower levels of stigma [10, 14].

The aim of this study was to measure the level of stigma toward mental disorders in a population of healthcare workers, considering the potential influence of social, educational, political, and religious factors. The study also aimed to examine how professional roles, work experience and the specific healthcare settings within the organization—such as hospital, outpatient, and home care—may have influenced stigma levels. To guide the investigation, the study addressed the following questions: What is the level of stigma toward mental disorders among healthcare workers? Which social, educational, political, and religious factors are associated with the level of stigma? Do professional roles, work experience, and the different healthcare settings influence this level of stigma?

Based on prior literature, it was hypothesized that the stigma among healthcare workers would be consistent with findings from previous studies. Specifically, it was expected that healthcare workers with higher levels of education and specific training in mental health would exhibit lower levels of stigma. Furthermore, those with personal or professional experiences with mental disorders were anticipated to show lower levels of stigma and healthcare workers in psychiatric roles were hypothesized to display less stigmatizing attitudes than those in other medical specialties.

2. Methods

2.1. Study Design and Setting. This was a cross-sectional survey conducted at the Health Agency of [blind for review], employing 4365 people overall. The study healthcare organization comprises multiple care settings—including hospital wards, outpatient services, and community-based or home care units—allowing to explore stigma across different professional environments within a same system. The study adhered to the Checklist for Reporting Results of Internet E-Surveys (CHERRIES) guidelines [30, 31] and to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines [32].

2.2. Eligibility Criteria and Population. Participants were excluded if they did not work in direct contact with the public, or if they were temporary workers or contractors, as these groups may have had differing professional dynamics or access to mental health training. All individuals with a health or psychosocial work profile ($n = 3492$; 80%) were considered eligible.

The minimum sample size required to detect a medium effect size with 80% power for a multiple linear regression involving up to nine independent variables was 113 participants [33]. The final sample of 409 allowed for more precise estimation of stigma levels within subgroups (Lakens 2013).

2.3. Ethical Considerations. The study was approved by the Regional Ethics Committee (protocol number 117_2021T dated 22/2/22).

Participants were invited via institutional email, which included an explanation of the study's aims, a link to the anonymous online survey, hosted on EU-Survey (a platform supported by the European Commission), and a consent form for participation. Participants were informed about the duration of the survey (almost 10 min), the data storage location, the duration of data retention, and assured that their responses would remain confidential, with no personally identifiable information being collected or stored. The study's investigator identity and the study's purpose were disclosed in the informed consent section at the beginning of the survey. At the end of the study, all data will be securely destroyed in accordance with institutional and ethical guidelines to ensure the protection of participants' privacy.

2.4. Data Collection. The validated 15-item Opening Minds Scale for Healthcare Providers (OMS-HC-15) was used to assess the level of stigma toward individuals with mental disorders, as this tool had previously been considered suitable for healthcare providers [15, 24]. OMS-HC-15 assigns scores ranging from 15 to 75 points, based on three dimensions of stigma: (1) attitudes (attitudes of healthcare providers toward people with mental illness; score range 5–25); (2) disclosure and help seeking (attitudes of healthcare providers toward disclosure of a mental illness and help seeking; score range 4–20); and (3) social distance (social distance toward people with a mental illness, reflecting the willingness to engage with people who suffer from mental disorders and serving as a surrogate measure of behavioral intentions; score range 6–30). Total and subscale scores were calculated.

The anonymity provided by the survey platform was expected to reduce social desirability bias, although such a factor cannot be completely eliminated in self-report stigma assessments [24]. The effects of response bias associated with a self-administered questionnaire and the potential for data integrity issues, such as individuals responding multiple times, could not be determined. The following variables, previously reported in the literature as linked to stigma, were also collected: sex assigned at birth, age, profession, work setting, experiences with friends or family who have suffered or are currently experiencing mental disorders, professional experiences with mental disorders, specific training in mental health, religious beliefs, and political orientation. For this variable, participants were asked to position themselves on a scale ranging from 1 (far left-wing) to 10 (far right-wing) [34]. The results were categorized as follows: "left-wing" (scores 1–3), "center" (4–7), and "right-wing" (8–10). Political orientation was assessed using this scale, which has been widely used in public opinion research and shown to be a reliable tool for measuring left-right political orientation. While the 10-point scale is not formally validated in the context of our study, it is commonly employed in the [Country: blinded for review] context and provides a straightforward means for participants to self-assess their political views. The scale's effectiveness has been supported by studies such as Kroh [34], which demonstrate its reliability and validity for capturing political orientation. In general, we interpreted political orientation on the left of the spectrum as being associated with liberal or progressive ideologies, which emphasize social equality, government intervention in the economy, and policies promoting social welfare. The "center" category, including scores from 4 to 7, represents a moderate or centrist stance, balancing both liberal and conservative views. Lastly, the "right-wing" group (scores 8–10) reflects conservative or traditional values, emphasizing limited government intervention, individual freedoms, and preserving cultural or social traditions. The entire survey comprised a maximum of 32 mandatory questions, each including a "Rather not answer" option, all displayed on a single page. Inclusion and exclusion criteria were addressed in the first two questions; if these criteria were not met, participants could not proceed further in the survey.

2.5. Data Analysis. All analyses were performed using the Jamovi statistical software (version 2.3.21.0).

The normality of the distributions was assessed using the Shapiro–Wilk test, and the homogeneity of the variance between groups was tested with the Levene test. Sociodemographic and mental disorder "exposure" variables were presented using the median and interquartile ranges, as data were non-normally distributed. Internal consistency of the scale was evaluated using Cronbach's α; internal consistency was considered acceptable if $\alpha > 0.7$ for the overall scale and $\alpha > 0.6$ for the subscales [35]. Differences between variables of interest and sociodemographic characteristics of subjects were analyzed using the Mann–Whitney U test when comparing two groups and the Kruskall–Wallis test for comparisons involving more than two groups. Categorical variables were presented as numbers and percentages, and differences between proportions were assessed using the χ^2 test or Fisher's exact test, as appropriate.

Categories with fewer than 20 responses were excluded from the statistical analysis. Responses marked as "Rather not answer" were treated as missing data.

Variables showing a statistically significant association with stigma level were examined using a linear regression model [36] To evaluate multicollinearity in the linear regression model, we used the variance inflation factor (VIF). The level of statistical significance was established at $p < 0.05$.

3. Results

In total, 494 eligible subjects took part in the survey, conducted in March 2022, yielding a response rate of 14.1% from the 3492 invited individuals. This sample size was adequate to detect a medium effect size with 80% power for the planned statistical analyses, as described in the Methods section. After excluding 85 participants who did not meet the inclusion criteria (21: working in a different healthcare agency; 64: work that did not involve contact with the public), the final study population consisted of 409 participants (median age 46 years, IQR 34–53; women: $n = 300$,

74.1%). Table 1 presents the key characteristics of the study population.

The internal consistency of the OMS-HC-15 scale and all subscales was acceptable (overall: $\alpha = 0.75$; attitude: $\alpha = 0.64$; disclosure: $\alpha = 0.63$; social distance: $\alpha = 0.65$). A median stigma level of 33 (IQR 28–38) was documented. Unfortunately, the OMS-HC-15 scores reported by the literature cannot inform whether the documented level of stigma should be considered high, moderate, or low, because no thresholds have been established yet for this tool. Since the OMS-HC-15 ranges from 15 to 75 points, with higher scores indicating greater stigma and 45 as the central value, we could speculate that, with an IQR of 28–38 points, most of the population enrolled in the present investigation presented a low to moderate level of stigma. The results for the attitude, disclosure, and social distance subscales were 13 (IQR 10–16), 9 (IQR 7-11), and 11 (IQR 8–13), respectively (Table 1).

Table 2 shows the relationship between the OMS-HC-15 scores and the study variables. A lower score (indicating a lower level of stigma) was associated with having a "left-wing" political orientation, prior professional experience with mental disorders, working in mental health/addiction services, having received specific mental health training, and identifying as atheist/agnostic.

Variables associated with the OMS-HC-15 score with a p-value of < 0.05 in bivariate analyses were tested using a linear regression model. No collinearity was detected between variables (VIF < 1.10 for all variables). The tested model produced an adjusted R^2 of 0.142 (F 7.04; $p < 0.001$). Having attended preliminary specific mental health training and working in mental health, addiction, or primary/community care settings were found to predict lower stigma, while a "right-wing" political orientation was predictive of higher stigma (Table 3).

Table 1: Main characteristics of the study population.

Variable	*n* (%)
Sex assigned at birth ($n = 405$)	
Male	105 (25.9%)
Female	300 (74.1%)
Workplace department ($n = 400$)	
Hospital wards	195 (48.8%)
Primary/community care	74 (18.5%)
Mental health/addiction department	52 (13.0%)
Public health department	21 (5.3%)
Others	58 (14.5%)
Employment role ($n = 398$)	
Nurse	178 (44.7%)
Physician	71 (17.8%)
Healthcare assistant	45 (11.3%)
Others	104 (26.1%)
Specific mental health training ($n = 409$)	137 (33.5%)
Professional experience with mental disorder ($n = 407$)	360 (88.5%)
Friends/family experience with mental disorder ($n = 401$)	257 (64.1%)
Religious belief ($n = 367$)	
Atheist/agnostic	166 (45.2%)
Christian	186 (50.7%)
Others	15 (4.1%)
Political orientation ($n = 332$)	
Left-wing	90 (27.1%)
Center	227 (68.4%)
Right-wing	15 (4.5%)

4. Discussion

The study found a median OMS-HC-15 score of 33, suggesting a generally low to moderate level of stigma among healthcare workers. This result is consistent with previous literature [15, 23, 24] and represents a key finding of the study (Table 4). Given the absence of established thresholds for the OMS-HC-15, this score was interpreted in relation to the scale's range (15–75) and the interquartile distribution (IQR 28–38), supporting the interpretation of a relatively low stigma level. This finding reinforces existing evidence on the protective role of mental health training and professional experience in reducing stigma among healthcare professionals, [15–24], also providing a valuable baseline for future interventions aimed at further reducing stigma in clinical settings. It is important to recognize that, although an ideal scenario would be the complete absence of stigma, this remains a complex and human issue. All healthcare professionals, like any individuals, may have attitudes influenced by personal experiences, education, and cultural factors. Therefore, the goal is working towards minimizing stigma as much as possible, because healthcare workers and healthcare agency employees, in general, should serve as role models for the whole population in how to treat individuals with mental disorders, offering appropriate interventions without harboring prejudices [37, 38]. Specific interventions, such as periodic workshops for healthcare personnel in hospital settings, could represent a significant step in fostering empathy and understanding toward patients. Ongoing training is crucial in this context, as education can help reduce stigma by addressing fears rooted in misinformation and by promoting a more inclusive care environment. Our findings underline the importance of addressing not only technical competencies but also underlying beliefs that may perpetuate stigma. Further studies investigating predictors of stigma are needed to guide the development of more effective and inclusive mental health policies.

Reducing stigma is essential to improve both clinical outcomes and the quality of life of individuals with mental disorders [39–42]. In the present study, participants with greater exposure to mental disorders—either personally or professionally—tended to report lower levels of stigma, supporting the idea that targeted experiences and awareness foster more inclusive attitudes. This reinforces the importance of structured stigma-reduction efforts in healthcare.

Table 2: Associations between the OMS-HC-15 score, the stigma dimension subscale, and other variables.

Variables	OMS-HC-15 median [IQR]	*p* value
Sex assigned at birth		
Female ($n = 300$)	33.0 [27.8–37.3]	0.378
Male ($n = 105$)	34.0 [28.0–39.0]	
Specific mental health training		
No ($n = 272$)	35.0 [29.0–39.0]	**< 0.001**
Yes ($n = 137$)	29.0 [25.0–36.0]	
Professional experience with mental disorder		
No ($n = 47$)	36.0 [32.0–38.0]	**0.007**
Yes ($n = 360$)	32.0 [27.0–38.0]	
Friends/family experience with mental disorder		
No ($n = 144$)	33.0 [27.8–39.0]	0.221
Yes ($n = 257$)	32.0 [27.0–37.0]	
Religion		
Agnostic/atheist ($n = 166$)	32.0 [27.0–36.0]	**0.017**
Christian ($n = 186$)	34.0 [28.0–39.0]	
Workplace department		
Hospital ($n = 195$)	35.0 [29.0–39.0]	**< 0.001**
Mental health/addiction ($n = 52$)	29.0 [28.0–37.0]	
Primary care ($n = 74$)	31.5 [25.0–36.0]	
Others ($n = 79$)	34.0 [28.0–37.0]	
Profession		
Nurse ($n = 178$)	32.0 [28.0–38.8]	0.391
Healthcare assistant ($n = 45$)	33.0 [29.0–37.0]	
Physician ($n = 71$)	31.0 [27.0–37.0]	
Others ($n = 104$)	34.0 [27.0–38.0]	
Political orientation ($n = 332$)		
Left-wing	30.0 [25.0–34.0]	**< 0.001**
Center	33.0 [28.0–38.0]	
Right-wing	40.0 [37.0–41.5]	

Note: Bold values represent statistically significant associations.

Table 3: Multiple linear regression of the total OMS-HC-15 score on study variables.

Predictor	Estimate	SE	*T*	*p* value
Political orientation				
Center (reference)				
Left-wing	−1.60	0.903	−1.77	0.077
Right-wing	5.91	2.143	2.76	**0.006**
Specific mental health training (yes)	2.54	0.907	2.80	**0.005**
Christian religion (yes)	−1.41	0.817	−1.73	0.085
Workplace department				
Hospital (reference)				
Mental health/addiction	−3.95	1.294	−3.05	**0.003**
Primary care	−2.68	1.095	−2.45	**0.015**
Others	−2.07	1.158	−1.79	0.075
Professional experience with mental disorder (yes)	1.75	1.370	1.28	0.202
Intercept	33.02	0.987	33.45	< 0.001

Note: Bold values represent statistically significant values.

Table 4: Stigma level measured by OMS-HC-15 in previous publications and in the present study.

Research	Year	Nation	Participants	Mean score
Present study	2022	Italy	Healthcare workers	33*
Modgill et al. [24]	2014	Canada	Healthcare professionals	33.4
Destrebecq et al. [21]	2018	Italy	Bachelor health profession students	34*
			Bachelor nursing students	36
Kolb et al. [23]	2022	USA	Mental health nurses	26.4
			Medical/surgical nurses	33.3
Lasalvia et al. [17]	2025	Italy	Ambulance service staff	43.2

*Median score.

Professionals working in community-based services—such as mental health, addiction, and primary care—reported significantly lower levels of stigma than those in hospital settings, suggesting that the care environment may influence attitudes. This is particularly relevant, as stigma among healthcare providers has been linked to worse outcome across medical domains, including surgery [1], and may contribute to delays in diagnosis, undertreatment, and reduced quality of care. These results align with previous research [43], which suggests that greater professional exposure to individuals with mental and behavioral disorders can enhance empathy and promote more open attitudes among healthcare workers.

Although caution is warranted when comparing studies that report different statistical measures (e.g., mean vs. median), it is worth noting that the level of stigma observed in our sample is in line with that reported by Modgill et al. [24], who found a similarly low level of stigma among healthcare workers shortly after they had received targeted mental health training In our study, having attended specific training in mental health was also associated with a lower stigma. However, the lack of detailed information on the nature, duration, or content of the training limits our ability to identify which components are most effective. Therefore, while training in mental health appears to be associated with reduced stigma, the specific aspects of such training (e.g., theoretical vs. practical, duration, focus) remain unclear. While only one-third of participants reported receiving such training, the overall low to moderate level of stigma observed in the entire sample may be considered encouraging, especially given that the majority had no formal preparation in this area. This supports the hypothesis that broader exposure to mental health content—even informal or experiential—may contribute to more positive attitudes. This interpretation is consistent with previous findings [21–24, 44, 45], reinforcing the strategic role of education in stigma reduction. Even healthcare workers not directly involved in mental health services should be included in interprofessional training programs, designed to enhance knowledge about mental disorder, raise awareness of stigma-related risks, and encourage structured contact with people experiencing mental illness [46–48]. Such programs should also highlight clinical outcomes potentially affected by stigma, underscoring the relevance of this issue across all areas of healthcare [47].

On the other side, we found that having a "right-wing" political orientation was predictive of a higher level of stigma. Although this subgroup represented only 4.5% of the sample, the finding is consistent with existing literature suggesting that conservative or authoritarian worldviews are more likely to be associated with stigmatizing attitudes toward mental illness [28, 49]. This association may reflect the broader ideological orientation of right-wing perspectives, which tend to favor traditional norms and may be less accepting of behaviors perceived as divergent or unconventional. Globally, conservative governments have often prioritized other health areas over mental health, resulting in reduced investment and more limited care for people with mental disorders [50, 51]. However, given the small proportion of participants in this category, further studies with more balanced political representation are needed to confirm this finding.

Although not confirmed in the multivariate analysis, it is worth discussing other variables that showed significant associations with the level of stigma in the bivariate analysis. For instance, identifying as Christian was associated with higher stigma scores. This result aligns with findings by Johnson-Kwochka et al. [25] who reported that certain religious orientations—particularly extrinsic-social religious beliefs—were significantly associated with greater endorsement of stigmatizing attitudes, as measured using validated tools such as the Attribution Questionnaire-27 (AQ-27), the Social Distance Scale (SDS), and the Level of Contact Report (LOR). Unlike our study, which used median scores to account for non-normal distribution, their analyses relied on continuous data and regression-based approaches, reporting means and standard deviations. Nonetheless, the association between specific religious orientations and stigmatizing beliefs was consistent across both studies.

Previous literature has suggested that religious individuals—particularly those with more conservative or traditionalist worldviews—may be less open to changing attitudes toward people with mental disorders [50, 51]. Religion, in this context, may serve as a moral framework that reinforces established social norms, and any perceived deviation from those norms (e.g., mental illness) may be viewed as threatening to group cohesion [25]. Historically, some Christian doctrines associated mental illness with moral failing or sin (Wesselmann and Graziano 2010), though such views are less common today. Nevertheless, residual attitudes rooted in these interpretations may still influence present-day stigma.

4.1. Limitations. Some limitations of this study should be considered when interpreting our results. First, the observational, cross-sectional design did not allow for causal inferences, only capturing participants' attitudes at a single point in time, which may be influenced by temporary or situational factors. Second, although the survey was anonymous, we cannot completely rule out the possibility of response bias, including the risk of socially desirable answers or multiple submissions, as no technical control was implemented to prevent repeated entries. Additionally, the sample size was relatively small and drawn from a single healthcare center, which limits the generalizability of the study findings. Our results indicated that stigma levels were relatively consistent across various occupational groups. However, this observation may have been influenced by the underrepresentation or exclusion of some professional categories, such as psychologists, psychiatric rehabilitation technicians, and social workers, who are described in the literature as exhibiting the lowest levels of stigma [24]. Our study did not explore the intersectionality of stigma with race, as the very large majority of healthcare workers in the institution were Caucasian. This made it difficult to gather meaningful data on racial differences without potentially

compromising participant anonymity. Socioeconomic status was not directly assessed; however, it was largely inferred from professional roles, given that all participants had standardized salaries based on national contractual agreements. Future studies could benefit from exploring these factors more deeply, particularly in settings where there is greater diversity in terms of race, gender, and socioeconomic background. Furthermore, the linear regression model explained only a limited portion of the variance, suggesting that important predictive variables may not have been captured in our study.

Despite these limitations, this study contributes to the growing body of literature on mental health stigma among healthcare professionals and provides insights from a diverse range of frontline workers, including those from both hospital and community settings. The use of a validated tool (OMS-HC-15) enhances the reliability of the findings, and the analysis of sociodemographic correlates offers valuable directions for targeted anti-stigma interventions in the healthcare field.

5. Conclusions

Measurement of stigma and identification of the most influential predictive factors within a specific context can pave the way for strategies to reduce its impact on both the quality of care and the quality of life of individuals with mental disorders. Our findings underscore the complex interplay of personal, professional and social factors in shaping healthcare providers toward individuals with mental disorders, offering valuable information for targeted interventions to reduce stigma in healthcare settings. It could be particularly useful, especially for hospital-based healthcare workers, to organize regular workshops that can help bridge the gap between healthcare providers and the mental health community, fostering a deeper understanding and empathy towards individuals with mental disorders.

Like all forms of prejudice or intolerance, stigma often stems from fear of the unknown, which can arise from lack of information. Investigating this phenomenon and expanding professional knowledge represent essential steps toward improving care, as a basis to improve mental health in this frail population despite the presence of a mental disorder. This remains the ultimate goal in the fight against stigma.

Future studies are required to investigate potential predictive variables of stigma, in order to understand whether specific sociopolitical ideologies or spiritual tendencies harbor aspects of inclusion or exclusion related to the topics under consideration.

6. Relevance for Clinical Practice

Healthcare workers are not immune from stigma toward individuals affected by mental health problems. The study findings highlight as stigma is more evident in individual having a "right-wing" political orientation, while is less probable in those working in community care settings and who have undergone specific training courses. Accordingly, the study provides valuable insights that can be used to design targeted interventions aimed at reducing stigma. Implementing such measures could enhance the quality of care and create a more inclusive and supportive environment for patients suffering from mental health disorders in any clinical settings. [52].

Data Availability Statement

The raw data supporting the conclusions of this article will be made available by the authors upon request.

Disclosure

This work is original and has not been published elsewhere nor is it currently under consideration for publication elsewhere.

Conflicts of Interest

The authors declare no conflicts of interest.

Author Contributions

Claudia Fantuzzi: conception and design of the study, acquisition, analysis and interpretation of data, drafting of the article, and final approval of the version to be submitted.

Davide Bagozzi: conception and design of the study, acquisition, analysis and interpretation of data, and final approval of the version to be submitted.

Roberta Accardo: conception and design of the study, acquisition and interpretation of data, and final approval of the version to be submitted.

Gabriella D'Ambrosi: acquisition and interpretation of data and final approval of the version to be submitted.

Gianfranco Sanson: analysis and interpretation of data, drafting of the article, and final approval of the version to be submitted.

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