



Attitudes towards depression of Argentinian, Chilean, and Venezuelan healthcare professionals using the Spanish validated version of the revised depression attitude questionnaire (SR-DAQ)

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ARTICLE INFO

Keywords:

Depression
Latin America
Attitudes
Physicians

ABSTRACT

Background: The beliefs and attitudes of physicians toward depression may predict whether they are supportive or avoidant of patients diagnosed with this condition. Describing the attitudes toward depression of Argentinian, Chilean, and Venezuelan healthcare professionals could be a valuable tool for understanding the Latin American perspective on depression recognition, management, and prevention.

Materials and methods: A cross-sectional study was conducted among healthcare professionals in Argentina, Chile, and Venezuela using the Spanish validated version of the revised depression attitude questionnaire (R-DAQ). The questionnaire was collected online from August to November 2021, in a quota-based sample of 1759 health professionals (the final analytical sample is 1234). Descriptive data analyses were performed using STATA version 16 statistical software.

Results: Depression was considered a disease that anyone could suffer by 90% of the respondents. However, 70% of professionals answered that they feel more comfortable dealing with physical illness than mental illness. Furthermore, the findings show that a quarter of the participants in the study believed that either medical treatment (28.6%) or psychosocial approach (<20%) were ineffective tools for people suffering from depression. Findings also show that depression is seen as a more natural part of life by Argentinian professionals and men. Finally, psychologists and psychiatrists are most likely to treat depression as any other physical disease. Medical providers who routinely perform surgeries are not as likely to know how to treat depression or consider it an actual disease.

Conclusions: Healthcare professionals in Argentina, Chile, and Venezuela have varying attitudes toward depression. While they recognize depression as a disease on the same level as other physical diseases, most do not know how to treat it. The findings point to the need for these countries to promote the training of healthcare workers in areas such as depression diagnosis, treatment, and social interventions.

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<https://doi.org/10.1016/j.ssmph.2022.101180>

Received 26 April 2022; Received in revised form 26 June 2022; Accepted 19 July 2022

Available online 6 August 2022

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1. Introduction

Latin America and the Caribbean are home to over 658 million people, accounting for 8.6% of the world's population. According to the World Health Organization, an estimated 5% of adults in the region suffered from depression in 2015, and most of these patients did not seek or receive medical attention (United Nations, 2015). According to UNICEF, in 2021, about 16 million teenagers had a mental illness. Anxiety and depression were the two most common mental illnesses (50 percent) (Unicef, 2022).

Depression is becoming more prevalent throughout the world. According to WHO, the global prevalence of depression has increased by 25% since the start of the COVID-19 pandemic (World Health Organization, 2022). Despite this, patients continue to receive inadequate management and treatment from healthcare professionals who, in many cases, ignore that patients suffering from depression and schizophrenia have a 40–60% increased risk of premature death compared to the general population (Errazuriz & Crisostomo, 2021).

Although some countries have conducted significant research to assess physicians' willingness to treat and follow patients with depression, the results are discouraging due to the large number of professionals who present with a negative willingness to diagnose, follow, and handle these patients. Most justify their position by patients' conditions such as failure to follow treatment, refusal to disregard negative thoughts, and a high risk of suicide (Haddad et al., 2015).

Depression, as perceived by physicians in different countries, may be influenced by societal stigmas. For example, medical students' attitudes toward mental illness in Venezuela may harm their attitudes as future physicians due to a lack of proper training for identifying and treating mental diseases such as depression (Medina-Ortiz et al., 2021). In 2018, Vistorte et al. found that, despite their proclivity to treat depression, most primary care physicians (PCPs) would prefer to refer these patients to a psychiatrist. This may indicate a trend of stigmatizing mental health illnesses by South American physicians, which may serve as a barrier for people suffering from depression who require treatment (Vistorte et al., 2018).

Suarez Richards (2009) conducted an exploratory cross-sectional study among 288 general practitioner physicians in Argentina to assess knowledge about depressive disorders, finding that while most participants (97.6%) considered depression to be a disease, they felt they lacked knowledge about depressive disorders and their causes, treatments, and comorbidities.

In 2016, Acuna et al. (2016) assessed the clinical skills of Chilean general practitioners (GPs) for managing depressive disorders in 56 GPs without previous mental health. They revealed a below level of 50% in their basic knowledge and 46% who showed poor diagnosis and treatment skills, demonstrating the need for a profound review in mental health training for students and GPs. Therefore, in 2018 the health system in Chile implemented strategies for educating physicians in the management of mental health disorders following a WHO project about mental health training; 5776 physicians were trained with positive results, leading to an increase in medical visits for mental health by 85.4% (Minoletti et al., 2018).

The present cross-sectional study aims to collect current data on the perception and stigma of depression and assess physicians' attitudes and confidence in managing and treating patients with depression in Chile, Venezuela, and Argentina. We chose three countries to get heterogeneity in the quality of their healthcare services. In this regard, Chile was considered as having one of the best healthcare services in the region, Venezuela as having experienced the most significant decline in essential services, including healthcare services, in recent years, and Argentina as having a medium level of healthcare services (CEOWORLD, 2021).

We also investigate the relationship between participant attitudes and demographic and training characteristics. The Revised Depression Attitude Questionnaire instrument, specifically the Spanish validated

version (SR-DAQ), was used to assess the attitudes of healthcare professionals. Cherrez-Ojeda et al. (2019) validated this questionnaire in Spanish in 2019.

2. Methods

2.1. Questionnaire and data collection

The Spanish validated revised depression attitude questionnaire (R-DAQ) was employed in this study (Cherrez-Ojeda et al., 2019). Question answers went from "Totally disagree" to "Totally agree." In their validation work, Cronbach's coefficient was used to determine the internal consistency of the SR-DAQ, with values ranging from 0.61 to 0.80. The correlations between the Spanish and English versions demonstrated adequate validity.

Due to the difficulties in obtaining a probability sample in these three countries during the pandemic because of the schedule instability of the health professionals during the COVID-19 pandemic, responses were collected in Argentina, Chile, and Venezuela using quota non-probability sampling. To enhance sample representativeness, quota sampling was applied in terms of sex and medical specialty commensurate with each country's profile. First, for each country we considered that we would like to sample the equivalent or more than a probability infinite sample (around 400 with precision error of $\pm 5\%$) (Israel, 1992). Second, we selected the number of participants interviewed from each specialty resembling the medical specialties distribution of each country (Clouet-Huerta et al., 2017; Guillou et al., 2011; Ministerio de Salud - Argentina, 2015; Rojas-Quijada & Bianchet, 2021). Third, participants were recruited exclusively online, sending them the questionnaire link via electronic listservs, emails, and social networking sites. Data were collected from August to November 2021. A total of 1759 participants answered the survey. Only 1234 health professionals from Argentina, Chile, and Venezuela with active medical/clinical practice were kept in the analytical sample.

2.2. Statistical analysis

STATA version 17 statistical software was used for all data analyses (StataCorp, 2007). We dichotomized "Agree" and "Totally agree" to mean agreement with that specific statement. Cronbach's coefficient values of the SR-DAQ dichotomized items were between 0.87 and 0.91, which reveals good internal consistency of the instrument (more can be explored in Table 2). We present three sets of results. First, univariate and bivariate (by sex and country) descriptive statistics were obtained for all variables of interest except for SR-DAQ items. Second, we show the overall descriptive statistics of SR-DAQ items separated by country and sex. Third, we show descriptive statistics of the SR-DAQ items but separated by a collapsed medical specialty group: non-surgical, surgical, and mental health professionals. We additionally show p values for variable comparisons between sex, country, and medical specialty groups percentages using chi-square.

2.3. Ethics review

This study complies with the World Medical Association Declaration of Helsinki on Ethical. It was approved by the ethics committee: Comité de ética e Investigación en Seres Humanos (CEISH), Guayaquil-Ecuador (#HCK-CEISH-18-0060). Informed consent was obtained from all participants before their voluntary participation in the survey. The participants could not be personally identified using the information recollected in the survey; thus, their anonymity was preserved, and their personal data were protected.

3. Results

3.1. Sample characteristics

Table 1 shows general descriptive statistics of the sample but is also separated by sex and country. Overall, 65.1% of respondents identified themselves as female. 34%, 33.9%, and 32.2% were from Argentina, Chile, and Venezuela, correspondingly. 42.7% were GPs, 12.3% were family doctors, 7.4% were surgeons, and 5.3% were psychologists. The rest of the sample consists of other medical specialists. 69% worked in urban areas only, 16.9% in rural areas, and the remaining 14.0% in both. 37.3% of the sample had previous training in depression.

3.2. SR-DAQ descriptive results (by sex and country)

Table 2 shows the SR-DAQ items in the original order of the instrument. However, in the following paragraphs, we will present the results in overall frequency order. Indistinct of sex or country, almost 9 out of 10 health professionals answered, "Anyone can suffer from depression." A similar percentage answered that "all health professionals should have skills in recognising and managing depression," with most health providers thinking so in Chile (94.7%). Then, approximately 70% of health professionals agreed that "depression is a disease like any other" (with no significant changes by country). A similar percentage of participants agreed they are "more comfortable working with physical illness than with mental illnesses like depression." In this particular statement, Argentinian providers agreed the least (59.9%), and Chilean providers agreed the most (77%). Approximately 70% also answered that the care for depressed patients is similar to those with physical diseases (although this does not vary by country or sex).

A little less than half the respondents (45%) agreed with the statement "I feel confident in assessing depression in patients" (there were no variations by country, but men agreed slightly more with this statement). A similar percentage (41%) answered that their "profession is well placed to assist patients with depression." In this particular

question, Venezuelan health professionals felt the least confident (37.8%). Only 38% of respondents answered that "it is rewarding to spend time looking after depressed patients" with no significant variations by country or sex. However, Venezuelans agreed to the most with this statement (44.1%). 37.5% of the sample felt "comfortable" dealing with depressed patients' needs, with no significant differences between sex or countries. 32.5% felt "confident in assessing suicide risk in patients presenting with depression." There are significant differences in this statement between countries. 40.1%, 25.8, and 31.5% of respondents in Argentina, Chile, and Venezuela agreed with this statement. This echoes that only 28.6% felt confident in treating patients with depression (Argentinians being the most secure about it), and the same percentage agree that depression treatments medicalise unhappiness; however, only 16.1% of Venezuelans agree with this statement.

When asked if "becoming depressed is a way that people with poor stamina deal with life difficulties," 26.7% agreed with this statement. Argentinians agreed the most with it, though (36%). Less than 20% of the sample agreed that "one of the main causes of depression is a lack of self-discipline and willpower" and "psychological therapy tends to be unsuccessful with people who are depressed" (more men than women agreeing with both).

Only 10% of medical professionals agreed that "there is little to be offered to depressed patients who do not respond to initial treatments." This statement was the only one with the most variation across sex and country. 16% of men and 7% of women agreed with this. 18.4%, 8.5%, and 3.3% of health professionals in Argentina, Chile, and Venezuela agreed with this statement. About 6–10% of surveyed people agreed that "once a person has made up their mind about taking their own life, no one can stop them" and that "becoming depressed is a natural part of being old" (12% of Argentinians agreed to this in comparison to 3.6% and 1.3% of Chilean and Venezuelan medical providers). About 3% believed that getting depressed is part of being an adolescent, although there are many differences by sex and country. More males and more Argentinians agree with that statement. Finally, about 1% agreed that "antidepressant therapy tends to be unsuccessful with people who are

Table 1
Descriptive Statistics (percentage) of the Overall Sample, and separated by Sex and Country.

Variable	Overall	Sex		p value	Country			p-value
		Male	Female		Argentina	Chile	Venezuela	
Sex								0.000***
Female	65.1%	–	–		52.5%	68.7%	74.6%	
Male	34.9%	–	–		47.5%	31.3%	25.4%	
Country				0.000***				
Argentina	34.0%	46.2%	27.4%		–	–	–	
Chile	33.9%	30.4%	35.7%		–	–	–	
Venezuela	32.2%	23.4%	36.9%		–	–	–	
Medical Specialty				0.286				0.000***
General Practitioner	42.7%	39.0%	44.7%		33.2%	55.0%	39.8%	
Anesthesiologist	5.8%	6.3%	5.6%		8.4%	2.6%	6.6%	
Surgeon	7.4%	7.7%	7.2%		7.4%	5.7%	9.1%	
Gynecologist/Obstetrician	3.7%	4.9%	3.0%		5.3%	1.7%	4.0%	
Internal Medicine Doctor	4.3%	5.1%	3.9%		4.1%	3.8%	5.0%	
Family Medicine Doctor	12.3%	13.5%	11.7%		17.7%	8.6%	10.6%	
Pediatrician	4.2%	3.9%	4.4%		5.3%	2.2%	5.3%	
Psychologist	5.3%	6.0%	4.9%		9.1%	1.2%	5.5%	
Psychiatrist	7.8%	7.2%	8.1%		4.3%	13.4%	5.5%	
Traumatologist	4.5%	5.3%	4.0%		4.8%	5.0%	3.5%	
Other	2.1%	1.2%	2.6%		0.7%	0.7%	5.0%	
Work Area				0.000***				0.000***
Urban	69.0%	62.7%	72.5%		57.3%	75.4%	74.8%	
Rural	16.9%	25.3%	12.5%		28.2%	12.4%	9.8%	
Both	14.0%	12.1%	15.1%		14.6%	12.2%	15.4%	
Previous training in depression				0.967				1.000
Yes	37.3%	37.4%	37.2%		37.2%	37.3%	37.3%	
No	62.7%	62.6%	62.8%		62.8%	62.7%	62.7%	
Sample size	1234	803	431		419	418	397	

Note: In this table, the sum of the categories of each variable will add up to 100%. p values for comparison between sex and country percentages using chi-square. +p < .1; *p < .05; **p < .01; ***p < .001.

Table 2

Descriptive Statistics (percentage) of the Spanish validated version of the revised depression attitude questionnaire (R-DAQ) items overall and separated by Sex and Country.

SR-DAQ Item (Agreement)	Overall	Sex			Country			
		Male	Female	p value	Argentina	Chile	Venezuela	p-value
1. I feel comfortable in dealing with depressed patients' needs	37.5%	37.4%	37.6%	0.930	35.6%	40.7%	36.3%	0.257
2. Depression is a disease like any other (e.g., asthma, diabetes)	74.6%	72.2%	75.8%	0.157	72.6%	74.7%	76.3%	0.458
3. Psychological therapy tends to be unsuccessful with people who are depressed	15.2%	17.6%	13.8%	0.075+	16.5%	10.5%	18.6%	0.004**
4. Antidepressant therapy tends to be unsuccessful with people who are depressed	1.0%	1.4%	0.7%	0.271	0.7%	0.7%	1.5%	0.414
5. One of the main causes of depression is a lack of self-discipline and will-power	16.9%	21.1%	14.7%	0.004**	21.7%	16.3%	12.6%	0.002**
6. Depression treatments medicalise unhappiness	28.6%	39.4%	22.8%	0.000***	46.1%	23.0%	16.1%	0.000***
7. I feel confident in assessing depression in patients	45.1%	49.2%	43.0%	0.036*	45.4%	44.7%	45.3%	0.980
8. I am more comfortable working with physical illness than with mental illnesses like depression	70.3%	66.1%	72.6%	0.018*	59.9%	77.0%	74.3%	0.000***
9. Becoming depressed is a natural part of being old	5.8%	9.5%	3.7%	0.000***	12.2%	3.6%	1.3%	0.000***
10. All health professionals should have skills in recognising and managing depression	88.3%	85.2%	90.0%	0.011*	81.8%	94.7%	87.4%	0.000***
11. My profession is well placed to assist patients with depression	41.2%	40.6%	41.5%	0.011*	41.1%	44.5%	37.8%	0.000***
12. Becoming depressed is a way that people with poor stamina deal with life difficulties	26.7%	34.8%	22.3%	0.768	36.0%	23.2%	20.4%	0.150
13. Once a person has made up their mind about taking their own life no one can stop them	6.7%	7.7%	6.1%	0.000***	5.7%	4.1%	10.3%	0.000***
14. People with depression have care needs similar to other medical conditions like diabetes,	70.2%	62.4%	74.4%	0.296	56.8%	83.3%	70.5%	0.001**
15. My profession is well trained to assist patients with depression	28.6%	31.8%	26.9%	0.000***	34.1%	24.6%	27.0%	0.000***
16. Recognising and managing depression is often an important part of managing other health problems	81.0%	73.6%	84.9%	0.070+	64.2%	93.3%	85.6%	0.007**
17. I feel confident in assessing suicide risk in patients presenting with depression	32.5%	33.9%	31.8%	0.000***	40.1%	25.8%	31.5%	0.000***
18. Depression reflects a response which is not amenable to change	6.64%	7.66%	6.11%	0.449	5.73%	4.07%	10.33%	0.000***
19. It is rewarding to spend time looking after depressed patients	38.2%	39.7%	37.4%	0.425	34.1%	36.6%	44.1%	0.010*
20. Becoming depressed is a natural part of adolescence	3.2%	5.3%	2.0%	0.001**	6.9%	1.0%	1.5%	0.000***
21. There is little to be offered to depressed patients who do not respond to initial treatments	10.3%	16.0%	7.2%	0.000***	18.4%	8.5%	3.3%	0.000***
22. Anyone can suffer from depression	92.2%	89.6%	93.7%	0.011*	90.2%	93.1%	93.5%	0.165
Cronbach's alpha	0.87	0.88	0.89		0.91	0.88	0.87	
Sample size	1234	803	431		419	418	397	

Note: Each item represents the percentage of the specific sample that agrees with the item in the questionnaire in the specific specified sample. p values for comparison between sex and country percentages using chi-square. +p < .1; *p < .05; **p < .01; ***p < .001.

depressed" with no significant country or sex differences.

In conclusion, three main trends align with the results. The first is that health professionals recognize depression as a disease on the same level as other physical diseases. The second trend is that they know it is a disease that needs to be addressed and that pharmacotherapy can help. However, on average, they are unsure how to manage it or how to help their patients deal with it. Third, Argentinians and male providers overall seem more prone to agree that depression is part of natural processes of life course.

3.3. SR-DAQ descriptive results (by collapsed medical specialties)

While it is essential to understand the attitudes of healthcare professionals overall, the inclusion of mental health professionals like psychologists and psychiatrists can distort the results as these professions value this issue more. In Table 3, we examine attitudes separately for surgical, non-surgical, and mental health professionals.

The results from Table 3 reveal these specific trends. There is more belief of depression as a "real disease" from mental health professionals. For example, 100% agree that anyone can suffer from depression, that depression is like another physical disease, and that depression management helps manage other health problems. There are also the most confident when treating depression. In the middle point, we have non-surgical health professionals. For example, 70% of them agree that people with depression have care needs similar to other medical conditions like diabetes. Also, one-quarter of them agrees that becoming depressed is a way that people with poor stamina deal with life difficulties (in comparison to half of the surgical ones and none of the mental health ones). At the end of the spectrum, we have the surgical ones. They are the ones who are in most disbelief that depression is an actual disease

and agree the least on being capable of treating mental health diseases.

4. Discussion

Given the variability in the attitude towards depression among the health professionals shown worldwide and considering the increasing rates of the diagnosis of this condition, the realization of this research is justified insofar as it reveals healthcare providers' perspectives on depression in Latin America (World Health Organization, 2022).

The results show four main takeaways to take into consideration. The first is that health professionals generally recognize depression as a disease on the same level as other physical diseases. The second trend is that they know it is a disease that must be treated, and that pharmacotherapy can help. On average, they do not know how to deal with it or help their patients. Now, more specifically, health providers from Argentina and male providers, in general, seem more likely to agree that depression is normal as someone grows up. The fourth trend is that it is noticeable that mental health practitioners know how to deal the best with depression and think it is intertwined with other physical diseases. The non-surgical professionals recognize both phenomena but not to the same extent. Surgical professionals are the least likely to agree to know about depression. Based on this premise, the findings of this study show that most respondents (90%) perceive depression as a disease that anyone can suffer from; as a result, most respondents also agreed that all health professionals should be trained in recognising and managing it (70%). However, the results show that a quarter of the participants considered either the medical treatment (28.6%) or the psychosocial approach (<20%) unsuccessful in people with depression. These findings are consistent with several evaluations of Latin American mental health services, which report that stigma, including physicians' beliefs

Table 3
Descriptive Statistics (percentage) of the Spanish validated version of the revised depression attitude questionnaire (R-DAQ) items overall and separated collapsed medical specialty.

SR DAQ Item (Agreement)	Overall	Collapsed medical specialty			p-value
		Non-surgical	Surgical	Mental Health	
1. I feel comfortable in dealing with depressed patients' needs	37.5%	31.84%	10.50%	98.76%	0.000***
2. Depression is a disease like any other (e.g., asthma, diabetes)	74.6%	32.99%	8.00%	100.00%	0.000***
3. Psychological therapy tends to be unsuccessful with people who are depressed	15.2%	74.23%	55.50%	14.29%	0.715
4. Antidepressant therapy tends to be unsuccessful with people who are depressed	1.0%	14.89%	17.00%	0.00%	0.396
5. One of the main causes of depression is a lack of self-discipline and will-power	16.9%	1.15%	1.00%	0.00%	0.000***
6. Depression treatments medicalise unhappiness	28.6%	20.27%	16.00%	1.24%	0.000***
7. I feel confident in assessing depression in patients	45.1%	27.61%	55.00%	100.00%	0.000***
8. I am more comfortable working with physical illness than with mental illnesses like depression	70.3%	42.84%	11.00%	1.24%	0.004**
9. Becoming depressed is a natural part of being old	5.8%	77.89%	93.00%	1.24%	0.000***
10. All health professionals should have skills in recognising and managing depression	88.3%	7.10%	3.50%	98.14%	0.000***
11. My profession is well placed to assist patients with depression	41.2%	91.18%	68.00%	99.38%	0.000***
12. Becoming depressed is a way that people with poor stamina deal with life difficulties	26.7%	38.49%	6.00%	0.00%	0.000***
13. Once a person has made up their mind about taking their own life no one can stop them	6.7%	25.77%	52.00%	0.00%	0.000***
14. People with depression have care needs similar to other medical conditions like diabetes,	70.2%	8.25%	5.00%	97.52%	0.000***
15. My profession is well trained to assist	28.6%	71.82%	41.00%	99.38%	0.000***

Table 3 (continued)

SR DAQ Item (Agreement)	Overall	Collapsed medical specialty			p-value
		Non-surgical	Surgical	Mental Health	
patients with depression					
16. Recognising and managing depression is often an important part of managing other health problems	81.0%	21.19%	4.00%	100.00%	0.000***
17. I feel confident in assessing suicide risk in patients presenting with depression	32.5%	83.85%	53.00%	99.38%	0.000***
18. Depression reflects a response which is not amenable to change	6.64%	26.58%	4.50%	97.52%	0.000***
19. It is rewarding to spend time looking after depressed patients	38.2%	33.68%	10.00%	1.24%	0.010*
20. Becoming depressed is a natural part of adolescence	3.2%	4.01%	1.00%	0.00%	0.030*
21. There is little to be offered to depressed patients who do not respond to initial treatments	10.3%	12.37%	9.50%	100.00%	0.000***
22. Anyone can suffer from depression	92.2%	94.73%	75.00%	98.76%	0.000***
Sample size	1234	873	200	161	

Note: Each item represents the percentage of the specific sample that agrees with the item in the questionnaire in the specific specified sample. p values for comparison between medical specialty groups percentages using chi-square. +p < .1; *p < .05; **p < .01; ***p < .001.

and attitudes toward depression, remains an essential barrier because it often sets the stage for how they interact with, provides opportunities for, and support patients with depression (Caldas de Almeida & Horvitz-Lennon, 2010; Mascayano et al., 2016).

Between 6 and 10% of the surveyed people agreed that once a person decides to commit suicide, no one can stop them, being this the feature the most variation across gender and country. These results are similar to a study published by the CDC in 2012 across the United States, showing that fewer of the surveyed adults (>80%), health professionals or not, disagreed that treatment can help people living with mental illness lead normal lives (Behavioral Healthcare Executive, 2012).

When we compare these findings to other studies that have looked at depression attitudes worldwide, we can see some similarities. According to a survey (n = 4011) conducted by Coppens et al. (2013) in four European countries (Germany, Hungary, Ireland, and Portugal), respondents had a moderate level of personal stigma toward depression, which is often perceived as a sign of personal weakness. Furthermore, only half of those polled thought professional assistance was valuable. On the other hand, another study conducted by Dowrick et al. (2000) in the UK shows a clear preference for psychotherapy and belief in successful treatment.

Meanwhile, a cross-sectional survey (n = 700) of non-psychiatrist medical practitioners in Pakistan shows that attitudes toward depression are even less favorable than among Europeans, with the belief that depression is caused by a lack of stamina and willpower and is a natural part of aging (Haddad et al., 2015). Primary healthcare workers in Tanzania and Cameroon had similar findings (Mbatia et al., 2009; Mulango et al., 2018).

Furthermore, a nationwide online survey ($n = 760$) conducted by UK medical students to examine their attitudes toward patients with five conditions revealed that Chinese and South Asian students had more stigmatizing attitudes toward mental illness than their British counterparts (Korszun et al., 2012). These attitudes in medical students may persist in the future, creating a paradigm in which the attention provided to patients suffering from depression is frequently insufficient and delayed.

Most professionals from the survey we conducted responded that they are more at ease dealing with physical illness than mental illness (70%). In comparison, a study conducted in Japan ($n = 367$) discovered that all non-psychiatric doctors interviewed ($n = 187$) believe that depression care is beyond the scope of their practice and that they are not comfortable dealing with the needs of depressed patients; thus, depression should be treated by psychiatrists (Ohtsuki et al., 2012).

Similarly, other studies in Latin America confirm that, even when general practitioners recognize depression as a disease, they believe they lack the knowledge to treat it, and those with more stigmas prefer to refer patients with depression to a psychiatrist (Suarez Richards, 2009; Vistorte et al., 2018).

Among the surveyed people, a significant percentage of healthcare workers present stigmatized attitudes towards patients with depression. These attitudes can be a significant barrier preventing patients from receiving the treatment they need. Therefore, health professionals should be better prepared with training and information to treat depression and other mental illnesses. This is a friendlier, unbiased way to address the high prevalence of mental disorders in primary care and community settings.

4.1. Limitations and further research

First, we could not assess perceived supernatural causes of depression, which appear to be one of the most critical determinants of culture and nationality differences (Hagmayer & Engelmann, 2014). Second, because the evaluation was conducted online, there could be sampling and recall bias.

Third, using a sample from just three countries may not represent what is indeed occurring in the whole Latin American region even when the country selection tried to capture different realities. Finally, even when this survey was directed to healthcare professionals, there is no way we could certify this rule was followed due to the type of data collection.

In order to address these issues, future research regarding attitudes toward depression in Latin America must focus on increasing the sample size and the number of countries participating in the study. New studies may also need to consider that magical/religious beliefs may account for some of the variability in the attitudes toward depression in Latin America. Thus, a proper way to measure these attitudes must be ensured.

5. Conclusion

A total of 1234 physicians from Argentina, Chile, and Venezuela were evaluated to explore their attitudes towards depression. Doctors generally realize the importance of recognising and managing depression. However, only slightly less than a third of the population evaluated feels safe managing it. Less than half of the healthcare professionals surveyed have received training for managing this illness. There was a general preference for the management of physical illness over the management of mental illness, as well as mistrust in the management of suicidal ideation. Depression is now more accepted as a normal part of life by men and Argentinian health care providers. Mental health practitioners know how to treat depression best and believe it is linked to other physical ailments, different from non-surgical and surgical professionals. The latter is the least likely to recognize depression as an actual disease.

According to the findings of this study, it is necessary to work on improving attitudes toward this disease and preparing health professionals of all specialties. In line with this, it would be beneficial to include high-quality mental health courses in all professionals' annual training and periodic evaluations of hospital mental health performance. To raise awareness about illnesses such as depression, it is also critical to promote a mental health week and include non-medical specialties in treating mental illnesses. These strategies could help develop a better healthcare system by reducing stigma and improving overall performance, increasing professionals' confidence in assessing and diagnosing depression, and improving the level of care for patients suffering from this disease.

Consent for publication

Not applicable.

Availability of data and material

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Funding

This work was funded by the authors.

Ethics review

This study was performed in compliance with the World Medical Association Declaration of Helsinki on Ethical and was approved by the ethics committee: Comité de ética e Investigación en Seres Humanos (CEISH), Guayaquil-Ecuador (#HCK-CEISH-18-0060).

Author statement

GCL conceptualized the paper, wrote, and reviewed the manuscript, and contributed to the methodology. MFH was a major contributor in data analysis, methodology, and reviewing of the draft. KC was a major contributor to writing and reviewing the draft. IDH, RA, KR, JC, and MB worked on the methodology, presentation of findings, and contributed to writing the draft. HM worked on the revision of the manuscript. ICO was the supervisor of the project and was a major contributor to the methodology and writing the manuscript.

Declaration of competing interest

The authors declare that they have no competing interests related to this work.

Acknowledgements

We would like to thank Dr. Evana Pina and Dr. Rey Varela for their assistance during the data collection process. We would also like to thank Dr. Jesus Guarecuco and Dr. Freddy Pachano Arenas for their ongoing assistance with our research. Finally, we acknowledge assistance provided by the Population Research Institute at Penn State University, which is supported by an infrastructure grant from NICHD (P2CHD041025).

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