



CONFIDENCE OF PRIMARY CARE PHYSICIANS IN DIAGNOSING AND TREATING MENTAL HEALTH DISORDERS”

Dr Fatima¹, Dr Aziz Muhammad², Dr Ala Orakzai³, Dr Osama Akhtar⁴, Dr Muhammad Aamir Khan⁵

¹Senior Registrar, Jinnah Medical College & Jinnah Teaching Hospital, Peshawar

²Assistant Professor of Psychiatry, KMC/ KTH Peshawar

^{3,4,5}Postgraduate Resident, Hayatabad Medical Complex, Peshawar

Corresponding Author: Dr Aziz Muhammad,

Email: azizms83@gmail.com

ABSTRACT

Background: Mental health disorders are highly likely to be met within the primary care setting, hence the primary care physician is at the center of diagnosing and treating. Nonetheless, confidence differences can have an impact on early detection and proper care.

Objective: To determine the confidence of primary care physicians in the diagnosis and treatment of mental health disorders and to determine factors that affect this confidence.

Materials and Methods: The study was a cross-sectional study among primary care physicians in Jinnah Medical College & Jinnah Teaching Hospital, Peshawar from March, 2025 to August, 2025. A structured, self-administered questionnaire that measured diagnostic, treatment, and referral confidence was used to collect data. Descriptive and inferential statistics were conducted.

Results: Physicians also indicated moderate confidence and greater confidence in symptom recognition and referral decisions. The decreased confidence was in psychosocial management and diagnostic certainty. Mental health training before the program was of great importance in increasing levels of confidence.

Conclusion: Primary care doctors often treat mental illnesses, but have significant confidence issues. Training and supportive systems should be focused on fortifying mental health care in primary practice.

Keywords: *Primary care physicians, mental health disorders, diagnostic confidence, treatment confidence, Pakistan*

INTRODUCTION

Mental health conditions form a major and growing disease burden in the globe and primary care facilities are initial point of contact to majority of the affected individuals. The initial point of identification, diagnosis and treatment of wide variety of mental health conditions, such as depression, anxiety, and stress disorders, is usually done by primary care physicians (PCPs). However, it has been pointed out that the perceived competence of the physicians to assess and manage mental health problems vary widely, which is often based on the exposure to training, clinical experience and the perceived role limits. The doubting nature of mental health assessment and judgement in assessing the symptoms, particularly when it is complicated or comorbid with physical conditions, and

competencies in first-line medical practice should be strengthened has also been revealed by the recent literature on self-reported confidence of foundation doctors (1).

Efficient diagnosis of mental illnesses during the primary care has been a long-standing issue, especially during the initial stages of communication when the symptoms might be quite subtle or difficult to pinpoint. Such comparisons of the tools aided with artificial intelligence with the primary care clinicians have shown that even well-experienced clinicians are not always able to identify depression and its determinants at the beginning of the treatment, which illustrates the inconsistency of the diagnostic process and the lack of confidence (2). However, despite these difficulties, primary care does play an important role in the delivery of behavioral health care which constitutes a significant part of the mental health care delivery in the world. Cross-sectional evidence shows that much of mental health care is delivered via primary care as opposed to specialists and this supports the idea that physician preparedness and competence successfully deliver care to such patients (3).

Mental disorders are also prone to be linked to chronic physical disorders, therefore normal practice makes it hard to diagnose and treat. According to the primary care population studies, it has revealed that the mental health burden is high in the non-psychiatric patients who are more likely to seek dermatological conditions where psychological difficulty is not significantly valued. This comorbidity has more diagnostic and treatment challenges to the primary care physician with whom there is a need to negotiate somatic and mental care and limited consultation time (4). Moreover, the mental health stigma anchoring on cultural beliefs and societal norms remains a major impediment to the effective treatment of psychiatric patients, which impacts the disclosure process of patients and the relationship of physicians across cultural contexts (5).

The artificial intelligence and machine learning are some of the advances that have been proposed to be used as clinical decision making support in mental health care. Integrative reviews observe that AI-based decision-support systems have the potential to assist physicians in screening, diagnosing and planning their treatment which can enhance clinical confidence in the appropriate environment (6). Nevertheless, the stigma of mental illness question remains quite entrenched in the majority of primary care facilities, as it affects not only the patients but also the medical professionals themselves. The findings of multi-country qualitative studies indicate that medical workers may possess implicit stigmatization attitudes, which influence diagnostic vigilance, referral behavior, and therapeutic contact, and therefore, confidence and quality of care (7).

The use of such technology-enabled diagnostic tools has been demonstrated to work in other fields of primary care, such as teledermatology, where AI-based systems were found to be more diagnostic and helpful to clinicians. The results suggest that more related innovations would contribute to the increased trust in the mental health diagnosis and management, as long as these are integrated into the clinical procedures in a responsible way (8). At the same time, the use of specialized training, e.g., suicide prevention programs, showed that formal education produces a significant positive effect on the sense of competence and confidence of the primary healthcare professional, in particular in the case of high-risk mental health situations (9).

Psychological well-being is also directly linked to the rest of the sociocultural factors, including body image, self-esteem, and exposure to social media, which is likely to be introduced during the primary care consultation. The literature reviews emphasizing on these dimensions point to the growing psychological complexity with which physicians are faced, hence justifying the need to rely on the holistic assessment of mental health (10). Other types of educational interventions such as high-fidelity simulation training have also been found to have positive outcomes such as anxiety relief and confidence development among medical trainees, which leads to prospects of effective forms of establishing mental health competency into the primary care educational process (11).

The common presenting complaints using primary care include fatigue and they usually have a multifactorial etiology which includes psychological factors. It has been established that failure to determine factors that can lead to mental health disorders can lead to misdiagnosis and lack of proper treatment, thus the capability of the physicians to differentiate between physical and psychological causes (12). In addition, psychosocial impact of severe mental illness is prolonged to caregivers, the

quality of life and burden of care which must be addressed by primary care physicians on a regular basis in the form of counseling and care coordination (13).

Specialized training programs have been proved to increase practice-based behavior and self-efficacy among physicians in treating some mental disorders such as autism spectrum disorders (14). Another advantage of continuity of care in family medicine is that continuity of care facilitates the relationship between patients and physicians, which facilitates trust, improved communication and increased confidence to talk openly about sensitive mental health concerns with time (15). However, there is always a problem with such phenomena as diagnostic overshadowing, when the impact of physical symptoms is mistakenly seen because of the existence of mental ill health, and it means that the primary care practice needs to be more confident and aware of diagnoses (16).

The outcomes of the mishandling of the mental health do not pertain to the sphere of psychiatry alone due to the fact that preexisting mental issues are associated with the increased adverse outcomes during medical and surgical cases. Diagnoses of mental health are linked to a higher rate of complication and readmission, and this fact presents the systemic importance of appropriate recognition and treatment in the primary care (17). The systematic reviews of training interventions in South and South-East Asia also indicate that training programs significantly influence the detection and management competencies of the healthcare workers, which is why such interventions that encourage the confidence in the environment of the South-Eastern region, such as in Pakistan, should be prioritized (18). Nevertheless, provision of adequate somatic and mental health care to severely mentally ill individuals is still marred by cogent barriers that include disrupted services, insufficient training and structural stigma that highlights the need to evaluate and improve trust of primary care physicians in such a crucial field.

Objective: To determine the confidence that primary care physicians have in the diagnosis and treatment of mental health conditions and determine training, systemic, and contextual variables that may impact clinical decision-making in a tertiary care hospital in Pakistan.

MATERIALS AND METHODS

Study Setting: The study was conducted at Jinnah Medical College & Jinnah Teaching Hospital, Peshawar.

STUDY DESIGN: A cross-sectional descriptive study design was used.

Study Duration: From March, 2025 to August, 2025.

Inclusion Criteria

The involved physicians were primarily caregivers and physicians in outpatient care who were actively involved and willing to participate in the program of primary care.

Exclusion Criteria

Doctors who only practiced psychiatry, who were not directly engaged in the treatment of patients, and those who were not willing to give consent were filtered out.

Methods

The structured self-administered questionnaire was used to collect the data in both printed and electronic formats. The instrument measured physicians' confidence to diagnose and treat common mental health conditions, such as depression, anxiety, and stress-related conditions, through a five-point Likert scale of very low confidence to very high confidence. Demographic variables, years of clinical experience, previous mental health training, and experience with mental health cases in regular practice were also recorded through the questionnaire. Senior family medicine faculty reviewed the content in order to ensure content validity and pilot-tested it to determine the clarity and reliability of the material. The sample consisted of participants recruited via convenience sampling, and completed questionnaires were filled out voluntarily during working hours. The data were analyzed using Statistical Package of the Social Sciences (SPSS) version 26. The characteristics of

the physicians and confidence level were summarized using descriptive statistics, and inferential tests were conducted to examine the relationship between confidence and some explanatory variables.

Results

The study involved **162 primary care physicians**, and its response rate was 81%. The overall age of the respondents was 34.7 ± 6.2 years (with a range of 26-55 years old). The sample was made up of male physicians, 58.6% ($n = 95$), and female physicians, 41.4% ($n = 67$). Regarding professional experience, 46.3% of the respondents had less than five years of clinical practice, 34.6% five-to-ten years of clinical practice, and 19.1% greater than ten years of clinical practice. Almost two-thirds of respondents (63.6% said they met patients with mental health issues at least once a week, indicating the high load of mental health care in primary care settings.

Table 1 presents the baseline demographic and professional characteristics of the study participants. **Table 1. Demographic and Professional Characteristics of Participants (n = 162)**

Variable	Category	n (%)
Gender	Male	95 (58.6)
	Female	67 (41.4)
Years of Experience	< 5 years	75 (46.3)
	5–10 years	56 (34.6)
	> 10 years	31 (19.1)
Prior Mental Health Training	Yes	68 (42.0)
	No	94 (58.0)

In terms of self-assuredness, doctors showed inconsistency in their judgment over the different areas related to mental health. 48.1% of doctors said that their ability to identify mental health symptoms was very high or high, and 31.5% gave a score of medium. Meanwhile, the ability to diagnose accurately was rated much lower, with just 29.6% of doctors saying they were very sure and 22.2% who were not sure at all. On the other hand, 34.0% reported high confidence in the area of starting medication, and only 22.2% confirmed being low confident when it came to the area of providing counseling or psychosocial support. The referral confidence was also relatively high, with 61.7%, up to two-thirds of physicians, saying that they were at least somewhat confident in spotting those cases that needed specialists' attention.

Table 2. Self-Perceived Confidence in Mental Health Care (n = 162)

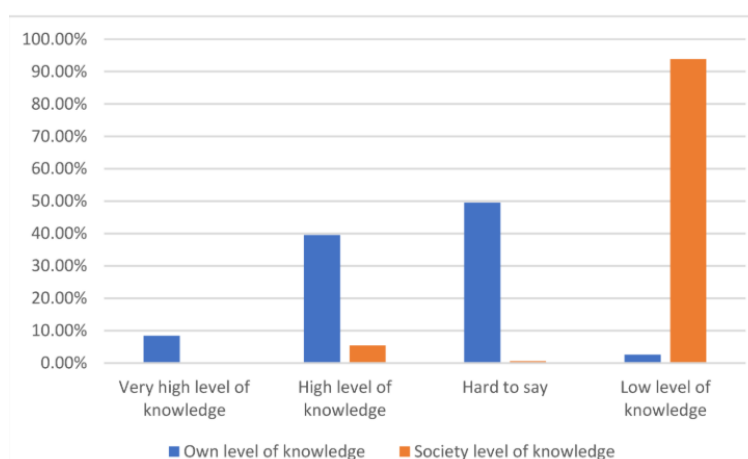
Domain	Low (%)	Moderate (%)	High (%)
Symptom recognition	20.4	31.5	48.1
Diagnostic confidence	22.2	48.2	29.6
Pharmacological treatment	26.0	40.0	34.0
Counseling/psychosocial care	44.4	36.4	19.2
Referral decision-making	15.4	46.9	37.7

The analysis of confidence levels concerning the previous mental health training revealed a distinct pattern. The medical practitioners who had taken formal mental health training showed drastically greater self-assurance in the diagnosis and treatment than those without such a background. Among the trained doctors, 45.6% said they had high confidence in diagnosing, while only 18.1% of the untrained ones did. Likewise, the percentage of high-confidence doctors who would start treatment was 47.1% for trained and 24.5% for untrained physicians as well.

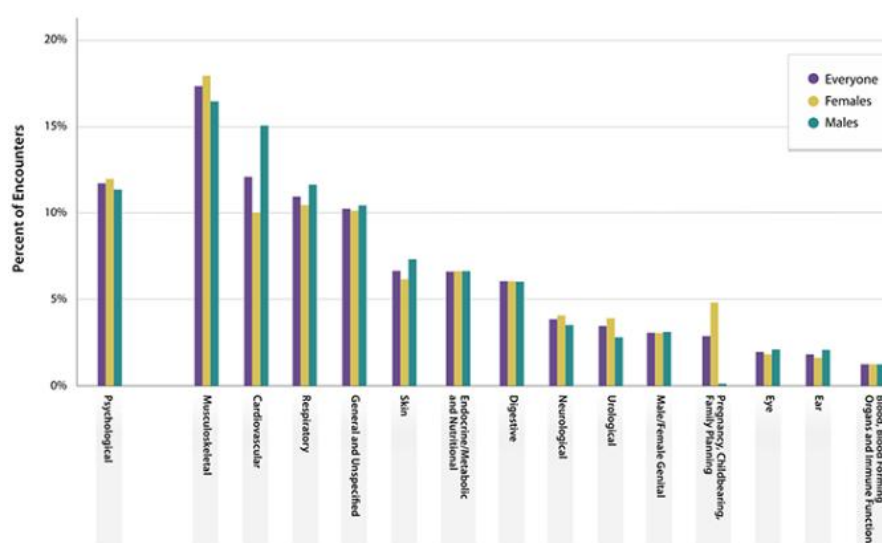
Table 3. Association Between Mental Health Training and High Confidence

Confidence Domain	Trained (%)	Untrained (%)
Diagnostic confidence	45.6	18.1
Treatment confidence	47.1	24.5
Referral confidence	52.9	26.6

The proportion of physicians reporting low, moderate, and high confidence in diagnosing and treating mental health disorders is shown in **Figure 1** for the purpose of depicting overall confidence distribution visually. The figure suggests that moderate confidence is the most common, whereas high confidence is quite rare, especially in counseling-related areas.



The overall findings suggest that, despite the fact that general practitioners predominantly handle cases with mental ailments, significant discrepancies still exist regarding the doctors' diagnostic and treatment confidence, especially in the area of psychotherapy. A doctor with previous formal mental health training have a better confidence level than one without, and thus it becomes evident that continuous professional education in this area is a necessity.



Discussion

As the findings of the present study demonstrate, there exist high gaps in the way primary care doctors are assured in diagnosing and treating mental health disorders, despite their prevalence being

extremely high in the daily clinical setting. The majority of the physicians have reported that they have been interacting with mentally ill patients quite often, however, the confidence in different aspects of care varied considerably. The mismatch of this gap indicates a historical problem of primary care where physicians are put in a position to be the first point of intake as far as mental care is concerned and that they are typically inadequately prepared to satisfy this need. The same tendency has been observed in recent studies when clinicians reported having greater confidence in symptom identification than definite diagnosis and creation of a comprehensive treatment plan which proves that the awareness is not always converted to clinical confidence (1).

The credibility of the decision-making in the diagnosis was observed to be among the weak points of the provided study. The finding conforms to the earlier research studies with findings revealing discrepancy and uncertainty between primary care physicians in making diagnoses of mental health conditions especially in the early stages of treatment or where the conditions resemble physical ones (2). The time factor, as well as the opposing clinical priorities within the primary care setting where the individuals with the mental disorders should be diagnosed equally to the chronic non-mental illnesses, complicates the lack of the diagnostic clarity as well. It has been suggested that primary care has a major stake in the behavioral health services but there are systemic limitations which still limit the optimum diagnostic confidence and consistency (3).

The loss of faith in counseling and psychosocial management also fits the literature. Low levels of training and role boundary among the primary care physicians are often reported against the provision of non-pharmacological mental health interventions. The studies that have given attention to comorbid mental health conditions among patients in primary care, including those with long term dermatological conditions, have indicated that psychological distress has not been identified and appropriately managed partly due to lack of certainty and expertise by the clinicians (4). This difference is particularly concerning under the conditions of heightened attention to the models of holistic and patient-centered care.

The cultural and societal factors also influence the confidence of the physicians to mental health care. Most healthcare settings, including South Asian, have the stigma of mental health that influences the level of disclosures that the patients make and their relationships with the physicians. Already, narrative and qualitative reviews have determined stigma to result in the discomfort with the delivery of mental health symptomatology, lack of willing to formally identify conditions, and lack of willingness to initiate treatment (5). The responses of the multi-country study affirm that stigmatizing attitudes are not unique with the other healthcare providers and might be implicitly influencing the confidence and the clinical decision-making of the primary care setting (7).

The possibility of the technology to enhance the confidence of the physician is worth considering. It has been established that the creation of decision support systems, which are based on artificial intelligence, can be potentially helpful to allow clinicians to assist with the screening and diagnostic process in mental health care (6). Such experience in other areas, such as AI-assisted dermatological diagnosis, suggests that assistive technologies may increase the accuracy of the diagnosis and the confidence of clinicians in the outcomes, provided that they are used appropriately (8). Even though these tools are not supposed to replace clinical judgment, they may be used during primary care and could be used to solve the problem of uncertainty and help less experienced doctors.

Training and education proved to be such characteristics of confidence in this research and this is strongly supported by the literature. Physicians who reported having undergone some prior mental health training reflected a much higher degree of confidence with diagnosis and treatment. Similar gains have been reported in the post-suicide prevention and focal mental health training which have increased self-perceived competence among primary healthcare professionals (9). The use of the method of experiential learning has also proved to be effective in anxiety reduction and confidence in medical trainees that undergo an educational intervention, which utilizes methods of simulation-based learning, suggesting the possibility of a particular method of learning, which is based on the principles of experiential learning, being particularly helpful (11).

The more expansive psychosocial setting to which patients are exposed also contributes to the further complication of mental health care in the primary care setting. Issues related to body image, self-

esteem, and social media gain even greater topicality as the factors of psychological trauma during the consultation process, and a physician must operate with complex psychosocial backgrounds (10). In the meantime, the non-specific symptoms would be mixed up with the underlying mental health states, which creates a chance of misdiagnosis in the case of clinicians who do not understand whether the use of psychological assessment should be done (12). These challenges justify the need to have more training where physicians will be equipped to detect and treat mental health issues that are concealed in a typical medical presentation.

Mental health issues not only impact on the patients themselves but also on the families and caregivers, who are almost invariably made to endure great psychological trauma and burden of care. Primary care physicians may play a key role in assisting these caregivers although the lack of confidence may act as a hindrance to successful interactions and teaching (13). Condition-specific educational programs, such as autism spectrum disorder-oriented educational programs, have been demonstrated to have a positive effect in physician self-efficacy and practice behavior, which confirms the relevance of condition-specific educational programs (14).

Continuity of care is another variable that might influence confidence. It is shown that the relationships between physicians and patients are developed over time, which leads to trust and increased communication as well as more open discussion of mental health concerns (15). Still, the existing risks of incorrect confidence and awareness in primary care practice are highlighted by other problems such as diagnostic overshadowing, reflecting physical symptoms by underlying mental illness, and so on (16). The overall effect of the improper handling of mental health problems, including the deterioration of outcomes in surgical and medical procedures also contribute to the need to identify these problems correctly and intervene during the primary care phase (17).

Finally, the works in South and South-East Asia indicate that educational and training campaigns that are well-structured contribute to the improvement of the capacity of healthcare professionals to recognize and respond to mental health challenges and this fact explains the relevance of the provided strategies in the Pakistani setting (18). The barriers that are at the systemic level, including the lack of full integration of mental and somatic care and fragmented services, continue to exist and interfere with confidence and access to the corresponding treatment. Overall, the findings of this study can be discussed as supplementary to the existing literature and the need to introduce certain training initiatives, supportive systems, and culturally sensitive practices that are to be utilized to ensure that primary care doctors become more comfortable when diagnosing and treating mental disorders.

Conclusion

This paper shows that primary care doctors often have to face patients with mental health issues, but in many aspects, their reliability in diagnosing and treating them is inconsistent and, in some fields, not optimal. Although the physicians demonstrated a relatively higher degree of confidence in the process of symptom identification and referral decision making, a significant disparity was observed in diagnostic certainty, counseling, and psychosocial management. The results are in line with the available literature that suggests that lack of training, stigma, and institutional barriers lead to the lack of confidence in primary care mental health practice. Notably, physicians who had received mental health training in the past demonstrated greater confidence in diagnostic and treatment-related fields, which is why education should be organized and structured. Enhancing the competence and confidence of physicians could be achieved through the strengthening of undergraduate and continuing medical education and involving mental health training in primary care practice, as well as in favorable clinical settings. These gaps are critical to tackling the issues of early detection, timely treatment, and quality in mental health care in primary healthcare systems.

References

1. Forrest LN, Waschbusch DA, Pearl AM, Bixler EO, Sinoway LI, Kraschnewski JL, Liao D, Saunders EF. Urban vs. rural differences in psychiatric diagnoses, symptom severity, and functioning in a psychiatric sample. *PLOS One*. 2023;18(10):e0286366.

2. Hung P, Probst JC, Shih Y, Ranganathan R, Brown MJ, Crouch E, Eberth JM. Rural–urban disparities in quality of inpatient psychiatric care. *Psychiatric Services*. 2023;74(5):446–454.
3. Sun CF, Correll CU, Trestman RL, Lin Y, Xie H, Hankey MS, Uymatiao RP, Patel RT, Metsutnan VL, McDaid EC, Saha A. Low availability, long wait times, and high geographic disparity of psychiatric outpatient care in the United States. *General Hospital Psychiatry*. 2023;84:12–17.
4. Maxwell JM, Coleman JR, Breen G, Vassos E. Association between genetic risk for psychiatric disorders and the probability of living in urban settings. *JAMA Psychiatry*. 2021;78(12):1355–1364.
5. Lankila T, Laatikainen T, Wikström K, Linna M, Antikainen H. Association of travel time with mental health service use in primary health care according to contact type: a register-based study in Kainuu, Finland. *BMC Health Services Research*. 2022;22(1):1458.
6. Yang LH, Phillips MR, Li X, Yu G, Grivel MM, Zhang J, Shi Q, Ding Z, Pang S, Susser E. Determinants of never-treated status in rural versus urban contexts for individuals with schizophrenia in China. *BMC Psychiatry*. 2022;22(1):128.
7. Kvello-Alme M, Bråthen G, White LR, Sando SB. Time to diagnosis in young-onset Alzheimer’s disease: a population-based study from central Norway. *Journal of Alzheimer’s Disease*. 2021;82(3):965–974.
8. Lin L, Zhang L, Kim HM, Frost MC. Impact of COVID-19 telehealth policy changes on buprenorphine treatment for opioid use disorder. *American Journal of Psychiatry*. 2022;179(10):740–747.
9. Newbury JB, Stewart R, Fisher HL, Beevers S, Dajnak D, Broadbent M, Pritchard M, Shiode N, Heslin M, Hammoud R, Hotopf M. Association between air pollution exposure and mental health service use among individuals with first presentations of psychotic and mood disorders. *British Journal of Psychiatry*. 2021;219(6):678–685.
10. Kaur A, Kallakuri S, Mukherjee A, Wahid SS, Kohrt BA, Thornicroft G, Maulik PK. Mental health-related stigma, service provision, and utilization in Northern India: a situational analysis. *International Journal of Mental Health Systems*. 2023;17(1):10.
11. Deng M, Zhai S, Ouyang X, Liu Z, Ross B. Factors influencing medication adherence among patients with severe mental disorders from the perspective of mental health professionals. *BMC Psychiatry*. 2022;22(1):22.
12. Raghavan R, Brown B, Horne F, Kumar S, Parameswaran U, Ali AB, Raghu A, Wilson A, Sviryzdenka N, Venkateswaran C, Kumar M. Stigma and mental health problems in an Indian context: perceptions of people with mental disorders in urban, rural, and tribal areas of Kerala. *International Journal of Social Psychiatry*. 2023;69(2):362–369.
13. Babicki M, Małacka M, Kowalski K, Bogudzińska B, Piotrowski P. Stigma levels toward psychiatric patients among medical students: a worldwide online survey across 65 countries. *Frontiers in Psychiatry*. 2021;12:798909.
14. Moulaei K, Sheikhtaheri A, Fatehi F, Shanbehzadeh M, Bahaadinbeigy K. Patients’ perspectives and preferences toward telemedicine versus in-person visits: a mixed-methods study. *BMC Medical Informatics and Decision Making*. 2023;23(1):261.
15. Kurdyak P, Gandhi S, Holder L, Rashid M, Saunders N, Chiu M, Guttmann A, Vigod S. Access to ambulatory mental health care prior to psychiatric emergency department visits among adults in Ontario. *JAMA Network Open*. 2021;4(4):e215902.
16. Fonseca Barbosa J, Gama Marques J. The revolving door phenomenon in severe psychiatric disorders: a systematic review. *International Journal of Social Psychiatry*. 2023;69(5):1075–1089.
17. Elsayed Ahmed B, Ibrahim Elmaleky M, Mahmoud Zaki M. Relationship between suicidal thoughts and positive symptoms among schizophrenic patients. *Journal of Nursing Science Benha University*. 2022;3(1):966–980.

18. Ghosh P, Balasundaram S, Sankaran A, Chandrasekaran V, Sarkar S, Choudhury S. Factors associated with medication non-adherence among patients with severe mental disorders. *Exploratory Research in Clinical and Social Pharmacy*. 2022;7:100178.