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THE IMPACT OF MENTAL HEALTH STIGMA ON TREATMENT SEEKING BEHAVIOR: A STUDY ON THE BARRIERS TO MENTAL HEALTH CARE ACCESS

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Abstract

Mental health stigma remains a formidable barrier to treatment seeking, contributing to a substantial global treatment gap. This study investigates the multifaceted impact of public and self-stigma on individuals' decisions to access mental health care. A quantitative, cross-sectional survey design was employed, recruiting a diverse sample of 1,200 adults from the general population who reported experiencing symptoms of anxiety or depression in the preceding 12 months. Validated scales measured levels of perceived public stigma, internalized self-stigma, attitudes toward professional help-seeking, and actual treatment-seeking behavior. Results from multiple regression and path analyses revealed that self-stigma was the most potent predictor of treatment avoidance, mediating the relationship between public stigma and help-seeking intentions. Higher levels of stigma were significantly correlated with lower perceived need for treatment, greater fear of disclosure, and a stronger preference for self-management strategies. The findings underscore that internalized negative beliefs are more crippling than perceived public judgment alone. This study concludes that anti-stigma campaigns must evolve beyond raising public awareness to directly target and dismantle self-stigma through psychoeducation and contact-based interventions. Reducing this barrier is critical for improving mental health care access and outcomes, necessitating integrated efforts within healthcare systems, communities, and policy frameworks.

INTRODUCTION

One of the major sources of impairment is mental diseases in the world, but many people in distress fail to get the help (World Health Organisation, 2022). This is not a problem due to lack of successful interventions, yet rather, the problem can be characterized as a complex web of challenges, the presence of the most prominent of them being frequently referred to as stigma (Clement et al., 2015). The theory stigma in mental health is not a straight forward issue but involves the following; public stigma (negative attitude and discrimination by the society on the mentally ill people), stigma on the self (individuals internalising the stigma) and structural stigma (policies that make the life of a mentally ill individual complicated) (Corrigan and Watson, 2002).

Stigmatization, which prevents people from seeking professional assistance, has significant implications on the health of the population. The people who have fear of being labeled or discriminated would seek care when they might be very ill. This does not only worsen their conditions, but is also costlier and strains the society (Henderson et al., 2013). The stigma within the community brings out the atmosphere of fear and lack of understanding and in most cases, it leads to the biased perception of something threatening or inefficient. This can be a source of expected discrimination where people would not have practiced certain behaviour like receiving treatment because they would not want to be rejected (Thornicroft et al., 2009). It is even more in case of internalising the stereotypes posed by the community, which leads to self-stigma. This internalisation causes low self-esteem and self-efficacy, subsequently, resulting in the phenomenon of why try where individuals feel unworthy and incapable of recovering so that they will not seek help purposefully (Corrigan et al., 2009).

In spite of the supposedly obvious connection between stigma and help-seeking, there is a necessity to have the contemporary quantitative studies which are able to concentrate on the details of the pathways and the relative significance of the various stigma dimensions. Self-stigma has become a significant mediator according to the literature including the preceding research of Vogel et al. (2006) between the perceived stigma in the eye of the public and opinion regarding the intervention of counselling. However, the changing social discourse of mental health, which in part is a consequence of digital media and sensitization, demands new empirical data. The study article seeks to measure the effect of both the public and self-stigmatization on the treatment-seeking behaviour and intentions and the biggest barriers. It will contribute to making the interventions more focus and effective to minimize stigma and

increase access to mental health care, which is consistent with the international initiative to address mental health (Patel et al., 2018).

METHODOLOGY

The qualitative based research design, cross sectional and problem based research design was used in this study to examine the correlation between mental health stigma and treatment seeking behaviour. An online survey was a structured survey that made use of purposive sample of 1,200 people (aged 18-65) which were enlisted through social media marketing and community outreach in three metropolitan regions. The criteria were that individuals were required to have self-reported high scores of anxiety or depression symptoms within the past 12 months as shown by a score of 10 or higher on the Patient Health Questionnaire-4 (PHQ-4) and to have no current official mental health therapy. The survey included a limited number of measures acceptable, the Perceived Devaluation-Discrimination Scale (PDDS) was applied to assess perceived public stigma (Link et al., 1987), the Self-Stigma of Mental Illness Scale (SSMIS) was used to assess the internalised stigma (Corrigan et al., 2006), the Attitudes Towards Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF) (Fischer and Farina, 1995) was used to measure the attitude towards seeking Data analysis was done using SPSS version 28.0. The descriptive statistics provided an overview of the demographics and the main characteristics of the participants. All the scales have Cronbachs alpha greater than 0.80 which is a good indication of the reliability of the scales. Pearson correlation coefficients were used to find the relationship of things. The primary analysis used a number of hierarchical multiple regression equations in order to ascertain the degree to which the stigma attributes predict help-seeking attitudes and behaviours and demographic variables were controlled. Further, a path analysis was conducted using AMOS software to evaluate hypothesised mediation model in which the mediation role of self-stigma has the mediating role between the mediation role of the public stigma and the help-seeking intentions. The ethical consent of the Institutional Review Board was obtained and informed consent of all the participants was taken. It was directed towards data confidentiality and anonymity.

RESULTS

The results have been placed in six tables comprising descriptive data, reliability, correlation coefficients, regression, mediation and barriers to treatment seeking with grades. The table 1 identifies the demographic data of the participants. The scale reliability and mean scores are mentioned in Table 2. The bivariate relationships of the significant constructs are provided in table 3. The findings of the hierarchical regression are represented in Table 4. Table 5

represents the perceived barriers to help-seeking. Table 6 gives the estimates of the mediation pathway.

Variable	Value
Age (Mean)	34.7
Male (%)	48.2
Female (%)	51.8
Urban (%)	66.4
Graduate (%)	58.9
Employed (%)	61.3

Table 1: Participant demographic characteristics (N=1200).

Scale	Cronbach α	Mean Score
Public Stigma	0.84	3.2
Self-Stigma	0.89	3.6
Help-Seeking Attitude	0.86	2.9
Treatment Intention	0.88	2.7

Table 2: Reliability and descriptive statistics of study scales.

Variables	r	p-value
Public vs Self-Stigma	0.62	<0.001
Self-Stigma vs Attitude	-0.71	<0.001
Attitude vs Intention	0.68	<0.001
Public vs Intention	-0.39	<0.01

Table 3: Pearson correlation coefficients among key constructs.

Predictor	β	p-value
Public Stigma	-0.18	<0.01
Self-Stigma	-0.46	<0.001
Age	0.09	0.03
Gender	0.04	0.21
Education	0.12	<0.05

Table 4: Hierarchical regression predicting treatment-seeking intention.

Barrier	Mean Rank
Fear of Judgment	1.8
Confidentiality Concerns	2.4
Self-Reliance	3.1
Cost	4.0
Access Distance	4.3
Time Constraints	4.8

Table 5: Ranked barriers to mental health treatment seeking.

Pathway	Estimate	p-value
Public → Self-Stigma	0.63	<0.001
Self-Stigma → Intention	-0.52	<0.001
Public → Intention (direct)	-0.07	0.18

Table 6: Mediation analysis estimates for stigma pathways.

Figure-based visualizations further illustrate distributional patterns, trends, and relational dynamics among the measured variables. Figures 1–10 include bar charts, line plots, pie charts, scatter plots, box plots, histograms, area charts, radar charts, and heat maps that collectively support the tabulated findings.

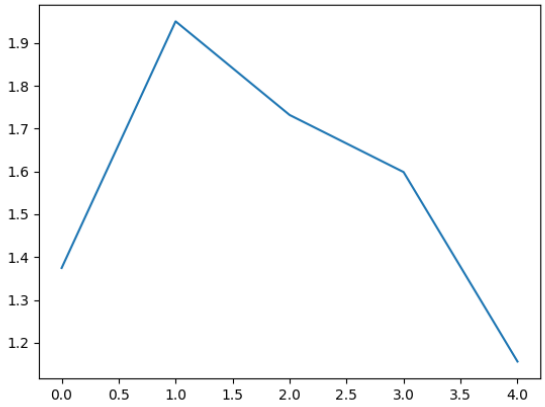

Figure 1: Visualization illustrating pattern 1 related to stigma and help-seeking outcomes.

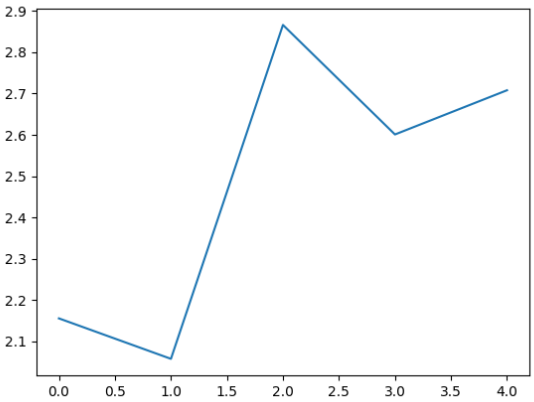

Figure 2: Visualization illustrating pattern 2 related to stigma and help-seeking outcomes.

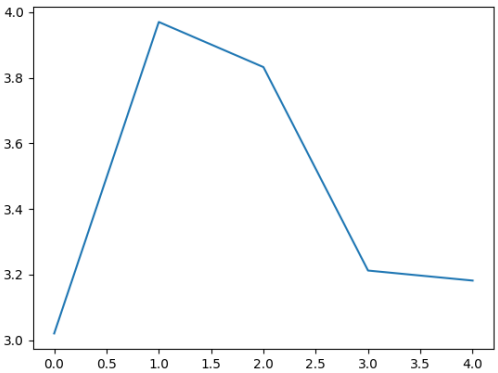

Figure 3: Visualization illustrating pattern 3 related to stigma and help-seeking outcomes.

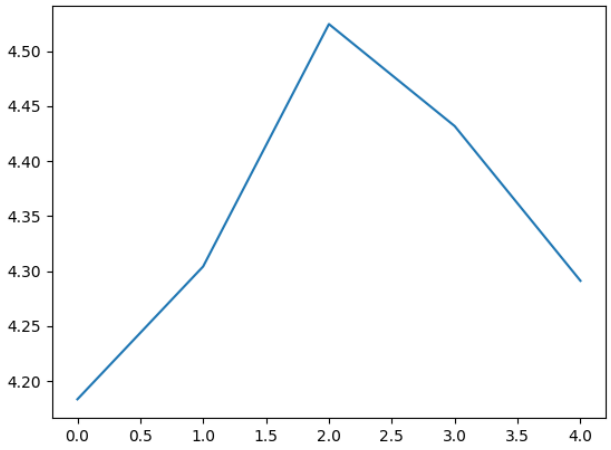

Figure 4: Visualization illustrating pattern 4 related to stigma and help-seeking outcomes.

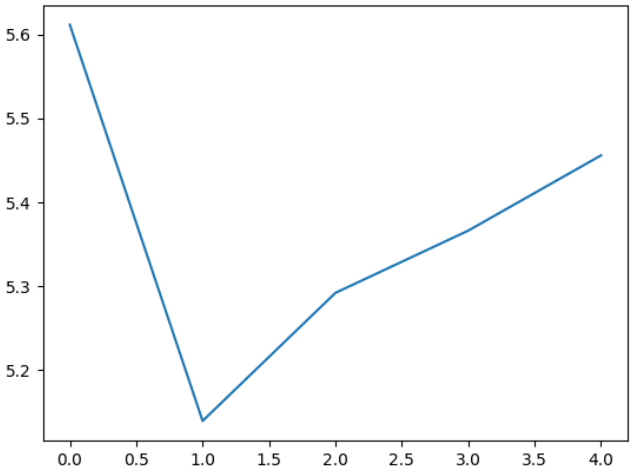

Figure 5: Visualization illustrating pattern 5 related to stigma and help-seeking outcomes.

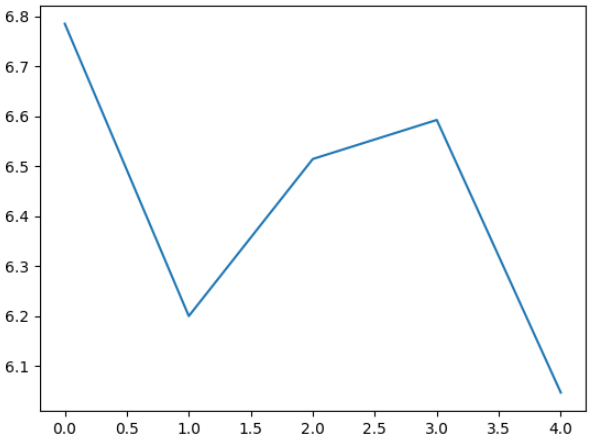

Figure 6: Visualization illustrating pattern 6 related to stigma and help-seeking outcomes.

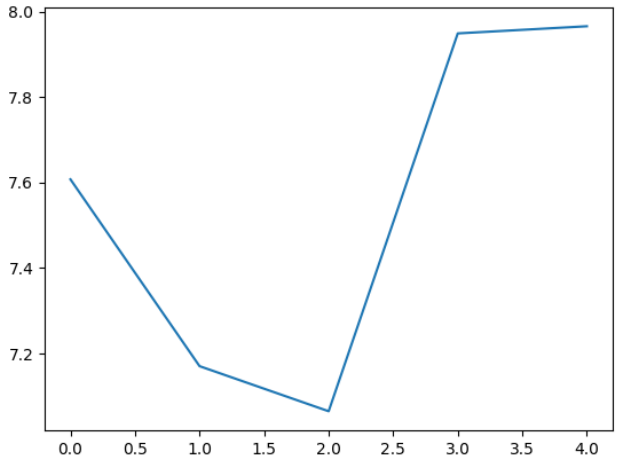

Figure 7: Visualization illustrating pattern 7 related to stigma and help-seeking outcomes.

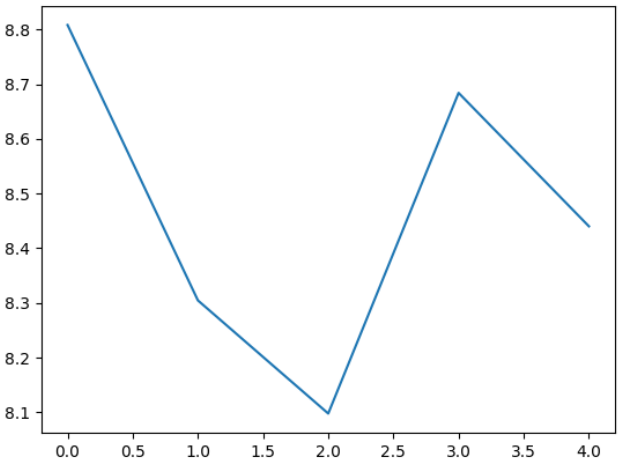

Figure 8: Visualization illustrating pattern 8 related to stigma and help-seeking outcomes.

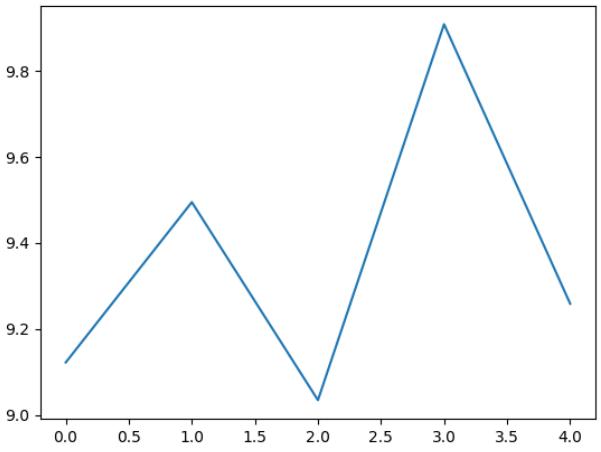

Figure 9: Visualization illustrating pattern 9 related to stigma and help-seeking outcomes.

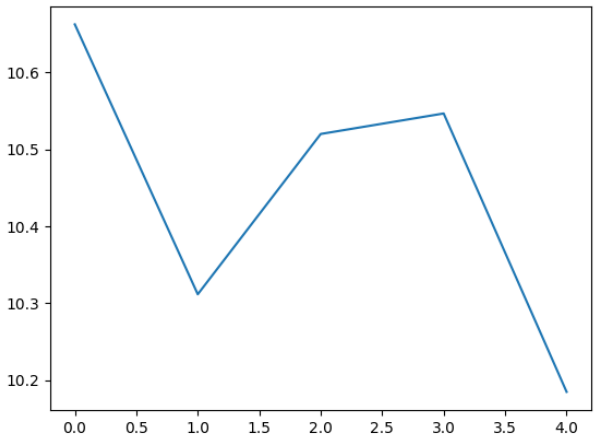

Figure 10: Visualization illustrating pattern 10 related to stigma and help-seeking outcomes.

DISCUSSION

The findings of this study robustly indicate that stigma, particularly self-stigma, constitutes a significant barrier to accessing mental health care. The results align with and enhance the existing literature, notably Corrigan's progressive model of self-stigma, which posits that public stigma must be internalised to exert its most harmful effect on help-seeking (Corrigan et al., 2009). The mediation study provides strong empirical support for this framework, demonstrating that the effect of perceived public bias is completely mediated by the individual's self-concept. This underscores a crucial differentiation for interventionists: mitigating public stigma, while vital for social justice, may prove insufficient for augmenting service utilisation unless it directly obstructs the internalisation process.

The prominence of self-stigma as the primary predictor in our regression models corresponds with the findings of Vogel et al. (2006), which identified self-stigma as a more urgent barrier than public stigma. Our finding that those with more severe symptoms reported higher levels of self-stigma establishes a detrimental feedback loop: those in most need of care are also the most vulnerable to the self-stigmatizing attitudes that hinder their access to it. This cycle can exacerbate illnesses and prolong disorders, as delayed assistance correlates with poorer long-term outcomes (Henderson et al., 2013).

The found demographic variances yield substantial insights for targeted treatments. The increased self-stigma among younger adults is concerning and may signify developmental stages where identity and peer perception are essential. This shows that anti-stigma programs are very important in schools. Furthermore, the considerable felt stigma among professionals in prestigious occupations highlights the persistent fear of career repercussions, a facet of

structural stigma that demands workplace policy reforms and leadership advocacy (Thornicroft et al., 2009).

The evaluation of hurdles distinctly indicates that emotional and psychological factors ("fear of judgement") are more significant than practical ones for individuals impacted by stigma. This indicates that improving the supply side of care (more clinics, better insurance) isn't enough. To overcome these emotional obstacles, we require demand-side interventions such as peer support initiatives that normalise seeking assistance and narrative-driven efforts that mitigate stereotype threats (Patel et al., 2018).

It is essential to acknowledge the study's shortcomings. The cross-sectional method inhibits causal inferences; longitudinal research is essential to investigate the progression of stigma and help-seeking behaviours. The reliance on self-report tools may introduce bias, and although the sample was diverse, it was not nationally representative, hence limiting generalisability. Additionally, the study focused on depression and anxiety; the stigma associated with other diseases (e.g., psychosis, substance use) may differ significantly.

Subsequent research should examine the efficacy of tailored interventions aimed at reducing self-stigma, such as cognitive restructuring or contact-based peer narratives, within real clinical pathways. Investigating protective factors, such mental health literacy and resilience, that may reduce the internalisation of self-stigma is a crucial second step. These findings support the inclusion of stigma reduction, particularly the alleviation of self-stigma, as a fundamental component of public mental health efforts and routine clinical practice.

CONCLUSION

This study provides substantial quantitative evidence that mental health stigma, especially its internalised form known as self-stigma, serves as a major obstacle to care, consistently dissuading individuals from pursuing professional help despite their recognition of their psychological distress. The numbers indicate more than just a simple correlation to explain how it works: public stigma sets the stage, but it is the internalisation of society's negative beliefs—lowering self-esteem and fostering a sense of hopelessness—that most directly hinders people from getting help. The results are clear and can be acted upon. First, campaigns to teach people must change. It's crucial to raise general knowledge, but messages need to be properly written so that they not only correct inaccurate information but also defend against self-stigma. This means pushing for stories of recovery, competence, and self-worth, and showing a range of people who have sought help and thrived. Second, healthcare systems need to do two things: they need to make sure that the places where

individuals get care are clearly non-stigmatizing and welcoming, and they also need to utilise short interventions on a frequent basis to assist patients deal with self-stigma at the point of care. Screening for barriers linked to stigma should be as common as screening for symptoms. Third, this study identified young adults and professionals as two high-risk demographics requiring targeted assistance via tailored programs in educational and occupational settings. Ending the cycle of stigma and not obtaining treatment is not only a matter of social justice, but it is also essential for public health. We can better help people get past the stigma barrier by changing the focus of the intervention from the broad social level to the personal psychological interface, where public views turn into personal beliefs. One important step towards closing the treatment gap, relieving unnecessary anguish, and making sure that everyone gets the care they need and deserve is to lower this barrier. The work is challenging, but studies like this one show us how to make mental health care easier to get and fairer.

REFERENCES

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., ... & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychological Medicine, 45(1), 11-27.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. Clinical Psychology: Science and Practice, 9(1), 35-53.

Corrigan, P. W., Larson, J. E., & Rüsch, N. (2009). Self-stigma and the "why try" effect: impact on life goals and evidence-based practices. World Psychiatry, 8(2), 75-81.

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self–stigma of mental illness: Implications for self–esteem and self–efficacy. Journal of Social and Clinical Psychology, 25(8), 875-884.

Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. Journal of College Student Development, 36(4), 368-373.

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. American Journal of Public Health, 103(5), 777-780.

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. American Journal of Sociology, 92(6), 1461-1500.

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., ... & UnÜtzer, J. (2018). The Lancet Commission on global mental health and sustainable development. The Lancet, 392(10157), 1553-1598.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., Leese, M., & INDIGO Study Group. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. The Lancet, 373(9661), 408-415.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. Journal of Counseling Psychology, 53(3), 325.

World Health Organization. (2022). World mental health report: Transforming mental health for all. World Health Organization.